eHealth Council
February 29, 2012
1:30 PM CT – 4:00 PM CT

Lincoln: Nebraska Educational Telecommunications, 1800 N. 33rd, Board Rm., 1st Floor
Omaha: UNMC, College of Public Health/Maurer Center for Public Health, Room 3020 (see map in meeting documents)
Kearney: Good Samaritan Hospital
To set up additional sites, members can contact Linda Wagner at NET at 402 471-4130.

Meeting Documents

Tentative Agenda

1:30	Roll Call Notice of Posting of Agenda Notice of Nebraska Open Meetings Act Posting ***Approval of April 1, 2011 minutes**** ***Approval of October 5, 2011 minutes**** Public Comment
1:45	**Prescription Drug Monitoring Program**--Dr. Joann Schaefer, Chief Medical Officer and Director, DHHS Division of Public Health, Anne Dworak and Chris Henkenius, NeHII • NeHII PDMP and Immunization Registry Script for HIMSS
2:15	**Membership** ***Membership Renewals**** • Dr. Delane Wycoff • John Roberts • Harold Krueger • Joel Dougherty • Nancy Shank • Donna Hammack **Two vacant positions**
2:20	**Updating Nebraska's Strategic and Operational eHealth Plans** • State HIE Metrics • State HIE Cooperative Agreement Expenditures • ONC Program Information Notice on Updating State eHealth Plans • Expected ONC Program Information Notice on Privacy and Security • ***Proposed Approach to Updating Nebraska's State Plans**** • ***Vision, Goals, Objectives**** • Expected Changes to Nebraska's Plans

2:35	**Direct--**Chris Henkenius, NeHII • NeHII Direct Brochure
3:00	**Updates** • Expected Notices of Proposed Rule Making on Meaningful Use • Legislation—LB 574 Adopt the Electronic Prescription Transmission Act • Evaluation Site visit by NORC at the University of Chicago • NeHII • eBHIN • Wide River Technology Extension Center • Medicaid • Nebraska Statewide Telehealth Network
4:00	Adjourn

Meeting notice posted to the NITC and Public Meeting Website on Feb. 3, 2012. The agenda was posted on Feb. 24, 2012.

**** Indicates action items.***

Dodge Street

40th Street

N

Access to MCPH (Maurer Center for Public Health)

Take Dodge to 40th Street

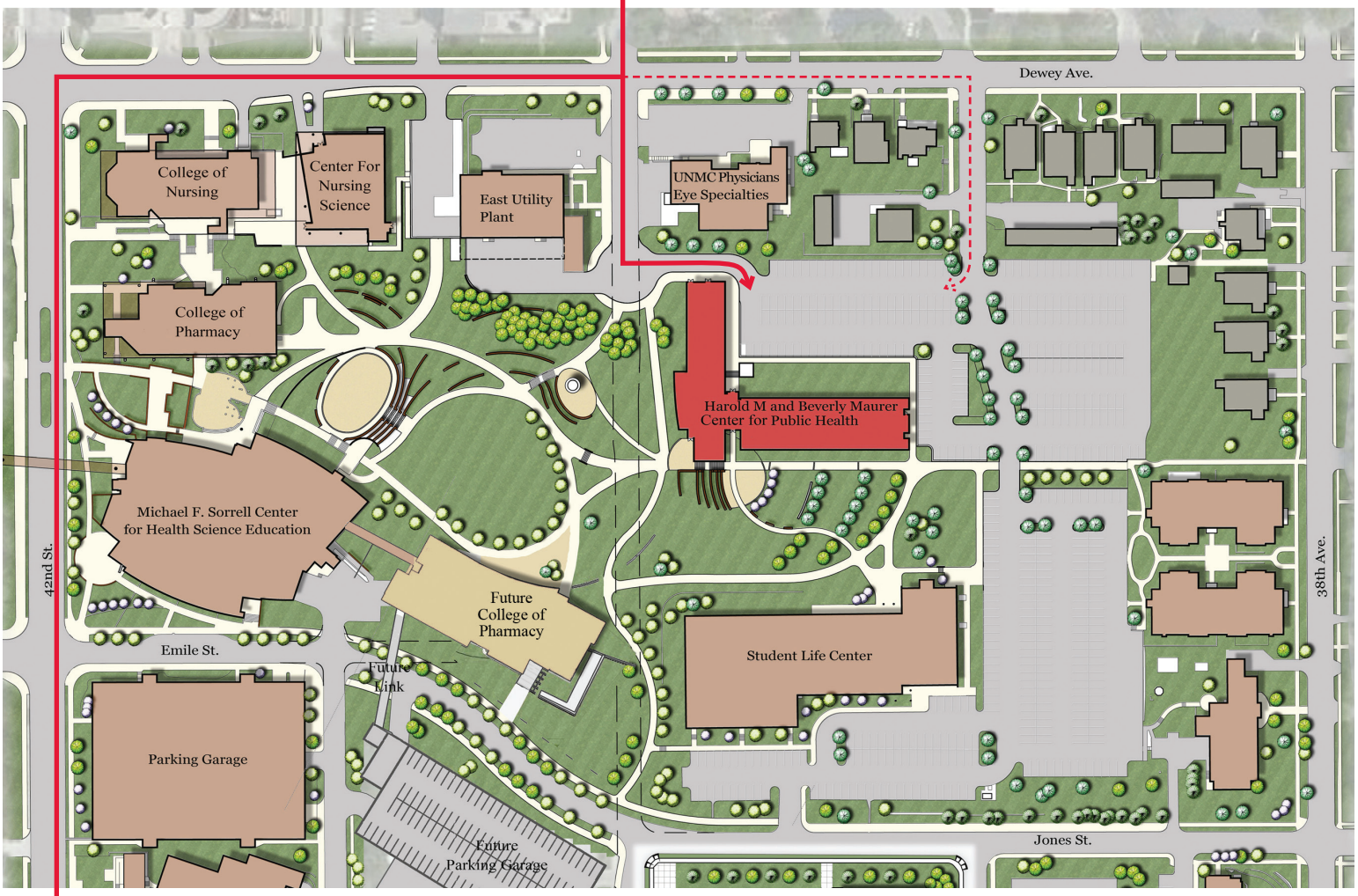
Turn South on 40th Street

Drive past Dewey Street

Turn left into the parking lot behind (north side) the MCPH

Visitor parking is towards the west end of the parking lot

------- alternatre route during construction



From I-80:

Take 42nd Street North to Dewey

Turn Right on Dewey

Turn Right on 40th Street

Turn Left into the parking lot behind (north side) the MCPH

University of Nebraska Medical Center

EHEALTH COUNCIL

April 1, 2011, 9:30 PM CT – 12:00 PM noon CT
Lincoln: Nebraska Educational Telecommunications, 1800 N. 33rd, Board Rm., 1st Floor
Omaha: UNMC, Durham Research Center Room 1006*

PROPOSED MINUTES

MEMBERS PRESENT
Wende Baker (Lincoln site)
Joyce Beck (Hebron)
Vivianne Chaumont (Lincoln site)
Joni Cover (Lincoln site)
Joel Dougherty (Lincoln site)
Donna Hammack (Lincoln site)
Rama Kolli, Alt. for Susan Courtney (Lincoln site)
Ken Lawonn (Omaha Site)
Sue Medinger (Lincoln site)
Marsha Morien (Omaha Site)
Greg Schieke (Lincoln site)
Lianne Stevens (Lincoln site)
Patrick Werner, Alt. for Steve Urosevich (Lincoln site)
Delane Wycoff (North Platte)

MEMBERS ABSENT: Senator Annette Dubas, Congressman Jeff Fortenberry, Kimberly Galt, Alice Henneman, Harold Krueger, Kay Oestmann, John Roberts, Nancy Shanks

Guests and Staff: Anne Byers, Lori Lopez Urdiales, Deb Bass, and Chris Henkenius

ROLL CALL, NOTICE OF POSTING OF AGENDA, NOTICE OF NEBRASKA OPEN MEETINGS ACT POSTING

The meeting notice was posted to the NITC and Public Meeting Website on March 22, 2011. The agenda was posted on March 25, 2011.

APPROVAL OF SEPTEMBER 13, 2010 MINUTES

Mr. Lawonn pointed out that his last name was misspelled in the NeHII update section.

Mr. Hammack moved to approve the September 13, 2010 minutes with the noted correction. Ms. Baker seconded. Roll call vote: Baker-Yes, Beck-Yes, Chaumont-Yes, Kolli-Yes, Cover-Yes, Dougherty-Yes, Hammack-Yes, Lawonn-Yes, Medinger-Yes, Morien-Yes, Schieke-Yes, Stevens-Yes, Werner-Yes, and Wycoff-Yes. Results: Yes-14, No-0, Abstain-0. Motion carried.

PUBLIC COMMENT

There was no public comment.

MEMBERSHIP (Renewals and New Members)

The terms of several members were up for renewal, including Lianne Stevens, September Stone, Ken Lawonn, Sue Medinger, Marsha Morien, Vivianne Chaumount, and Greg Schieke. Laura Meyers, Nebraska Statewide Telehealth Network, was nominated as a new member. NITC staff is waiting to hear from the Lt. Governor's Office regarding the legislative and congressional memberships.

Ms. Cover moved to approve the slate of membership renewals and the nomination of Laura Meyers. Mr. Dougherty seconded. Roll call vote: Wycoff-Yes, Werner-Yes, Stevens-Yes, Schieke-Yes, Morien-Yes, Medinger-Yes, Lawonn-Yes, Hammack-Yes, Dougherty-Yes, Cover-Yes, Kolli-Yes, Chaumont-Yes, Beck-Yes, and Baker-Yes., Results: Yes-14, No-0, Abstain-0. Motion carried.

UPDATES FROM RELATED INITIATIVES

NeHII. Deb Bass reported that NeHII currently has 1200 users. There has been an increase in e-prescribing. A letter of understanding has been signed with the State of Wyoming to provide services. Discussion meetings with Medicaid have been going well. The exchange of immunization data is in the testing phase. Membership is expanding to include chiropractors. Two pharmacies in Omaha have signed participation agreements. NeHII's annual meeting will be held on July 21st in North Platte. Council members were invited to attend.

eBHIN. Wende Baker distributed the BHIN Fact Sheet Winter 2010/2011. Equipment has been purchased and applications have been installed. Cooperative testing will be done. Great partnerships have been developed with non-profit organizations. This last quarter the project has been working on referral capabilities. In May, training will be developed and will hopefully occur in late spring.

Nebraska Statewide Telehealth Network. Laura Roberts gave a report on the Nebraska Statewide Telehealth network. A written report was provided in the meeting materials. The network had over 2,500 consultations last year. The six-month report is being developed that is due in May. The project has been in discussions with Veterans Administration to provide services. Neighboring states have been contacted regarding a regional telehealth network effort. Discussions have also occurred with the FCC regarding grandfathering sites eligible for support from the universal service fund. Critical Access Hospitals are now represented on the Governing Committee.

SENHIE. Joyce Beck gave an update on SENHIE. A new EMR will go live on July 1. In July, testing for meaningful use will occur. Telehealth equipment has been installed in the emergency room. Project staff have been providing presentations and promoting electronic health records all across the country.

Medicaid. Vivianne Chaumount gave an update on the EHR incentive program being implemented by the Centers for Medicare and Medicaid Services (CMS). Under this program, states will distribute incentive payments to qualified Medicaid providers that adopt, implement or upgrade, and meaningfully use certified EHR technology. It is anticipated that Nebraska will submit its State Medicaid Health IT Plan (SMHP) this summer. In preparation, a survey of approximately 3,200 eligible professionals will be conducted. DHHS anticipates receiving CMS approval and beginning EHR Incentive program registration in late 2011. The Department of Health and Human Services has an EHR Incentive Program web page with more specific information and links about the incentive program.

Wide River TEC, Greg Schieke. Since the last Council meeting, the project has focused on the following activities:

- **Recruiting participants**. Currently primarily in rural settings, the project has 500 participants and over 100 clinics. The rural area is an ONC priority. The project is now working on urban participants. The goal is to reach 1,129 participants. Fees will be waived for priority providers.
- **Working with critical access hospitals**. In February, the project received funding to serve all critical access hospitals with meaningful use service.
- **Conducting educational events.** Quarterly, the project conducts events and a vendor fair is included. The next event will be combined with SIMRO in Omaha. After the Omaha event, the project will go out to a totally different part of Nebraska that has not been reached.
- **Integrating EHR in health curriculum.** The project is working with the University of Nebraska-Lincoln to provide grants for updating health curriculum. The second round of funding for instructors is now open. The project is offering an online accreditation training program for clients and partners of Wide River TEC at a cost of $150 for each session.

