

UNAPPROVED MINUTES
SOUTH DAKOTA e HEALTH COLLABORATIVE
BOARD MEETING
September 14 & 15, 2009

Minutes of the South Dakota eHealth Collaborative meeting held on Monday and Tuesday, September 14th and 15th, 2009, at Chamberlain.

Kevin called the meeting to order.

Roll Call was taken.

Holly Arends, SD Dept of Human Services-present
Nancy Beaumont, SDFMC-Present
Lynn Beck, SD DENR-present
Arlyn Broekhuis, Sanford Health- present
Jacque Cole, Dakota Care- Absent
Rebekah Craddock, SD Assoc of Healthcare Organizations-present
Mark East,SD State Medical Association-present
Laurie Gill, DOH-absent
Gary Goeden, SD BIT-Absent Proxy-Monty Gloe, SD BIT
Scott Graff, Community Healthcare Association of the Dakotas-Absent Proxy Scott Weatherill
Dennis Kaufman, The Evangelical Lutheran Good Samaritan Society-Present
Dick Latuchie, Regional Health-Present
Linda Maas, SD Health Information Management Association-Present
Randy Moses, SD Division of Insurance -Present
Jim Vachal, Brown Clinic-Absent
Gayle Varty, St. Mary's Healthcare Center-Present
Jim Veline, Avera Health-Absent Proxy-Jim Burkett, Avera Health
Revi Warne,SD Department of Social Services-Present
Sam Wilson-AARP, Absent

Gallery members included: Dan VanRoekdel and Daryl Bouma-Sanford Health , Surenda Sarnikar, Dan Friedrich, Dorine Bennett, Joyce Havlik, Rick Puetz, Lance Jahnig and Dianne Halverson – Dakota State University/CAHIT

Kevin DeWald welcomed everyone and delivered opening remarks.

Kevin asked if there were any additions or corrections to the July 13, 2009 minutes. Motion by Rebekah Craddock to approve the July 13, 2009 meeting, seconded by Randy Moses. Motion carried unanimously.

Kevin provided information about the upcoming “State Alliance for E-Health Second Annual State Learning Forum: Strengthening Teams and Building Networks” September 24-25, 2009 National Harbor, Maryland. Governors were invited to send state teams to the Learning Forum to develop and advance policies and strategies for implementing provisions of HITECH and Health Information Exchange in their state. The Learning Forum will enable states to:

- Bring policy makers from both the public and private sectors together to develop strategies for oversight and implementations of Health Information Exchange

- Work together and with other state teams on the challenges of implementing a nationwide health information network
- Receive the latest updates from federal agency representatives from ONC, CMS, HRSA and AHRQ on issues related to HITECH
- Identify next steps in advancing their state's implementation projects
- Strengthen their skills working with stakeholders and partnerships;
- Improve their understanding of the role of HIT in health care reform, quality improvement and system transformation;
- Explore options and issues related to privacy and security, sustainability and governance.

It should be emphasized that the Learning Forum is an interactive policy-development and strategic planning effort. The Learning Forum will rely on preparation from state attendees prior to the formal meeting, active team participation throughout the process and a strong commitment to implementing the plans generated from the process. Attending from SD will be Kevin DeWald, Dan Friedrich, Randy Moses, Rebekah Craddock, Nancy Beaumont, Gayle Varty, Jackie Cole, and Scott Graff. South Dakota is one of 23 states attending.

Rebekah Craddock provided a National Forum report. Some areas discussed included:

- Federal level funding
- silos are coming together
- meaningful use definitions
- Objectives-having lab results and e-prescribing
- State Role-Formalize identity-DOH
- Core Function-State level barrier
- Planning Process-Regional Centers (DSU)
- 3 funding cycles one beginning in December
- Medicaid received a letter-need to work together

Reminders from Kevin. He will need additional information from the members. Kevin will go over the timeline and may need to schedule additional meeting. The collaborative has formed a Finance AD HOC Group and will need members probably beginning after January 15, 2010.

Kevin asked for updates from the committees.

Policy Governance-Joyce Havlik

- Identified research tasks
 1. Adopt standardized, unique patient identifying numbers.
 2. Establish access limitations to those practitioners needing to provide emergent and urgent care and organizations.
 3. Authorize a state Master Patient Index (MPI) and data sharing (a data exchange)
 4. Providing support for patients' ability to opt-in/opt-out of the system
 - a. Opting-in/opting-out could be at the system level or the provider level
 5. Providing access control (this also includes the technical committee)
 - a. Different levels of access

Joyce reported that she investigated the support for patient's ability to opt-in/opt out of the system. She reviewed the policy of Minnesota and they are able to opt-in/opt-out at each encounter. Would this be too much for South Dakota to handle? Also reviewed Oklahoma's policy which is similar to Minnesota's policy.

Laurie Gill investigated State Master Patient Index. The need for policies to regulate that the data entering the systems are clean and accurate.

Jackie Cole studied the level of access control and will be working with the Technical Committee on this. Gayle Varty reported on the access limitations to practitioners. There will need to be policies in effect to audit who access the information. She reviewed information from Minnesota and Indiana.