Metropolitan Community College. Ms. Byers stated that the first group of students will graduate from Metropolitan Community College's health IT program. Ms. Morien stated that a colleague was participating in the program and was very pleased.

OneWorld Community Health Center. Joel Dougherty gave an update. Heartland Community Health Network serves five community health centers in Nebraska and Iowa. In regards to health information exchanged, the project continues to work with eBHIN and Wide River TEC.

UPDATES ON ONC PRIORITY AREAS
Updates on ONC priority areas (lab reporting, e-prescribing, summary care document, provider directory, and public health) will be covered in NeHII presentation. Members can ask questions for clarification during or after the presentation.

Ms. Bass reported that Erica Galvez, the ONC Project Officer assigned to Nebraska will be here in July to visit the project. In addition, site visits to other HIE projects will be conducted.

Ms. Byers participated in a meeting with the Department of Health and Human Services and the Veteran's Administration regarding sharing best practices. It was agreed to invite the VA to a future eHealth Council meeting.

UPCOMING ACTIVITIES
Anne Byers, Community I.T. Manager

In the next few months, Ms. Byers alerted the members that the Council will likely need to update the state eHealth plan as well as develop an evaluation plan.

CONSENT AND DISCLOSURE POLICIES TO ALLOW THE EXCHANGE OF DATA BETWEEN NEHII AND EBHIN, Deb Bass and Wende Baker

Copies of the NeHII Fact Sheet–March 2011 and the eBHIN Fact Sheet–Winter 2011/12 were distributed. Deb Bass gave an update on NeHII. NeHII has been a leader in health information exchange nationally.

NeHII Opt-Out Statistics
- Opt-out rates have remained below 3% since the implementation of NeHII
- Intended for health care professionals access only
- For treatment, payment, and public health purposes
- Personal health information will not be sold

What Health Information Will Be Shared
- Lab and X-ray Results
- Medication and Immunization History
- Transcribed Diagnostic and Treatment Records
- Records of Allergies and Drug Reactions
- Other Clinical Reports Created After the Start Date of NeHII in 2009

Participating providers will generally not share records related to:
- Alcohol or Substance Abuse Treatment Programs
- Emergency Protective Custody Proceedings
- Predictive Genetic Testing Performed for Genetic Counseling
- HIV Testing
- STD Testing or Treatment of Minors Consented to by the Minor
- Mental Health Treatment in Iowa

However, information about test results may be available or referred to elsewhere in the record.

Opt-In to Opt-Out/eBHIN to NeHII:
- Greatest challenge: policy and consent agreements
- Plan to use NHIN Direct/Statewide Provider Directory from the EMR to the HIE
- Use case for data flow
- Approval by the Privacy/Security Committees
- Go live date planned Summer 2011

Wende Baker gave a presentation on eBHIN. Statistically persons with behavioral health disorders tend to die 25 years sooner than those without behavioral disorders. This statistic is what drives eBHIN's goals.

Background:

- eBHIN participants are behavioral health and alcohol/drug abuse treatment programs
- HIPAA applies
- More stringent 42 CFR Part 2 also applies
- The challenge: exchanging specially-protected B/H and alcohol/drug abuse program information through an electronic health information exchange

Operating Features

- Based on centralized data repository and standardized patient record exchange
- Uses an opt-in platform
- HIPAA & 42 CFR Part 2 Compliant
- Utilizes software developed by NextGen Healthcare Information Systems - HIE integrated with BH EMR
- EMR posted in the Certified Health IT Products List (CHPL)

Challenges:

- Privacy and Security most consistent concerns expressed -- skepticism about ability to meet standards
- Technical requirements extend design investments
- Limited funding base for Behavioral Health makes stakeholder investments scant

Successes:

- Standard authorization data set made a reasonable place to start
- Consent Development process has built stakeholder confidence in standards compliance
- Capital Investment – ARRA and Regional BH Authority contributions have brought "buy-in" down and provided resources for development

Baird Holm is assisting the project with the consent form. BHIN wants the consent form to be understandable to the consumer.

HEALTH INSURANCE EXCHANGE
J.P. Sabby, Nebraska Department of Insurance

There are currently 210,000 uninsured persons in the State of Nebraska.

Current Status of Federal PPACA (Patient Protection and Affordable Care Act)

- States are required to begin planning and implementation
- Current lawsuits pending- A final decision will need to be made by the U.S. Supreme Court. This may not occur soon
- Now seeking public input

Statutory Timeline for Exchange Creation

- Each state will have some type of an Exchange
- Secretary of Federal HHS must certify, by January 1, 2013, a state's plan to operate a qualified exchange
- If a state does not operate an Exchange, the federal government will operate it.
- Each state must have the Exchange operational by January 1, 2014
- Includes both individual market and small group market Exchanges (these may be combined)
- The Exchange must be self-sustaining by 2015

Discussion Points Our State Needs to Address:

1. How should exchanges be governed? Should they be run by a state agency, a nonprofit or a quasi private public partnership?
2. What can be done to make exchanges attractive to employers?
3. How should the exchanges fulfill their responsibility to make both descriptive and evaluative information available to consumers?

The Nebraska Department of Insurance is in the process of determining if this is feasible for Nebraska. DOI has conducted five stakeholder meetings across the state to get input. They are also conducting research to determine if there is a sound business model. An RFI (Request for Information) for IT has

been released. Mr. Sabby asked for names of persons who would be interested The Center for Medicare and Medicaid Services (CMS) as well as suggestions for reaching more citizens.

BROADBAND MAPPING AND PLANNING

Ms. Byers reviewed the broadband maps and available layers of data. Service providers were not required to provide data, so not all providers are represented. Since the Nebraska and national maps are now available, more service providers have expressed interest in participating.
National Broadband Map—broadbandmap.gov
Nebraska Broadband Map—http://broadbandmap.nebraska.gov/

ADJOURNMENT

With no further business, Ms. Byers adjourned the meeting at 11:50 a.m.

The meeting minutes were taken by Lori Lopez Urdiales and reviewed by Anne Byers, Office of the CIO/NITC.

EHEALTH COUNCIL

October 5, 2011 9:30 a.m.–12:00 p.m. noon CT
Mahoney State Park, Peter Kiewit Lodge
Ashland, Nebraska

MEMBERS PRESENT

Wende Baker
Joni Cover
Sue Medinger
Laura Meyers
Marsha Morien
Rita Parris
Greg Schieke
Lianne Stevens
September Stone
Delane Wycoff

MEMBERS ABSENT: Joyce Beck, Susan Courtney, Vivianne Chaumont, Joel Dougherty; Senator Annette Dubas, Congressman Jeff Fortenberry, Kimberly Galt, Donna Hammack , Alice Henneman, Harold Krueger, Ken Lawonn, Kay Oestmann, John Roberts, Nancy Shanks, and Steve Urosevich

Guests and Staff: Anne Byers, Lori Lopez Urdiales, Sarah Briggs and Chris Henkenius

ROLL CALL NOTICE OF POSTING OF AGENDA NOTICE OF NEBRASKA OPEN MEETINGS ACT POSTING

Ms. Morien called the meeting to order at 9:35 a.m. Nine members were present. There was not a quorum to vote on action items. The meeting proceeded with informational items. The meeting notice was posted to the NITC and Public Meeting websites on October 3, 2011. The agenda was posted on October 3, 2011.

APPROVAL OF APRIL 1, 2011 MINUTES

Approval of the minutes was tabled until a quorum was present or until the next meeting.

Ms. Cover arrived to the meeting.

PUBLIC COMMENT

There was no public comment.

UPDATES

The Federal Health IT Strategic Plan: 2011-2015. This was provided as an informational item to members. Ms. Byers pointed out that there is a greater emphasis on the following:

- Long term care, behavioral health and emergency settings
- Continued focus on privacy
- Streamling licensure applications
- Patient safety
- Reporting adverse events

State HIE Progress Report. The most recent progress report for the State HIE Cooperative Agreement was submitted on September 30, 2012.

RELATED INITIATIVES

NeHII—Chris Henkenius. Fifteen new hospitals have signed participation agreements with NeHII. Pharmacies are being added to NeHII as well. NeHII is implementing Direct which allows users to send health information via secure e-mail. Pathology Services in North Platte will pilot the use of Direct to send lab results. The fee for using Direct will be $15/per person per month.

eBHIN—Wende Baker. In June, eBHIN went live with data entry and upload to Magellan. The feedback from users so far has been positive. Changing to electronic health records is a culture change, however. The project is currently working with 11 organizations and 15 private practices. A grant has been submitted which would allow eBHIN to expand services to Region I in the Nebraska Panhandle. Region 2 and Region 3 are considering connecting to EBHIN. Region 6 is also being approached to be a partner.

Nebraska Statewide Telehealth Network—Laura Meyers. The Nebraska Statewide Telehealth Network is in its third year of a grant from the Office for the Advancement of Telemedicine. Units continue to be placed in physician offices. Many hospital emergency departments statewide are using telehealth. The Nebraska Statewide Telehealth Network is piloting the use of VIDYO This system will allow iPad and iPhone end users to connect to the telehealth network. Max Thacker, University of Nebraska Medical Center (UNMC) has just started using VIDYO. The Nebraska Statewide Telehealth Network is exploring the use of a fee structure. The Nebraska Statewide Telehealth Network does not currently charge user fees. Each hospital pays $100/month for telecommunications charges.

Medicaid--Sarah Briggs, DHHS Division of Medicaid and Long-Term Care. Under the Medicaid Electronic Health Record (EHR) Incentive Program, states will distribute incentive payments to qualified Medicaid providers that adopt, implement or upgrade, and meaningfully use, certified EHR technology. Nebraska's draft State Medicaid Health Information Technology Plan (SMHP) is available on the State's Medicaid website. The Centers for Medicare & Medicaid Services (CMS) requested additional information on Nebraska's SMHP. The additional information requested was sent to CMS last week. The incentive program cannot begin until the SMHP is approved. DHHS will determine the best launch date once the SMHP is approved.

Wide River Technology Extension Center—Greg Schieke. Wide River Technology Extension Center is in the "heart" of the work of its four-year grant. It is technically a two-year grant with a two-year renewal. The project must go through a biennial evaluation. The evaluation will occur in January. Evaluation criteria include the number of providers recruited and the number of go-live sites. Wide River Technology Extension Center clients have been pleased with the services provided. Clients have given Wide River Technology Extension an average score of 4.8 out of 5 on customer satisfaction surveys.

UPDATES ON OFFICE OF THE NATIONAL COORDINATOR (ONC) PRIORITY AREAS

e-Prescribing/E-Prescribing Work Group. E-Prescribing continues to grow in Nebraska. ONC provided e-prescribing statistics from data from Surescripts. There are now over 2,300 e-prescribers in Nebraska. Eighty-eight percent of community pharmacies in Nebraska accept e-prescriptions. Rusty Keith from Surescripts participated in a conference call with the E-Prescribing Work Group. The call was very informative. There were questions regarding whether or not Nebraska's laws and regulations allow for e-prescribing Schedule II drugs. The E-Prescribing Work Group worked with Wide River Technology Extension Center to plan a panel discussion with pharmacists and prescribers at Wide River Technology Extension Center's Meaningful Use Summit in Scottsbluff on August 24.

Ms. Baker left the meeting.

Lab reporting, exchange of summary care documents, and public health will be discussed at the next meeting.

BROADBAND UPDATES

Members were reminded about the Broadband Conference to be held on November 1, 2011 at the Cornhusker Marriott in Lincoln, Nebraska.

IDENTIFICATION OF EVALUATION CRITERIA*

ONC requires State HIE grantees to conduct an evaluation. Ms. Byers asked Council members what measures they would like included in the evaluation. A two-tier approach is proposed to evaluate the project's goals and objectives:

- Tier one will assess outcomes. Outcome measures will focus on how well Nebraska has developed a functioning eHealth environment with widespread participation by providers and consumers.
- Tier two will assess impact. Impact measures will focus on improvements in health care quality and efficiency.

State purchasing laws will be followed to contract with an evaluator. The State of Nebraska can contract with Nebraska public entities without issuing an RFP. If it is determined that a public entity is not qualified to conduct the evaluation, an RFP will need to be released.

Council members liked the two-tiered approach. Members discussed evaluating reductions in redundant lab testing. The rate of redundancy would be difficult to evaluate because doctors often order new lab tests to see if there is a change in the conditions of patients. Members suggested focusing on diagnostic radiology testing. Members suggested checking with ONC for measures being used by Beacon Communities. Members also suggested evaluating the value of HIE in emergency departments.

Ms. Byers will take the Council's input back to the work group to revise the document. Council approval was not needed to move the evaluation tool forward.

CONSUMER EDUCATION WEBSITE

The State Cooperative Agreement includes funding for the development of a consumer education website. Members recommended using the funding for other another consumer-related activity.

ADJOURN

With no further business, Ms. Morien adjourned the meeting at 11:45.

The meeting minutes were taken by Lori Lopez Urdiales and reviewed by Anne Byers of the Office of the CIO.

HIMSS 2012 NeHII PDMP & Immunization Registry Talking Points:

- LB 237 authorizes the Department of Health and Human Services to collaborate with NeHII to establish a prescription drug monitoring program and was approved by Governor Heineman on April 14, 2011.
- We use the medication history information found on NeHII's Virtual Health Record (VHR). NeHII can only be accessed by providers (law enforcement does not have access) and the process is as follows:
    - Physician logs into VHR with username and password
    - Physician searches for patient by entering first name, last name, and date of birth on the PT Index Page
    - Physician clicks on patient summary tab and scrolls down to medication history
    - Physician clicks on the query button to display all prescriptions that have been filled as provided by the PBM (pharmacy benefit manager)
    - Benefit of NeHII is near real time and includes all medications, not just narcotics
    - The physician also has access to the complete medical history in order to make critical decisions regarding the use of pain relievers

- LB591 was passed in August, 2011 that supports immunization reporting.
- Through the EMRLite and the HIE, NeHII transmits vaccination information from the EMRLite to NESIIS, the Nebraska State Immunization Registry. The process is as follows:
    - Physician logs into the EMRLite application
    - Physician searches for patient by entering the patient's first name, last name, and date of birth on the PT Index Page
    - Patient information is populated and physician can scroll down to vaccinations
        - Dorothy Way is the test patient used in this demo to view vaccinations entered into the EMRLite and transmitted to NESIIS
        - The 11/9/2011 flu, rabies, TD and varicella vaccinations were the test vaccinations sent from NeHII to NESIIS, the screenshots are from NESIIS
    - To show how vaccinations are entered into the EMR, we will use a test patient Tad Dockendorf
    - Search prescription vaccine and choose appropriate vaccine
    - Complete the required information
    - Educate patient regarding the vaccination and possible side effects, allergies etc
    - Save Rx information
        - Batch file is created each night in NeHII moving vaccination information from the medication list to the vaccination list
        - A Public Health Information Network Messaging System (PHINMS) interface sends the batched immunization file directly to NESIIS.
        - Records are updated/added to NESIIS for viewing by any providers who utilize NESIIS.

eHealth Council Members

The State of Nebraska/Federal Government

- **Senator Annette Dubas**, Nebraska Legislature (term ends Dec. 2010, renew every 2 years)
- **Steve Urosevich (**term ends Dec. 2012)
- **Congressman Jeff Fortenberry**, represented by Marie Woodhead (term ends Dec. 2012, renew every 2 years)

Health Care Providers

- **Lianne Stevens**, The Nebraska Medical Center (term ends Dec. 2013)
- **Dr. Delane Wycoff**, Pathology Services, PC (term ends Dec. 2011)
  - **Dr. Harris A. Frankel** (alternate)
- **Joni Cover,** Nebraska Pharmacists Association (term ends Dec. 2012)
- **September Stone**, Nebraska Health Care Association (term ends Dec. 2013)
- **John Roberts**, Nebraska Rural Health Association (term ends Dec. 2011)

eHealth Initiatives

- **Laura Meyers,** Nebraska Statewide Telehealth Network and St. Elizabeth Foundation (term would end Dec. 2012)
- **Ken Lawonn**, NeHII and Alegent Health (term ends Dec. 2013)
- **Harold Krueger**, Western Nebraska Health Information Exchange and Chadron Community Hospital (term ends Dec. 2011)
- **Wende Baker**, Southeast Nebraska Behavioral Health Information Network and Region V Systems (term ends Dec. 2012)
- **Joyce Beck**, Thayer County Health Services (term ends Dec. 2011)

Public Health

- **Sue Medinger**, Department of Health and Human Services, Division of Public Health (term ends Dec. 2013)
- Vacant (term ends Dec. 2011)
  Rita Parris, Public Health Association of Nebraska, alternate
- **Kay Oestmann**, Southeast District Health Department (term ends Dec. 2012)
- **Marsha Morien**, UNMC College of Public Health (term ends Dec. 2013)
- **Joel Dougherty**, OneWorld Community Health Centers (term ends Dec. 2011)

Payers and Employers

- **Susan Courtney**, Blue Cross Blue Shield (term ends Dec. 2012)
- **Vivianne Chaumont**, Department of Health And Human Services, Division of Medicaid and Long Term Care (term ends Dec. 2013)

Consumers

- **Nancy Shank**, Public Policy Center (term ends Dec. 2011)
- **Alice Henneman**, University of Nebraska-Lincoln Extension in Lancaster County (term ends Dec. 2012))

Resource Providers, Experts, and Others

- **Kimberly Galt**, Creighton University School of Pharmacy and Health Professions (term ends Dec. 2012).
- **Greg Schieke, Wide River Technology Extension Center** (term ends Dec. 2013)
  - Todd Searls, Wide River Technology Extension Center (alternate)
- **Donna Hammack, St. Elizabeth Medical Center (term ends Dec. 2011)**

Nebraska eHealth

Stakeholder Update

January 2012

Progress of eHealth in 2011

On March 15, 2010, the Nebraska Information Technology Commission received $6.8 million in funding from the U.S. Department of Health and Human Services, Office of the National Coordinator for Health IT through the HITECH ACT enacted as part of the American Recovery and Reinvestment Act of 2009. The Nebraska Information Technology Commission is partnering with NeHII (Nebraska Health Information Initiative), eBHIN (Electronic Behavioral Health Information Network, the Nebraska Department of Health and Human Services Division of Public Health, and the Nebraska Statewide Telehealth Network to implement the cooperative agreement.

Over the past seven months, NeHII has begun implementation activities with 1 new hospital—Regional West Medical Center in Scottsbluff—and recruited 19 hospitals, including 15 Critical Access Hospitals, Boys Town National Research Hospital, Columbus Community Hospital, BryanLGH West and BryanLGH East. When these hospital implementations are completed in 2012, approximately two-thirds of the state's hospital beds will be covered by NeHII. NeHII now has over 2,000 users up from 1,288 on Dec. 31, 2010.

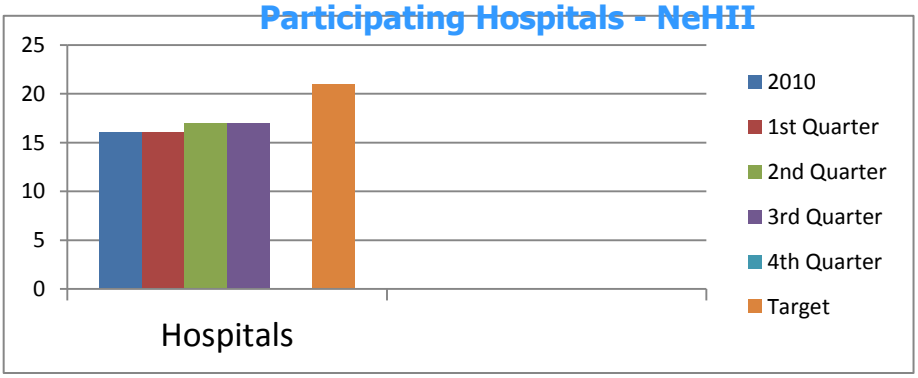
NeHII and the Nebraska Department of Health and Services Division of Public Health have been working with NeHII's vendor, Axolotl, to exchange information between the State of Nebraska's immunization registry, NESIIS, and NeHII. Phase I of the exchange is operational, allowing the exchange of data from NeHII's EHR users to the immunization registry. Work continues on the other two phases of the project. NeHII, Axolotl, and the NDHSS Division of Public Health are also working on the exchange of information between NeHII and the State's disease reporting system (NEDSS) and the State's syndromic surveillance system.

NeHII began a pilot of the Direct project in late 2011 for results delivery with Pathology Services in North Platte.

Nebraska is also developing one of the country's first behavioral health information exchanges. eBHIN went live with its EHR/EPM system and data upload to Magellan, the State's administrative services organization, in the summer of 2011 in southeast Nebraska. In December 2011, behavioral health providers in Region I in the Panhandle went live with the EHR/EPM system. The HIE will go live in both regions early in 2012.

Inside this issue:

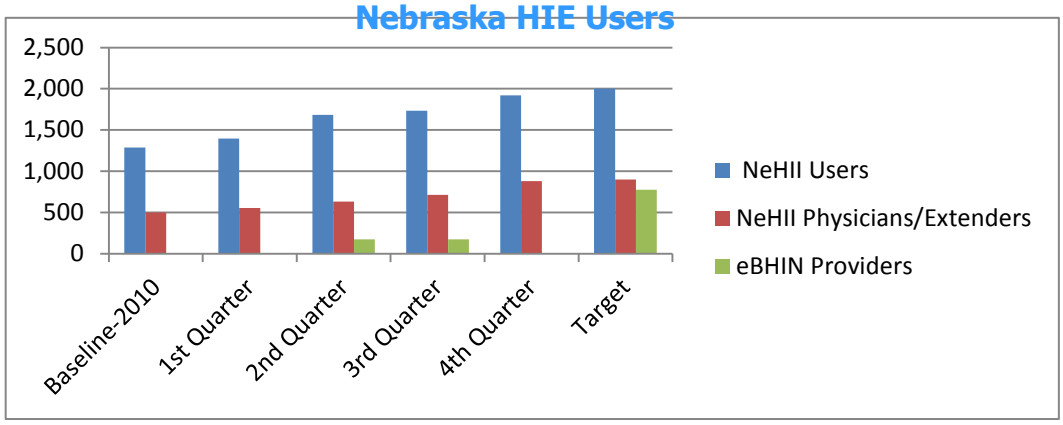
Participating Hospitals - NeHII



Baseline—2010	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Target-2011
NeHII 16 hospitals* 13% of Nebraska hospitals 39% of hospital beds	16 hospitals (13 Nebraska & 3 Iowa)	17 hospitals (14 Nebraska & 3 Iowa)	17 hospitals (14 Nebraska & 3 Iowa) *14 Critical Access Hospitals, 2 regional hospitals and 1 research hospital have signed participation agreements in Q3	17 hospitals (14 Nebraska & 3 Iowa) with Regional West Medical Center in implementation phase. 19 hospitals, including 15 Critical Access Hospitals, Boys Town National Research Hospital, Columbus Community Hospital, BryanLGH West and BryanLGH East have signed participation agreements.	NeHII 21 hospitals 22% of Nebraska hospitals 45% of hospital beds eBHIN 1 hospital

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
• Bellevue Medical Center - Bellevue, NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital -Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital -Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital - Corning, IA • Mercy Hospital - Council Bluffs, IA	• Bellevue Medical Center - Bellevue, NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Creighton University and Medical Center, Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital -Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital -Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital - Corning, IA • Mercy Hospital - Council Bluffs, IA	• Bellevue Medical Center - Bellevue, NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Creighton University and Medical Center, Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital -Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital -Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital - Corning, IA • Mercy Hospital - Council Bluffs, IA • 14 Critical Access Hospitals, 2 regional hospitals and 1 research hospital have signed participation agreements in Q3	• Bellevue Medical Center - Bellevue, NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Creighton University and Medical Center, Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital -Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital -Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital - Corning, IA • Mercy Hospital - Council Bluffs, IA • 19 hospitals, including 15 Critical Access Hospitals, Boys Town National Research Hospital, Columbus Community Hospital, BryanLGH West and BryanLGH East have signed participation agreements.

Nebraska HIE Users

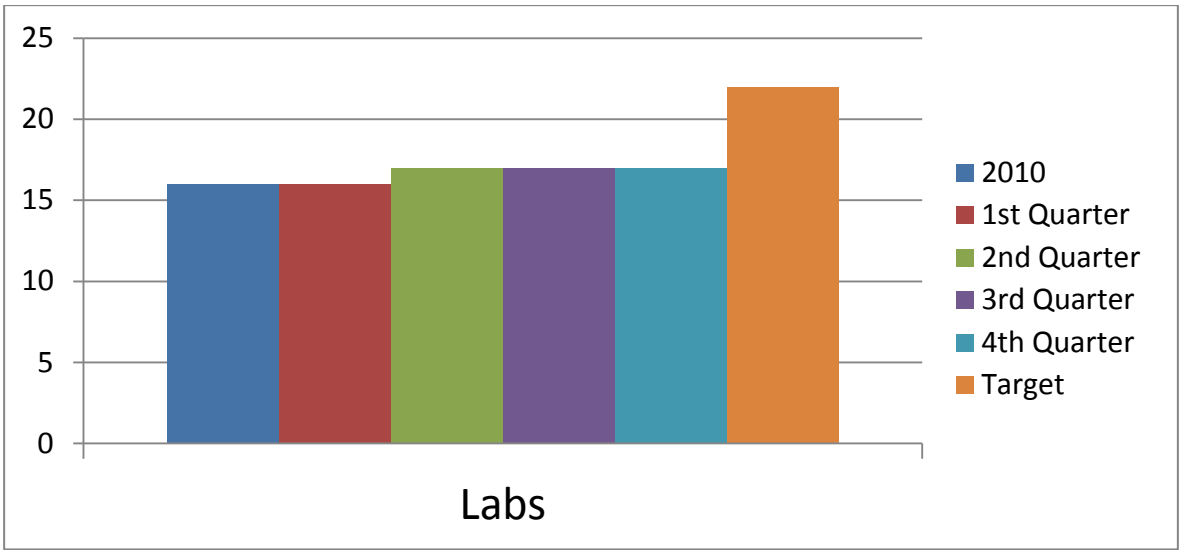


Baseline-2010	1st Quarter 2011	2nd Quarter 2011	3rd Quarter 2011	4th Quarter 2011	Target 2011
NeHII 1,288 total users, including physicians, mid-levels, nurses, pharmacists, and staff 500 Physician and Physician Extenders out of 4,266 in state 12% of physicians and physician extenders	1,396 total users, including physicians, mid-levels, nurses, pharmacists, and staff 554 physician and physician extenders	1,683 total users including physicians, mid-levels, nurses, pharmacists and staff 633 physician and physician extenders eBHIN – 175 providers 4% of behavioral health providers	1,773 total users including physicians, mid-levels, nurses, pharmacists and staff 714 physician and physician extenders eBHIN – 175 providers 4% of behavioral health providers	1,922 total users including physicians, mid-levels, nurses, long-term care providers, and home health) 880 physicians and physician extenders eBHIN – 259 providers	2,000 total users, including physicians, mid-levels, nurses, pharmacists, and staff 900 physicians and physician extenders out of 4,266 in state 21% of physicians and physician extenders eBHIN 776 providers out of 3,929 behavioral health providers 20% of behavioral health providers

Health Plan Participation - NeHII

Baseline-2010	1st Quarter 2011	2nd Quarter 2011	3rd Quarter 2011	4th Quarter 2011	Target 2011
1 health plan (BlueCross BlueShield of Nebraska) currently participates	1 health plan	1	1	1	1

Quantity of Participating Laboratories—NeHII



Baseline-2010	1st Quarter 2011	2nd Quarter 2011	3rd Quarter 2011	4th Quarter 2011	Target 2011
NeHII 0 out of six independent reference labs 10 hospital labs out of 90 hospital labs 10% of 96 hospital and major independent reference labs	16 hospitals (13 Nebraska & 3 Iowa)	17 hospitals (14 Nebraska & 3 Iowa)	17 hospitals (14 Nebraska & 3 Iowa) *14 Critical Access Hospitals, 2 regional hospitals and 1 research hospital have signed participation agreements in Q3	17 hospitals (14 Nebraska & 3 Iowa) *14 Critical Access Hospitals, 2 regional hospitals and 1 research hospital have signed participation agreements in Q3	NeHII 1 out of six independent reference labs 21 hospital labs out of 90 hospital labs 21% of hospital and independent reference labs eBHIN N/A. eBHIN will most likely go through NeHII for laboratory information.

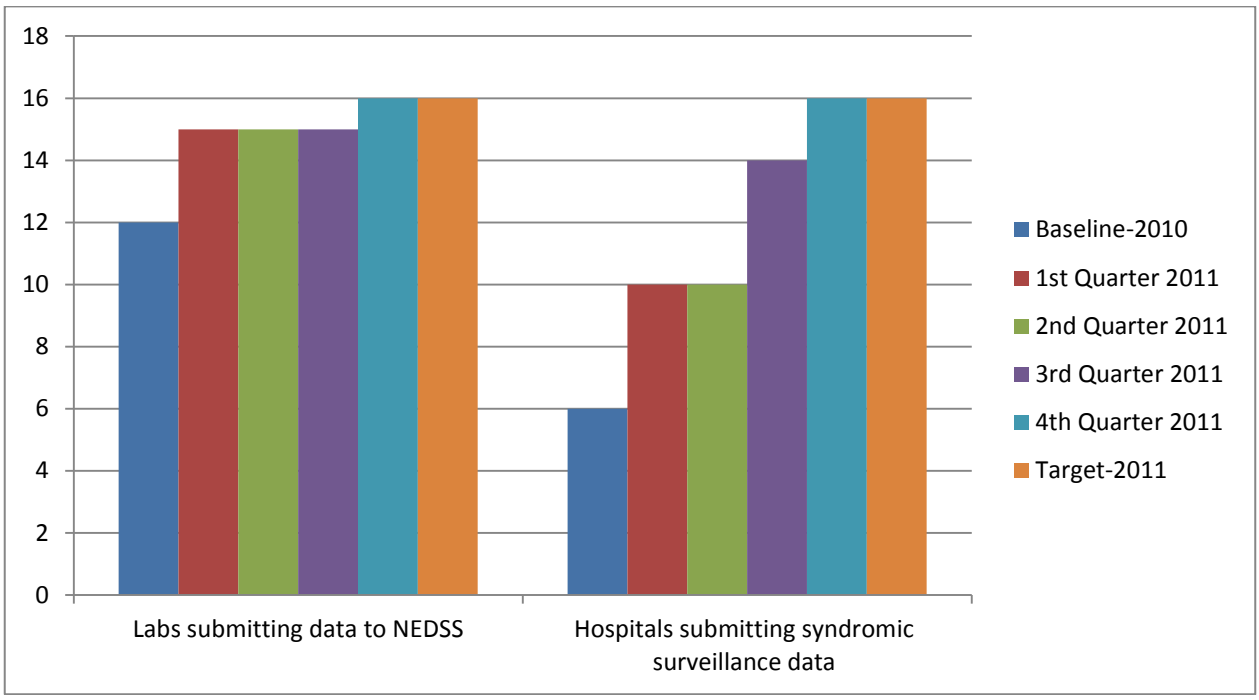
Specific Laboratory Participation—NeHII

1st Quarter 2011	2nd Quarter 2011	3rd Quarter 2011	4th Quarter 2011
• Bellevue Medical Center - Bellevue, NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital - Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital - Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital, Corning, IA • Mercy Hospital – Council Bluffs, IA	• Bellevue Medical Center - Bellevue, NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Creighton University and Medical Center, Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital - Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital - Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital - Corning, IA • Mercy Hospital - Council Bluffs, IA	• Bellevue Medical Center - Bellevue, NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Creighton University and Medical Center, Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital - Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital - Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital - Corning, IA • Mercy Hospital - Council Bluffs, IA *14 Critical Access Hospitals, 2 regional hospitals and 1 research hospital have signed participation agreements in Q3	• Bellevue Medical Center - Bellevue NE • Bergan Mercy Hospital - Omaha, NE • Children's Hospital and Medical Center - Omaha, NE • Creighton University and Medical Center, Omaha, NE • Great Plains Regional Medical Center - Omaha, NE • Lakeside Hospital - Omaha, NE • Immanuel Hospital - Omaha, NE • Mary Lanning Memorial Hospital - Hastings, NE • Memorial Hospital - Schuyler, NE • Methodist Hospital - Omaha, NE • Methodist Women's Hospital – Omaha, NE • Midlands Hospital -Papillion, NE • Nebraska Spine Hospital - Omaha, NE • The Nebraska Medical Center - Omaha, NE • Community Memorial Hospital - Missouri Valley, IA • Mercy Hospital - Corning, IA • Mercy Hospital - Council Bluffs, IA *14 Critical Access Hospitals, 2 regional hospitals and 1 research hospital have signed participation agreements in Q3

Providers Submitting to Immunization Registry

Baseline—2010	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Target—End of 2011
238	284	284	290*	450**	An increase of 20% to 286

*Note: 31 providers were sending immunization data electronically at the end of the third quarter.
**Note: 450 providers were sending immunization data electronically at the end of the fourth quarter.



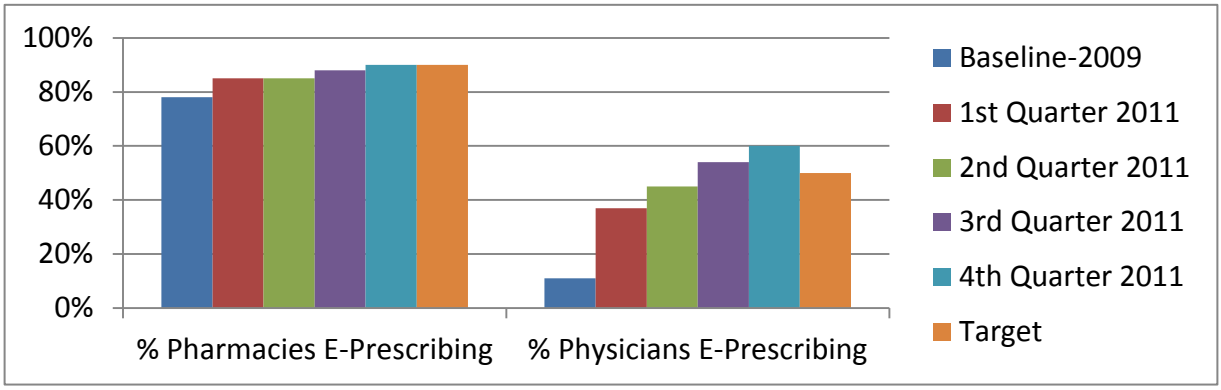
Public Health Reporting	Baseline—2010	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Target—End of 2011
# of labs submitting data to NEDSS	12	15	15	15	16	An increase of 30% to 16
# of hospitals submitting data to the syndromic surveillance system	6	10	10	14	16	16

Labs and Hospitals Participating in Public Health Reporting

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Labs submitting to NEDSS	UNMC - Omaha Bryan LGH - Lincoln Columbus Community Hospital Faith Regional Medical Center - Norfolk Great Plains Regional-North Platte Regional West-Scottsbluff Children's Hospital-Omaha ARUP-serves multiple cities in NE Cerner-serves multiple cities in NE Kearney Good Samaritan-Kearney Creighton Medical-Omaha PLab-Lincoln Quest-serves multiple cities in NE Catholic Health-Grand Island Alegent-Lincoln	UNMC - Omaha Bryan LGH - Lincoln Columbus Community Hospital Faith Regional Medical Center - Norfolk Great Plains Regional-North Platte Regional West-Scottsbluff Children's Hospital-Omaha ARUP-serves multiple cities in NE Cerner-serves multiple cities in NE Kearney Good Samaritan-Kearney Creighton Medical-Omaha PLab-Lincoln Quest-serves multiple cities in NE Catholic Health-Grand Island Alegent-Lincoln	UNMC - Omaha Bryan LGH - Lincoln Columbus Community Hospital Faith Regional Medical Center - Norfolk Great Plains Regional-North Platte Regional West-Scottsbluff Children's Hospital-Omaha ARUP-serves multiple cities in NE Cerner-serves multiple cities in NE Kearney Good Samaritan-Kearney Creighton Medical-Omaha PLab-Lincoln Quest-serves multiple cities in NE Catholic Health-Grand Island Alegent-Lincoln	UNMC - Omaha Bryan LGH - Lincoln Columbus Community Hospital Faith Regional Medical Center - Norfolk Great Plains Regional-North Platte Regional West-Scottsbluff Children's Hospital-Omaha ARUP-serves multiple cities in NE Cerner-serves multiple cities in NE Kearney Good Samaritan-Kearney Creighton Medical-Omaha PLab-Lincoln Quest-serves multiple cities in NE Catholic Health-Grand Island Alegent-Lincoln Fremont Area Medical Center
Hospitals submitting syndromic surveillance data	York General Hospital Children's Hospital-Omaha Great Plains Reg Med Center-North Platte Fremont Area Medical Center Beatrice Comm. Hospital The NE Medical Center-Omaha Nebraska Methodist Hosp – Omaha Mary Lanning Hospital-Hastings Falls City Comm. Medical Center Box Butte General Hospital	York General Hospital Children's Hospital-Omaha Great Plains Reg Med Center-North Platte Fremont Area Medical Center Beatrice Comm. Hospital The NE Medical Center-Omaha Nebraska Methodist Hosp – Omaha Mary Lanning Hospital-Hastings Falls City Comm. Medical Center Box Butte General Hospital	Children's Hospital-Omaha Great Plains Reg Med Center-North Platte Fremont Area Medical Center Beatrice Comm. Hospital The NE Medical Center-Omaha Nebraska Methodist Hosp – Omaha Mary Lanning Hospital-Hastings Falls City Comm. Medical Center Box Butte General Hospital McCook Community Hospital Providence Medical Center (Wayne)	Children's Hospital-Omaha Great Plains Reg Med Center-North Platte Fremont Area Medical Center Beatrice Comm. Hospital The NE Medical Center-Omaha Nebraska Methodist Hosp – Omaha Mary Lanning Hospital-Hastings Falls City Comm. Medical Center Box Butte General Hospital McCook Community Hospital Providence Medical Center (Wayne) Crete Area Medical Center Box Butte Primary Care

Transaction Type	July –Dec 2011
Immunizations into NESIIS	232,458
Lab Results into NEDSS	65,501
Cardiovascular Disease Syndromic Syndromic Surveillance transactions	14,007
ED Syndromic Surveillance transactions	164,827
Total	476,793

E-Prescribing Adoption



Baseline--End of 2009	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Target—End of 2011
78% of community pharmacies activated for e-prescribing	85% of pharmacies are activated for e-prescribing (March 2011) **Note:** Two pharmacies joined NeHII	85% of pharmacies are activated for e-prescribing (May 2011) **Note:** Four more pharmacies joined NeHII, bring the total to six	88% of pharmacies are activated for e-prescribing (August 2011)	90% of community pharmacies are activated for e-prescribing (November 2011)	90% of community pharmacies activated for e-prescribing
11% of physicians in Nebraska routed prescriptions electronically	37% (1197 out of 3202) of physicians in Nebraska are routing prescriptions electronically (March 2011)	45% (1436 out of 3202) of physicians in Nebraska are routing prescriptions electronically (May 2011)	54% (2342 out of 3202) of physicians in Nebraska are routing prescriptions electronically (August 2011)	60% of physicians in Nebraska are routing prescriptions electronically (November 2011)	50% of physicians in Nebraska routing prescriptions electronically

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Nebraska State HIE Cooperative Agreement Expenditures

Feb. 22, 2012

	Expended	Allocated	% Expended
NeHII	$3,939,876.01	$4,898,275.00	80%
State/NITC	$84,290.91	$157,075.00	54%
Evaluation/UNMC	$0.00	$269,435.00	0%
eBHIN	$715,498.60	$1,112,275.00	64%
Pub Health	$48,936.94	$326,500.00	15%
Telehealth	$0.00	$73,620.00	0%
Total	**$4,788,602.46**	**$6,837,180.00**	**70%**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Office of the National Coordinator
for Health Information Technology
Washington, D.C. 20201

Program Information Notice

DATE: February 8, 2012

Document Number: ONC-HIE-PIN-002

SUBJECT: Requirements and Recommendations for the State Health Information Exchange Cooperative Agreement Program

TO: State Health Information Exchange Cooperative Agreement Program Award Grantees

As stated in the State Health Information Exchange Cooperative Agreement Program Funding Opportunity Announcement (FOA), the Office of the National Coordinator for Health Information Technology (ONC) may offer program guidance to provide assistance and direction to states and State Designated Entities (SDEs) that receive awards under the program (Grantees). This Program Information Notice (PIN) provides direction on the timing, content and review process for annual updates to Grantee Strategic and Operational Plans (SOPs). This cover letter provides a summary of recommendations and requirements spelled out in the PIN. Detailed guidance follows in the body of the document.

The State Health Information Exchange Cooperative Agreement Program is at a critical stage. Grantees are intensely focused on ensuring that providers have affordable and usable options to meet the health information exchange (HIE) requirements of Stage 1 Meaningful Use. The requirements include e-prescribing, receiving electronic structured lab results from labs and sharing care summaries electronically with other providers to support patient transitions. These are the basic exchange building blocks that will support numerous care improvements for patients including better treatment and diagnosis, improved chronic care and reductions in medication errors and unnecessary repeat testing. At a minimum, they require the availability of ubiquitous directed exchange—information can be *sent* and *received* easily, securely and electronically—replacing fax, mail and phone.

While these requirements may seem straightforward, the effort required to make rapid progress is considerable. According to the 2010 American Hospital Association survey, fewer than one fifth of all hospitals (19 percent) have a mechanism to share electronic patient information with ambulatory providers outside their systems. Fortunately, the vast majority of pharmacies already participate in e-prescribing. Many providers already receive electronic results from labs and many partners within the healthcare system, including EHR vendors and hospital systems, are supporting the development of exchange capacity, sharing this burden.

Grantees have the opportunity to leverage and take advantage of these local and private sector investments while providing the gap-filling services, policy support and core infrastructure needed to ensure that every provider has affordable exchange options and to connect these diverse exchange networks—including state-supported networks—avoiding the perpetuation of "information silos".

When the conditions are right, we see adoption of health IT rapidly progressing in a steep curve. For instance, provider participation in e-prescribing almost doubled in the last year, increasing from 26 to 43

percent, according to SureScripts data. In 2012 we expect to see a similar progression for care summary and lab results exchange. The conditions are in place:

- These are foundational requirements for Meaningful Use and were established as programmatic expectations in the State HIE Program Information Notice (PIN) issued July 6th, 2010 (#ONC-HIE-PIN-001). Every Grantee has identified and is executing the most effective strategies and tactics to make rapid progress in their state and local environments.
- Every certified EHR can produce a care summary and incorporate a structured lab result.
- ONC, working with a community of on-the-ground implementers, has specified essential transport and content standards that support exchange of structured lab results and patient care summaries.[1]
- In addition, and importantly, payment reforms such as medical home efforts and accountable care organizations and new initiatives such as Partnership for Patients[2] are providing new incentives, business cases, and market conditions for health information exchange and care coordination.

Building on guidance outlined in the 2010 PIN, our 2012 goal is clear - ensuring that providers have options to meet the health information exchange (HIE) requirements of Stage 1 Meaningful Use - including for e-prescribing, receiving structured electronic lab results and sharing care summaries. This PIN offers guidance to support rapid progress towards this goal:

- **Phasing**: Many Grantees have phased approaches in their approved Strategic and Operational Plans with the first phase strongly focused on enabling Stage 1 Meaningful Use requirements. If we are to achieve our goal this year, we must rapidly demonstrate the success and impact of these initial efforts.

  Subsequent phases of grantees' work focus on value-added services and more sophisticated exchange infrastructure. These services are essential and will be in increasing demand due to new payment approaches. In this area, as in others, Grantees will need to be creative and resourceful in identifying the specific gaps they should fill and the services that will deliver business value, leveraging the assets, infrastructure and business motivation of the private sector. Grantees should consider a "building block" approach deploying modular services like provider directories, identity management and master patient indices that can support multiple phases of work.

- **Sustainability**: Rapid progress will require two types of sustainability steps from Grantees. Both should be addressed in sustainability plans.

  1. In coordination with state Medicaid and health reform efforts, Grantees should work to increase demand for information and the business case for exchange through leadership actions and the

[1] Direct and SOAP for transport, consolidated Clinical Document Architecture (CDA) and Laboratory Results Interface specifications for care summary and lab exchange.

[2] http://www.healthcare.gov/compare/partnership-for-patients/index.html

use of policy and purchasing levers. This key policy leadership role was outlined in the 2010 PIN document:

A key role for states can be to provide leadership and direction to public and private stakeholders. States may also use policy and purchasing levers to extend and enhance existing HIE activities in the state so as to encourage key trading partners such as pharmacies and clinical laboratories to participate in electronic service delivery and to enable providers to meet Meaningful Use requirements.

2. Grantees should assure the business viability of any services they are directly providing, ensuring that the services deliver value, are in demand and are affordable (e.g., providers, payers or other stakeholders are willing and able to pay for them), fill gaps in the market and are easily adopted and used by providers.

- **Evaluation**: We are charting new waters. Incredible progress in health IT adoption and use has already been achieved in a short period. Our future progress and success rests on whether we can effectively learn from each other over the next two years. Openly and quickly sharing results will support ongoing progress, ensure we gain maximum value from limited resources and help us avoid repeating costly mistakes.

- **Tracking Program Progress:** We have set a clear goal for 2012: ensuring that providers have options to meet the Stage 1 Meaningful Use exchange requirements. But how will we know if we are on track to get there? Consistent with the 2010 PIN, we are asking Grantees to set goals and track progress for each of the three key core HIE program requirements—care summary exchange, lab exchange and e-prescribing—as well as for public health reporting.

If you have any questions or require further assistance, please do not hesitate to contact your State HIE Project Officer.

Sincerely,

Farzad Mostashari
National Coordinator for Health Information Technology

PURPOSE

This Program Information Notice (PIN) provides program guidance to all grantees under the State Health Information Exchange Cooperative Agreement Program (State HIE Program) on:

- What is required for Strategic and Operational Plans (SOP) updates
- Phasing of program activities
- The contents and information that will be required for sustainability and evaluation plans
- Requirements and measures for tracking program progress

ONC encourages grantees to coordinate all activities with their State Medicaid programs to ensure program alignment and rapid progress.

APPLICABILITY

This policy is applicable to all ONC State Health Information Exchange Cooperative Agreement Program Grantees (Grantees), whether the Grantee is a state government or a state designated entity. This PIN provides additional guidance to support the overall reporting requirements outlined in the Notice of Grant Award (NOA).

DISCUSSION

Grantees shall submit annual updates to their SOPs as required in the Funding Opportunity Announcement (FOA). This PIN provides a detailed explanation of the timing and contents of these SOP updates.

1. GENERAL REQUIREMENTS

1.1 Deadlines

Grantees shall submit SOP updates every year. Grantees whose SOPs were approved in 2010 will have 90 days from the release of this PIN to submit their SOP update. Grantees whose SOPs were approved in 2011 will have 120 days from the release of this PIN to submit their SOP update. The SOP update for 2013 will be due one year after the 2012 deadline. Only the "Tracking Program Progress" component of the SOP update will be required in 2014. This is due at the end of January, 2014.

Note: Grantees should disregard the annual SOP submission dates found in the NOA implementation requirements.

1.2 Review Process

If updates to the SOP do not require approval of a new budget, do not propose a significant shift in strategy or in phasing and do not propose substantial new services, the Project Officer will review and give written approval for the SOP update.

If proposed changes to the SOP require approval of a new budget, propose a significant shift in strategy or in phasing or propose substantial new services, the Program Manager and/or Program Director will review and give written approval for the SOP update.

In cases where the state has re-written the SOP with a new overall approach and strategy, re-approval by the National Coordinator will be required.

During review of all SOP updates, Program staff may ask for revisions or adjustments to the SOP.

Until written approval of SOP updates is provided, the existing SOP will be in effect.

1.3 SOP Update Format

Grantees shall use the following format for SOP updates:

Section	**Submit in First SOP Update**	**Submit in Subsequent SOP Updates**
1. Changes in HIE Strategy	Complete and submit relevant sections of *Changes in HIE Strategy* (Appendix A)	Complete and submit relevant sections of *Changes in HIE Strategy* (Appendix A)
2. Sustainability Plan	Submit *Sustainability Plan* (see section 2 of this PIN for requirements)	Complete and submit "Sustainability" section in *Changes in HIE Strategy* in Appendix A
3. Program Evaluation	Submit *Program Evaluation Plan* (see section 4 of this PIN for requirements)	Submit *Annual Program Evaluation Results Report* (see section 4 of this PIN for requirements)
4. Privacy and Security Framework	Submit *Privacy and Security Framework* (additional program guidance will be provided)	Complete and submit "Privacy and Security Framework" section in *Changes in HIE Strategy* in Appendix A
5. Project Management Plan	Submit updated *Project Management Plan* for the upcoming year, including an updated staffing plan and an updated discussion of risks and mitigation strategies as outlined in PIN #ONC-HIE-PIN-001, released on July 6, 2010. The project management plan should include an update of major activities for the upcoming year including timelines and milestones.	
6. Tracking Program Progress	Complete and submit *Tracking Program Progress* for relevant year (Appendix C) Descriptions of measures and sources are in Appendix B This section shall be included in the first SOP update. For subsequent years, all Grantees shall submit this section of the SOP update in January of each year (e.g., January 2013, January 2014 etc)	

In addition to completing the above modules, grantees shall also submit a "track changes" version of their Strategic and Operational plans once any revisions and additions are approved by the Project Officer.

1.4 PHASING

Many Grantees have phased approaches in their approved SOPs with the first phase strongly focused on rapidly enabling Stage 1 Meaningful Use exchange requirements. Success in these initial phases will be critical, ensuring that every provider has options to share care summaries, receive electronic lab results and e-prescribe, providing critical implementation experience and allowing time to scope and develop policies and approaches to implement future phases.

In keeping with these objectives, Grantees will need to demonstrate the success of the current phase and submit plans for implementation of the next phase before transitioning from one phase to the other.

We recognize that many providers have existing exchange options that support them in meeting Meaningful Use exchange requirements. Therefore, success of the first phase can be demonstrated in two ways. The first focuses on adoption and use of services offered or enabled by Grantees while the second addresses use of exchange services by providers whether or not these services are provided by the Grantee.

Grantees *with phased approaches* shall meet one of two thresholds in order to move from Phase One to Phase Two of their SOPs:

1. The number of providers actively using services offered or enabled by the Grantee to support care summary or lab exchange is at least 30 percent of the Priority Primary Care Providers (PPCP) Regional Extension Center (REC) target (with a maximum of 1000). The actual providers served by the Grantee do not need to be those registered with the REC nor do they need to be primary care providers.

2. At least 50 percent of REC-registered providers who have reached "Milestone Two" (providers have registered with the REC and implemented an EHR) have an option they are actively using to share care summaries with other providers and receive electronic lab results. Grantees would need to work with the REC to collect this information.*

*As the number of providers who have reached Milestone Two increases over time, Grantees choosing this option should consult their Project Officer for an updated threshold number

See Appendix D for target values for the two thresholds for each state. Note that not every state has a phased approach in their approved Strategic and Operational Plan.

While the targets are short of our goal—that EVERY eligible provider has options to meet Meaningful Use exchange requirements—they demonstrate that adoption and use of exchange services to meet Meaningful Use has reached a critical tipping point.

Grantees with more than two phases of work should consult with their Project Officers to determine success metrics and milestones that must be met for Phases Two and Three before proceeding to the next phase.

Information outlining plans for the next phase and demonstration of success with the current phase can be submitted separately at any time or as part of the annual SOP updates. The Project Officer shall provide written approval prior to the Grantee's transition from one phase to another.

To assure steady progress and provide the time and resources needed to plan and effectively implement the next phase, we would not expect a rigid stop and start of phases. For instance, planning for Phase Two can occur in Phase One. Planning activities might include work planning, developing policy requirements, issuing RFPs and potentially pilot testing approaches that will be deployed in the next phase. Grantees should discuss specifics with their Project Officers.

2. SUSTAINABILITY

Grantees are expected to create the "conditions" for the sustainability of information exchange in the state and also outline viable business plans for the sustainability of services they are directly providing or funding. As stated in PIN #ONC-HIE-PIN-001, released on July 6, 2010, "the primary focus of sustainability should be on sustaining information sharing efforts, and not necessarily the persistence of government-sponsored health information exchange entities".

As stated in the previous PIN released on July 6, 2010 (#ONC-HIE-PIN-001):

> *ONC is concerned that HIE sustainability models that rely on mandated provider or hospital participation in specific HIE services offered by the state or SDE might inappropriately limit provider choices in the full array of information exchange alternatives, thereby threatening the ability of providers to achieve Meaningful Use, particularly where state-designated services are still limited or nonfunctional.*

Grantees shall submit a sustainability plan as part of their first SOP update addressing these two distinct components:

Conditions for sustainability of health information exchange: The Grantee shall submit a strategy and coordination plan to create the business drivers for safe and secure health information exchange to support care transformation and provider achievement of Meaningful Use. The strategy and coordination plan may include use of policy levers, payment reforms and purchaser requirements. Examples include:

a. Create demand for exchange through policy and purchasing levers. For example:
    i. Medicaid uses reimbursement levers to encourage participating providers to electronically share visit summaries with primary care providers and patients.
    ii. State encourages private plans to give preference to labs sending electronic lab results in a structured format in their lab networks.
    iii. State includes health information exchange requirements in its state employee insurance plan contracts.

b. Advance care transformation models and payment reform initiatives that increase demand for exchange, and deliberately incorporate health IT adoption and health information exchange requirements into these efforts.

i. Accountable Care/Shared Savings Initiatives
ii. Health homes
iii. Pay for performance
iv. Integrated care for dual eligibles

c. Foster systemic changes to support health information exchange
    i. Engage consumers to request their own electronic health information, demand HIT-enabled care and expect that providers will make their transitions safe and effective.
    ii. Increase provider engagement and adoption.

(1) **Business sustainability of services directly offered or enabled**: The grantee shall also submit a thorough and thoughtful business plan for the sustainability of any services directly offered or funded by the Grantee. The starting place for this plan is not, "how do I generate enough income to maintain my organization at the current level of operation", but rather "which services will fill market gaps, and offer valuable, affordable exchange options that will be widely adopted and used." This plan should:

a. Offer a clear description of services offered and fees for those services to different participants
    i. Describe how these fees were set, including adoption assumptions
    ii. Include data on the current adoption and use

b. Provide evidence that there is demand for the services from participants
    i. Describe who will be adopting services and to perform what exchange tasks
    ii. Describe how services will provide value in a competitive market

c. Describe ongoing public or private contributions to support exchange services

As a condition of the grant, ONC expects that all grantees will meet the Meaningful Use exchange needs of eligible providers, including those serving Medicaid patients and rural and underserved communities. We recognize that there is a potential tension between offering services that are self-sustaining and serving communities and providers with the fewest resources. One way Grantees can resolve this tension is by offering affordable and easy-to-adopt exchange options.

3. TRACKING PROGRESS

Demonstrating progress and the tangible results of Grantee implementation efforts is critical for encouraging participation in HIE, maintaining provider/user buy-in and trust and establishing the long-term sustainability of health information exchange. Both local and national stakeholders are looking to understand how HIE Cooperative Agreement funds are enabling health information exchange and supporting providers in achieving Meaningful Use.

Consistent with and building on the PIN released on July 6, 2010 (#ONC-HIE-PIN-001), Grantees shall monitor and track key Meaningful Use HIE capabilities in the state. This PIN provides further clarity on measures, which include:

1. % pharmacies participating in e-prescribing

2. % clinical laboratories sending lab results electronically and in structured format
3. % providers and hospitals sharing patient care summaries electronically
4. % state health departments electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results. These data will need to be collected at the state or sub-state level, depending on the approach to public health reporting in the state.

Grantees shall report on progress and set annual targets for these key measures in their first SOP update due in 2012 and then separately in January 2013 and January 2014.

Appendix C provides a format for states to use in reporting progress and setting targets for these key measures while Appendix B outlines measure definitions and data sources.

As outlined in Appendix B, ONC will provide state-level data showing annual progress for areas 1 and 3 above. Grantees will need to collect data to show annual progress for areas 2 and 4.

4. PROGRAM EVALUATION

As required by section 3013 of the HITECH Act, ONC will conduct a national program evaluation and will provide documented lessons learned, technical assistance and program guidance based on the results.

As stated in the FOA, Grantees must comply with the requirements of and cooperate with ONC in completing the national evaluation. In addition, Grantees must conduct an annual state-level program evaluation. The grantee's evaluation plan shall be included in the first SOP update. The plan should be no more than 3,000 words. Revisions to the evaluation plan and annual evaluation results shall be reported in subsequent SOP updates. The FOA requires Grantees to use at least two percent of their funds for state-level program evaluations. ONC will make the national evaluation results available to Grantees to support rapid learning and encourages Grantees to quickly and openly share their own evaluation results.

State's program evaluations should:

1. Describe the approaches and strategies used to facilitate and expand health information exchange in the program priority areas and other areas as appropriate for the state's strategy. Program priority areas that must be included are:

    a. Laboratories participating in delivering electronic structured lab results
    b. Pharmacies participating in e-prescribing
    c. Providers exchanging patient summary of care records

2. Identify and understand conditions that support and hinder implementation of those strategies (e.g. how did your governance model or engagement with stakeholders support your strategy to increase lab exchange activity in your state?)

3. Analyze HIE performance in each of the key program priority areas (e.g., where did your state/territory begin at the start of the program and how have you progressed?) Grantees with operational health information exchange underway are encouraged to assess participant adoption and use (e.g. measure provider adoption) and analyze its impact (e.g. assess impact on care transitions, patient safety, duplicate lab test ordering, etc.)

4. Assess how the key approaches and strategies contributed to progress in these areas, including lessons learned.

The following elements are required for the *evaluation plan* that shall be submitted to ONC in the first annual SOP update:

- Aims of the evaluation (as noted above), including key evaluation questions that the Grantee seeks to address.
- Evaluation framework to assess the aims (e.g., context, process, outcomes)
- Evaluation methods including:
    - **Study Design:** describe the study design, which should include both qualitative and quantitative components. For quantitative analysis, the use of comparison or control groups or designs that assess change over time (pre-post) is suggested to enhance the validity of the findings.
    - **Study population:** describe the population to be included in the evaluation (e.g. providers, pharmacies, laboratories, etc.) Specify inclusion and exclusion criteria as appropriate, and the recruitment strategy.
    - **Data sources and data collection methods:** describe the data collection approach to answer key evaluation questions, which may include implementing surveys, analysis of existing survey data, focus groups, interviews and audit log data from HIE vendors.
    - **Data analysis**: describe the analytic methods that will be used including sample size.
- The following elements are required for the *annual evaluation results reports* that shall be submitted to ONC in the 2013 SOP update and 30 days after the end of the Program:
    - Updates or changes to evaluation plan (if any).
    - Progress on the evaluation (e.g. describe data collection efforts underway) and any issues encountered while conducting the evaluation.
    - Results and interpretation of those results. Findings can be summarized as briefs (3-5 pages) or peer-reviewed publications on key topics.
    - Implications of the evaluation findings for program implementation and strategy.

APPENDIX A - Changes to HIE Strategy

Domain/Sections	Short Description of Approved Portion of SOP that Grantee is Proposing to Change (include page numbers)	Proposed Changes	Reason for the Proposed Changes	Budget Implications of Proposed Changes
Include in First and Subsequent SOP Updates				
Overall HIE Strategy including Phasing				
Governance				
Technology				
Financial				
Business Operations				
Legal/Policy				
Strategies for e-Prescribing				
Strategies for Structured Lab Results Exchange				
Strategies for Care Summary Exchange				
The Core Documents Are Required As Part Of First SOP Update. Changes Should be Indicated in Subsequent SOP Update				
Sustainability				
Privacy and Security Framework				
Evaluation Plan				

APPENDIX B

Measure Definitions and Sources to be used in completing *Tracking Program Progress* (Appendix C)

PIN Priority	Numerator	Denominator	Source
1. **% of pharmacies participating in e-prescribing**	Number of pharmacies that sent or received any electronic new prescription, refill request, or refill response messages in December of the former year via Surescripts network	Total number of licensed pharmacies operating in the state (per NCPDP)	Surescripts/NCPDP data ***ONC will provide data to Grantees***
2. **% of labs sending electronic lab results to providers in a structured format**[3]	Number of hospital and independent clinical laboratories that send electronic lab results to ambulatory care providers in a structured format	Total number of hospital and independent clinical laboratories that respond to census	*Numerator: data collected through Grantee's lab census (a sample instrument will be provided following the release of this PIN)* *Denominator: Census should target all labs in "hospital" and "independent" lab categories, including LabCorp and Quest, in CLIA OSCAR database (http://wwwn.cdc.gov/clia/oscar.aspx)* ***Grantee assesses. ONC will provide a sample instrument.***

[3] **Structured format:** Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text).

PIN Priority	Numerator	Denominator	Source
3. **% of labs sending electronic lab results to providers using LOINC**	Number of hospital and independent clinical laboratories that send electronic lab results to ambulatory care providers using LOINC	Total number of hospital and independent clinical laboratories that respond to survey	*Numerator: data collected through Grantee's lab census* *Denominator: Census should target all labs in "hospital" and "independent" lab categories, including LabCorp and Quest, in CLIA OSCAR database (http://wwwn.cdc.gov/clia/oscar.aspx)* ***Grantee assesses. ONC will provide a sample instrument.***
4. **% of hospitals sharing electronic care summaries with (a) unaffiliated hospitals and (b) unaffiliated providers**	Number of non-federal acute care hospitals sharing electronic clinical care summaries with the following entities as reported in the AHA HIT Supplement survey: a. Hospitals outside their system b. Ambulatory care providers outside their system	Total number of non-federal acute care hospitals responding to AHA HIT supplement survey	AHA HIT supplement survey ***ONC will provide data to Grantees annually. Grantees may expect an annual release in December or January.***

PIN Priority	Numerator	Denominator	Source
5. % of ambulatory providers electronically sharing care summaries with other providers	Number of ambulatory care, office-based physicians who share electronic clinical summaries or summary of care records with other providers	Total number of ambulatory care, office-based physicians who responded to the survey	National Ambulatory Medical Care Survey (NAMCS) Electronic Medical Records (EMR) Supplement (also known as National Electronic Health Records Survey) ***ONC will provide data to Grantees annually. Grantees may expect an annual release in December or January.***
6. Public Health agencies receiving ELR data produced by EHRs or other electronic sources in HL7 2.5.1 format with LOINC and SNOMED.	1= Yes 0= No (or %)		Grantee assesses

PIN Priority	Numerator	Denominator	Source
7. Immunization registries receiving electronic immunization data produced by EHRs in HL7 2.3.1 or 2.5.1 formats using CVX codes.	1= Yes 0= No (or %)		Grantee assesses
8. Public Health agencies receiving electronic syndromic surveillance data from hospitals produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide)	1= Yes 0= No (or %)		Grantee assesses

PIN Priority	Numerator	Denominator	Source
9. Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1 formats.	1= Yes 0= No (or %)		

APPENDIX C

See Appendix B for measure definitions and sources

Tracking Program Progress

	Report in first SOP update		Report January, 2013		Report January, 2014	
Program Priority	**Status as of December, 2011**	**Target for December, 2012**	**Status as of December, 2012**	**Target for December, 2013**	**Status as of December, 2013**	**Target for end of grant period**
1. % of pharmacies participating in e-prescribing						
2. % of labs sending electronic lab results to providers in a structured format[4]						
3. % of labs sending electronic lab results to providers using LOINC						
4. % of hospitals sharing electronic care summaries with unaffiliated hospitals and providers						

[4] **Structured format:** Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text).

Program Priority	Report in first SOP update		Report January, 2013		Report January, 2014	
	Status as of December, 2011	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
5. % of ambulatory providers electronically sharing care summaries with other providers						
6. Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC and SNOMED. Yes/no or %						
7. Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code. Yes/no or %						

Program Priority	Report in first SOP update		Report January, 2013		Report January, 2014	
	Status as of December, 2011	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
8. Public Health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide). Yes/no or %						
9. Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1. Yes/no or %						

APPENDIX D - Threshold Levels to Demonstrate Phase One Success

State*	30% of REC Target (max of 1000)	50% of REC Providers at Milestone 2**
Alaska	300	90
Alabama	391	343
Arkansas	384	258
Arizona	587	295
California	1000	1682
Colorado	689	730
Connecticut	392	249
District of Columbia	300	234
Deleware	300	480
Florida	1000	965
Georgia	1000	1049
Hawaii	300	51
Iowa	360	156
Illinois	836	468
Indiana	660	616
Kansas	360	248
Kentucky	300	152
Louslana	313	112
Massachussetts	746	786
Maryland	300	281
Maine	300	143
Michigan	1000	680
Missouri	350	334
Mississippi	300	345
North Carolina	1000	835
Nebraska	339	143
New Hampshire	300	400
New Jersey	1000	1155
New Mexico	311	213
New York	1000	2173
Ohio	1000	1851
Oklahoma	300	258
Oregon	802	715
Pennsylvania	1000	1152
Puerto Rico	1000	213
Rhode Island	300	242
South Carolina	300	314
South Dakota	321	53
Tennesee	403	590
Texas	1000	664
Virginia	686	694
Vermont	330	278
Wisconsin	488	472
West Virginia	300	223
States in Mult-State RECs		
Idaho	130	146
Minnesota	962	949
Montana	197	102
Nevada	200	197
North Dakota	118	117
Utah	239	234
Washington	581	652
Wyoming	109	54

*Territories: Please consult your Project Officer for thresholds for American Somoa, Commonwealth of the Northern Mariana Islands, Guam, and the Virgin Islands.

**Please confirm current threshold with your Project Officer at time of submission.

Nebraska State HIE Plan Updates

Background Information and Approach

Feb. 22, 2012

The Office of the National Coordinator released a program information notice (PIN) on Feb. 8 outlining requirements for updates to state eHealth plans. Updated plans are due May 8 and must be approved by the Office of the National Coordinator. Major sections of the plan updates include:

- Changes in HIE strategy including:
  - Strategies for e-prescribing
  - Strategies for structured lab results exchange
  - Strategies for care summary exchange
- Sustainability plan
- Program evaluation (A webinar has been scheduled for March 1 to address program evaluation requirements.)
- Privacy and security framework (Additional information will be provided in another program information notice expected to be released the week of Feb. 20.)
- Project management plan
- Tracking program progress (Additional information will be provided including a template for surveying labs at a later date.)

Much work has already been done on the required topics. The eHealth Council approved an evaluation framework in October. The Nebraska Information Technology Commission/Office of the CIO has contracted with UNMC to conduct evaluation activities. NeHII and eBHIN have been working on sustainability plans. Both NeHII and eBHIN have well-developed privacy and security policies—although without any guidance on the privacy and security framework at this date, it is hard to evaluate how much additional work needs to be done in this area.

Nevertheless, it will require significant effort by all project partners to complete the plan updates by May 8.

A general process for completing the plan is described below:

- Anne Byers will analyze requirements and develop a work plan.
- The eHealth Council will discuss any changes to Nebraska's HIE strategy and will approve a general work plan for updating state eHealth plans in Februrary.

- Anne Byers will work with the Nebraska eHealth Implementation Team, the E-Prescribing Work Group, and the UNMC State HIE Evaluation Team to update the Nebraska eHealth Plan. The Nebraska eHealth Implementation Team consists of representatives of NeHII, eBHIN, the Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care, and the Nebraska Department of Health and Human Services Division of Public Health. Other stakeholders may also be consulted.
- The Nebraska Information Technology Commission will approve any changes in HIE strategy and the work plan
- The eHealth Council will approve targets for 2012 and a draft plan in late April.

Timeline

Feb. 24	Anne will start working on changes in HIE strategy section and will make further revisions to work plan
Feb. 29	eHealth Council will discuss any changes to HIE strategy and will approve the general approach to completing plan updates
March 13	Tracking program progress (minus lab and e-prescribing info) done
March 13	Program Evaluation section done
March 31	Changes in HIE strategy section done
April 11	NITC approves any changes in HIE strategy and general approach to completing the plan updates
April 13	Tracking program progress data complete
April 13	Privacy and security framework done
April 13	Project management—staffing and risk/mitigation done
Late April	eHealth Council approves targets for 2012 and plan draft
May 1	Sustainability section done
May 1	Project management plan done
May 8	Plan updates due

Nebraska State HIE Plan

Nebraska's Approach, Vision, Goals, and Objectives

Feb. 22, 2012

Nebraska's Approach

Delivering HIE capabilities affordably to a population broadly disbursed in rural areas has required a strategic approach to delivery. Nebraskans have responded to the challenges of providing services to a relatively small population over a large geographic area by leveraging existing resources, facilitating cooperation among various entities in the state, and by carefully allocating financial resources. Nebraska is applying these same principles to the development of health information exchange in the state.

When the Nebraska Information Technology Commission established the eHealth Council in 2007, four health information exchange initiatives were in development. The Nebraska Information Technology Commission created the eHealth Council to facilitate coordination among these efforts and to make recommendations on how the State should support health information exchange efforts. The eHealth Council felt strongly that it was important to respect and leverage existing investments in health information exchange. This is reflected in the State's vision for eHealth:

> Stakeholders in Nebraska will cooperatively improve the quality and efficiency of patient-centered health care and population health through a statewide, seamless, integrated consumer-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.

The eHealth Council also recognized that financial resources for health information exchange in the state were limited and that health information exchanges would need to develop sustainable business plans. Data on health information exchange sustainability is limited. However, it is generally recognized that a health information exchange may need to serve a population of 1 million or more to be sustainable. With a population of 1.8 million, it is clear that Nebraska most likely cannot support more than two health information exchanges.

The eHealth Council also recognized that successful health information exchanges would have to offer value in order to get health care providers to participate. The eHealth Council felt that health information exchange efforts led by health care providers and insurers would be more responsive to the needs of health care providers and private industry and better able to develop value propositions than a state-run health information exchange.

The eHealth Council also recognized the importance of achieving a critical mass of users. Networks become more valuable as more users participate. Achieving a critical mass of users will also support efforts to build sustainability.

The eHealth Council also recognized that participation in health information exchange is voluntary. Both providers and consumers can choose whether or not to participate in health information exchange. Health care providers also have a choice in how to participate in health information exchange. Health care

providers can participate through NeHII or develop the capacity for other options such as NHIN direct. At this time, Nebraska is not considering any policy, regulatory or legislative actions to make participation in NeHII mandatory. The State of Nebraska feels strongly that the best way to encourage participation is to offer and demonstrate value.

These principles are reflected in the guiding principles included in Nebraska's Strategic eHealth Plan:

Statewide health information exchange in Nebraska will:

- Utilize national standards and certification to facilitate meaningful use and interoperability.
- Utilize solutions which are cost-effective and provide the greatest return on investment.
- Utilize a sustainable business model for both the development of infrastructure and operations.
- Leverage existing eHealth initiatives and investments in Nebraska.
- Support the work processes of providers.
- Encourage ongoing stakeholder engagement and participation in development of the state plan and throughout all stages of implementation.
- Support consumer engagement and ensure the privacy of health information.
- Encourage transparency and accountability.
- Measure and report goal- and consumer-centered outcomes of investments of public dollars.

Nebraska's plan for health information exchange incorporates and balances all of these principles.

Vision

Stakeholders in Nebraska will cooperatively improve the quality and efficiency of patient-centered health care and population health through a statewide, seamless, integrated consumer-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.

Goals

These goals will be achieved while ensuring the privacy and security of health information, which is an essential requirement in successfully implementing health information technology and exchanging health information:

- Using information technology to continuously improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information.
- Improve patient care and consumer safety;
- Encourage greater consumer involvement in personal health care decisions;

- Enhance public health and disease surveillance efforts;
- Improve consumer access to health care;
- Improve consumer outcomes using evidence-based practices.

Health IT Adoption

Objectives

- Encourage and support health IT in order to achieve meaningful use by providers.
- Build an appropriately-trained, skilled health information technology workforce.
- Encourage and support the adoption of personal health records.
- Improve health literacy in the general population.

Governance

Objectives

- Address issues related to governance, oversight, and financing of health information exchange.
- Ensure transparency, accountability, and privacy.

Finance

Objectives

- Support the development of a sustainable business model for building and maintaining health information exchange in Nebraska.
- Leverage the state's role as a payer to support health information exchange.

Technical Infrastructure

Objectives

- Support the development and expansion of health information exchanges to improve the quality and efficiency of care.
- Support the development of interconnections among health information exchanges in the state and nationwide.
- Promote the development of a robust telecommunications infrastructure.

- Ensure the security of health information exchange.

Business and Technical Operations

Objectives

- Support meaningful use.
- Encourage the electronic exchange of public health data.
- Encourage the integration of health information exchange with telehealth delivery.

Legal/Policy

Objectives

- Continue to address health information security and privacy concerns of providers and consumers.
- Build awareness and trust of health information technology.

Changes to Nebraska's State HIE Plans and Strategy

Feb. 22, 2012

New/Updated Plan Requirements

- New required sections will address sustainability and program evaluation.
- Information on the privacy and security framework will likely be updated and expanded into a new section.
- The project management plan will need to be updated to reflect changes due to the voluntary nature of participation in HIE and vendor delays.
- The tracking program progress information will need to be updated and put in a separate section.

Changes in HIE Strategy

- The use of Direct is being integrated into Nebraska's State HIE strategy.
- LB 237, which was passed by the Legislature and signed by Governor Heineman in 2011, authorized the Department of Health and Human Services to collaborate with NeHII to establish a prescription drug monitoring program Development of a Prescription Drug Monitoring Program.
- Greater emphasis is being placed on pharmacy participation in e-prescribing, strategies for structured lab results exchange, and strategies for care summary exchange.
- NeHII and eBHIN have worked out an innovative way to manage consent and authorization for the release of health information.
- NeHII has made changes to its Security and Privacy Policies to allow the exchange of data for public health purposes. NeHII is also discussing policy changes to allow for the secondary use of data.
- NeHII has developed a strategy for critical access hospitals to share an edge server, reducing their costs for participation.
- Information on the legal environment will need to be updated to include the following legislation related to health IT:
    - **LB 591 Provide for a syndromic surveillance program and change immunization information exchange provisions**. The legislation includes provisions which will facilitate the electronic exchange of syndromic surveillance and immunization information. LB 591 passed on Final Reading and was presented to the Governor on May 12, 2011.

- **LB179 Change pharmacy provisions.** LB 179 eliminates the requirement for pharmacists to write the date of filling and sign the face of a prescription for controlled substances listed in Schedule II, facilitating the future use of e-prescribing for controlled substances. LB 197 was approved by Governor Heineman on March 10, 2011.
- **LB 237 Provide for creation of a prescription drug monitoring program.** LB 237 authorizes the Department of Health and Human Services to collaborate with NeHII to establish a prescription drug monitoring program. LB 237 was approved by Governor Heineman on April 14, 2011.

- Changes need to be made to the text to reflect changes in the Nebraska HIE environment (i.e, SNBHIN, WNHIE, and SENHIE).
- Changes need to be made to reflect increases in adoption of e-prescribing and EHRs.

Additionally, we are working on revisions to the budget to accelerate the spending of ARRA funds as directed by the Office of the National Coordinator and the Office of Management and Budget.

Nationwide Health Information Network – Direct Project

What is the Direct Project?

- Direct enables a healthcare provider to electronically and securely push specific health information, such as discharge summaries, clinical summaries from PCP and specialists, lab results to ordering providers, or referrals over the internet to another healthcare provider(s) who is a known and trusted recipient.

Why is Direct Important:

- Direct offers an entry level of data exchange needs to smaller organizations, such as rural providers, local independent labs, and VA hospitals.
- Direct will support the ability of participants to meet key Stage 1 Meaningful Use requirements by facilitating the electronic sharing of quality data, as well as data that supports care coordination and patient engagement.

Direct Benefits:

- Direct allows for the transmission of health information in a uni-directional flow using a secure, standard, scalable encrypted format and ensures that the information goes to the correct provider or organization.
- Direct augments previous inadequate, outdated and more expensive forms of sharing information such as fax or delivery of paper charts.
- Direct participants may send health data to any other individual or organization that is also a Direct participant outside of a formal RHIO (Regional Health Information Organization), HIE (Health Information Exchange) or other private network.
- Direct Addresses are available from HISPs (Health Information Service Provider), and are verifiable, "unspoofable," and may be updated.
- Direct is an initiative created by the ONC, well supported and internet friendly.

Direct is NOT:

- Direct is NOT a means of sending health data to unknown individuals, or to anyone with a generic email address.
- Direct does not support health information exchange services.
- Direct does not allow a user to send a query across multiple systems to seek health information.

NeHII's Objectives with Direct:

- NeHII will implement a solution to accomplish Direct compliance that will include as a core offering services for participating consumers at the Direct level. In order to develop Direct capabilities, NeHII will create and manage the Health Information Service Provider (HISP) for Nebraska.
- NeHII will also develop a Provider Directory that will contain demographic, digital certification, and routing information for every healthcare provider in Nebraska.
- NeHII's primary use cases for Direct include:
    - Independent labs to send lab data to providers or entities
    - Referrals between NeHII participants and the VA Hospital in Omaha
    - Patient information sharing of 42CFR Part 2 ePHI between eBHIN provider and NeHII provider
    - Patient information sharing between provider and patient via personal health record providers such as SimplyWell and Microsoft HealthVault
    - Patient information sharing across state lines

Nebraska Health Information Initiative

Product Services

Virtual Health Record (VHR)

- Provides a comprehensive electronic health record (EHR) accessible with a single click by an authorized healthcare provider.
- Retrieves and displays data from across the entire Health Information Exchange (HIE). All available patient data is pulled together virtually to create a complete electronic health record.
- Includes patients' laboratory, radiology, reports, including history and physicals, consults, discharge summaries, visit records, medication history, problem lists, allergies, up-to-date eligibility information, and exams ordered by clinicians, and any encounter notes and referrals.
- Cost - $10 per month per physician *

Electronic Medical Record (EMR)

- Provides the ability to quickly and effectively collaborate with any of the patient's caregivers, sharing data and processing referrals electronically.
- Connects physicians to the NeHII Health Information Exchange, giving the ability to receive ARRA stimulus monies and improve care for patients.
- Cost - $20 per month per physician *

e-Prescribing

- Provides significant efficiencies to practices and meets Meaningful Use requirements for ARRA stimulus compensation.
- Ensures the most accurate medication, problem, and patient information from NeHII for safe prescribing. Prescribers have the ability to view patients' eligibility, prescription history, formularies, and generic and therapeutic alternatives, which are displayed when prescribing. Prescriptions are automatically checked for dangerous interactions and allergies and are delivered to the patient's pharmacy. Refills are approved with a few clicks from any computer.
- Cost - $10 per month per physician *

Interoperability HUB/Physician Connection

- Builds a direct network from disparate certified EMRs and legacy systems enabling complete interoperability and full collaboration on patient care.
- Gives physician practices the ability to immediately exchange data such as referrals, and can also provide specific data for query by community-wide physicians; providing the entire community, regional, state or national HIEs with a complete picture of health for a patient.
- Cost - $10 per month per physician

Direct

- Enables a healthcare provider to electronically and securely push specific health information, such as discharge summaries, clinical summaries from a primary care provider or specialist, lab results to ordering providers, or referrals over the internet to another healthcare provider(s) who is a known and trusted recipient.
- Allows for the transmission of health information in a uni-directional flow using a secure, standard, scalable, encrypted format and ensures that the information goes to the correct provider or organization.
- Cost - $15 per month per e-mail address

*A $10 per month connection charge is required regardless of the product(s) purchased.

495.6 for Stage 1 to conform with this change in the definition of a meaningful EHR user.

For the Stage 1 public health objectives, beginning in 2013, we also propose to add "except where prohibited" to the regulation text, because we want to encourage all EPs, eligible hospitals, and CAHs to submit electronic immunization data, even when not required by State/local law. Therefore, if they are authorized to submit the data, they should do so even if it is not required by either law or practice. There are a few instances where some EPs, eligible hospitals, and CAHs are prohibited from submitting to a State/local immunization registry. For example, in sovereign tribal areas that do not permit transmission to an immunization registry or when the immunization registry only accepts data from certain age groups (for example, adults).

TABLE 3: CHANGES TO STAGE 1

Stage 1 Objective	Proposed Changes	Effective Year (CY/FY)
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines	**Change: Addition of an alternative measure** More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE	2013 Only (Optional)
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines	**Change: Replacing the measure** More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE	2014 – Onward (Required)
Record and chart changes in vital signs	**Change: Addition of alternative age limitations** More than50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure **(for patients age 3 and over only)** and height and weight **(for all ages)** recorded as structured data	2013 – Only (Optional)

Stage 1 Objective	Proposed Changes	Effective Year (CY/FY)
Record and chart changes in vital signs	**Change: Addition of alternative exclusions** **Any EP who** (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	2013 – Only (Optional)
Record and chart changes in vital signs	**Change: Age Limitations on Growth Charts and Blood Pressure** More than50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure **(for patients age 3 and over only)** and height and weight **(for all ages)** recorded as structured data	2014 – Onward (Required)
Record and chart changes in vital signs	**Change: Changing the age and splitting the EP exclusion** **Any EP who** (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	2014 – Onward (Required)
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically	**Change: Objective is no longer required**	2013 – Onward (Required)
Report ambulatory (hospital) clinical quality measures to CMS or the States	**Change: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6**	2013 – Onward (Required)

Stage 1 Objective	Proposed Changes	Effective Year (CY/FY)
EP Objective: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request. Hospital Objective: Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request. EP Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4business days of the information being available to the EP.	**Change: Replace these three objectives with the Stage 2 objective and one of the two Stage 2 measures.** EP Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP EP Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. Hospital Objective: Provide patients the ability to view online, download and transmit information about a hospital admission. Hospital Measure: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.	2014 – Onward (Required)
Public Health Objectives:	Change: Addition of "except where prohibited" to the objective regulation text for the public health objectives under 42 CFR 495.6	2013 – Onward (Required)

c. State Flexibility for Stage 2 of Meaningful Use

We propose to offer States flexibility with the public health measures in Stage 2, similar to that of Stage 1, subject to the same conditions and standards as the Stage 1 flexibility policy. This applies to the public health measures as well as the measure to generate lists of specific conditions to use for quality improvement, reduction of disparities, research or outreach.

In addition, whether moved to the core or left in the menu, States may also specify the means of transmission of the data or otherwise change the public health measure, as long as it does not require EHR functionality above and beyond that which is included in the ONC EHR certification criteria as finalized for Stage 2 of meaningful use.

TABLE 4: STAGE 2 MEANINGFUL USE OBJECTIVES AND ASSOCIATED MEASURES SORTED BY CORE AND MENU SET

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
CORE SET			
Improving quality, safety, efficiency, and reducing health disparities	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.	More than 60 percent of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.
	Generate and transmit permissible prescriptions electronically (eRx)		More than 65 percent of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.
	Record the following demographics • Preferred language • Gender • Race • Ethnicity • Date of birth	Record the following demographics • Preferred language • Gender • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	**Eligible Hospitals and CAHs**	
	Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data
	Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
	Use clinical decision support to improve performance on high-priority health conditions	Use clinical decision support to improve performance on high-priority health conditions	1. Implement 5 clinical decision support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. 2. The EP, eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entre EHR reporting period.

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
	Incorporate clinical lab-test results into Certified EHR Technology as structured data	Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data
	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.
	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care		More than 10 percent of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference
		Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)	More than 10 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR..

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
Engage patients and families in their health care	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.		1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information 2. More than 10 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download , or transmit to a third party their health information
		Provide patients the ability to view online, download, and transmit information about a hospital admission	1. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge 2. More than 10 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period
	Provide clinical summaries for patients for each office visit		Clinical summaries provided to patients within 24 hours for more than 50 percent of office visits.

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	**Eligible Hospitals and CAHs**	
	Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient	Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all office visits by the EP. More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology
	Use secure electronic messaging to communicate with patients on relevant health information		A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 percent of unique patients seen during the EHR reporting period
Improve care coordination	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH performs medication reconciliation for more than 65 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	**Eligible Hospitals and CAHs**	
	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 percent of transitions of care and referrals. 2. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals.
Improve population and public health	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period
		Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized.
		Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
Ensure adequate privacy and security protections for personal health information	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.
Menu Set			
Improving quality, safety, efficiency, and reducing health disparities		Record whether a patient 65 years old or older has an advance directive	More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.
	Imaging results and information are accessible through Certified EHR Technology.	Imaging results and information are accessible through Certified EHR Technology.	More than 40 percent of all scans and tests whose result is an image ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology
	Record patient family health history as structured data	Record patient family health history as structured data	More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives

Health Outcomes Policy Priority	Stage 2 Objectives		Stage 2 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
		Generate and transmit permissible discharge prescriptions electronically (eRx)	More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology
Improve Population and Public Health	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice		Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period
	Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.		Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period
	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.		Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period

CENTERPOINTE, INC.
Leaders in treating addiction and mental illness

MEDICATIONS LIST

Medications:

Rx Elsewhere?	Start Date	Stop Date	Medication Name	Directions
Y			Butrans 20 mcg/hour Transderm Patch	apply 1 patch (20MCG/H) by transdermal route every 7 days
Y			Humalog KwikPen 100 unit/mL Sub-Q Pen	inject by subcutaneous route as per insulin sliding scale protocol
Y			Savella 100 mg Tab	take 1 tablet (100MG) by oral route 2 times/day
Y			oxycodone 10 mg Tab	take 1 tablet (10MG) by oral route 4 - 6 hours
Y			indomethacin ER 75 mg Cap	take 1 capsule (75MG) by oral route 2 times every day with food
N	02/17/2012	05/17/2012	omeprazole 20 mg Cap, Delayed Release	take 1 capsule (20MG) by oral route every day before a meal
N	02/17/2012	05/17/2012	trazodone 150 mg Tab	take 1 tablet (150MG) by oral route every day at bedtime
N	02/17/2012	05/17/2012	Cymbalta 60 mg Cap	take 2 Capsule by oral route every day

Diagnosis:

Code	Diagnosis	Status	Note
250	Diabetes mellitus	Chronic	Insulin Dependent
296.80	Bipolar disorder, unspecified	Worse	Bipolar II and Seasonal Affective Disorder
301.9	Unspecified personality disorder	Routine	Dependence traits/borderline behaviors
304.00	Opioid type dependence, unspecified use	Chronic	
304.20	Cocaine dependence, unspecified use	Recurrent	
304.3	Cannabis dependence	Recurrent	Partial Remission
304.53	Hallucinogen dependence, in remission	Stable	
530.81	GERD	Stable	
729.1	Myalgia and myositis, unspecified	Recurrent	

Allergies:

Allergen/Ingredient	Reaction:
Pet Dander	Tightness Of Chest
Penicillins	Anaphylaxis

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