Linda Maas spoke on the need to define unique patient identifier numbers. No state has defined this yet. Bio-identifiers but you need a warm body for this.

Point system for last name, first name, birth date and social security number.

Education and Outreach-Dorine Bennett

Dorine's group met in August. They discussed timeline, guiding force for outreach and advertising. They worked on a draft budget that would work with the Strategic Plan.

Technical –Surrenda Sarnikar provided the following information.

Nebraska HIE Presentation in Sioux Falls on July 28th, 2009

1. Uses Axoloti's Elysium HIE.
2. Edge Servers at facility that mirror data
3. Interoperability hub in California

EPIC Presentation on September 3rd

1. Core everywhere
2. Continuity of care, no RLS
3. Connect with EPC, Non-EPIC
4. Richer data exchange when both systems are EPIC

MedPlus presentation will be in October

State Health Information Exchange Cooperative Agreement Program information presented by Kevin. Letter of Intent has been sent.

Proposal submitted on October 16th.

By the end of September we should know the amount we will be awarded.

Expect 50 awards with a minimum amount of \$4 million and a top of \$40 million.

Over a 4 year time frame but expect you to spend the majority in the first two years.

OVERVIEW

Cooperative Agreement

Initial funding for planning activities, must meet milestones to receive additional funding.

Roles of State Government & Private Sector

State government and Federal government, and the private sector will all play important roles in advancing HIE among health care providers, public health and those providing engagement services PHR.

Private Sector will participate in state level strategic planning and develop innovative solutions to HIE among health care providers.

Medicare/Medicaid meaningful use incentives will enable HIT advancement and will enable HIE to be meaningful.

Work in conjunction with any Regional Extension Center.

Program Structure and Approach

ONC will award one cooperative agreement per state for planning and implementation.

Focused on preparing states to support providers in achieving goals, objectives and measures related to HIE information exchange in both a statutory requirement for meaningful use incentives and critical to enabling care coordination and other to quality and efficiency.

Will allow for an incremental approach to ensure continuous improvement and expansion of HIE capabilities.

KEY STATE PLAN DOMAINS

GOVERNANCE

Functions:

- Convening health care stakeholders to create trust and consensus on an approach for statewide HIE
- Provide oversight and accountability of HIE to protect the public interest

Governance entity:

- Develops and maintains a multi stakeholder process to ensure HIE among providers is in compliance with applicable policies and laws.
- Government may have many different roles in the oversight of the electronic HIE. Roles that will likely change overtime.
- Therefore any structures need be amendable to change and should be responsive to industry needs.
Technology-Business-Policy

FINANCE

Functions:

- Identification and management of financial resources to fund health information exchange.

Includes

- Public and private financing for building HIE capacity and sustainability
- Pricing strategies, market research, public and private financing strategies, financial reporting.

TECHNICAL INFRASTRUCTURE

Functions:

- Physically enabling the technical services for HIE in a secure and appropriate manner.

Includes:

- Architecture

- hardware
- software applications
- network configurations and
- other technological aspects

BUSINESS AND TECHNICAL OPERATIONS

Includes (not limited to):

- Procurement
- Identifying requirements
- Process design
- Functionality development
- Project management
- Help desk
- Systems maintenance
- Change control
- Program evaluation
- Reporting

Operational Responsibilities:

- Some may fall to the entity or entities implementing the technical services needed for HIE.
- May be different models for distributing operational responsibilities.

LEGAL AND POLICY

Purpose:

- Create a common set of rules to enable inter-organizational and eventually interstate HIE while protecting consumer interests

Mechanisms and structures:

- Address legal and policy barriers and enablers related to electronic use and exchange of health information.

Includes (not limited to):

- Policy frameworks
- Privacy and security requirements for system development and use
- Data sharing agreements
- Laws and regulations
- Multi-state policy harmonization activities

Example Governance Model

Government Led Model

Public sector directly provides governance and infrastructure for HIE and is directly accountable for the privacy, security, fiscal integrity, interoperability of the system, and

for universal access to it. Examples include a Public Authority or Government Controlled Corporation (GCC).

Public Utility with Strong Government Oversight Model

Public sector regulates private sector provision of HIE. The government participates in activities such as rate setting, policy development, and ongoing monitoring of the industry.

Private Sector Led Model with Government Collaboration

Public sector participates in private HIE governance, exerting limited ‘control’ through financial and market based mechanisms. Government acts in an advisory role and participates in the regulation of privacy and security.

Details about each model can be found in the report *Public Governance Models for a Sustainable Health Information Exchange Industry*, available through the National Association of Governors at: www.nga.org/center/ehealth.

STRATEGIC PLAN COMPONENT

The strategic planning process includes the development of the initial Strategic Plan and ongoing updates across all domains.

General Topic Guidance

- Environmental Scan
- HIE Development and Adoption
- HIT Adoption
- Medicaid Coordination
- Medicare Coordination
- Participation with Federal Care Delivery Organizations (not required)
- Coordination with other ARRA Programs

Domain Requirements

- Governance - Model, State HIT Coordinator, Accountability, and Transparency
- Finance – Sustainability
- Technical Infrastructure – Interoperability, Technical Architecture and Approach
- Business and Technical Operations – Implementation
- Legal/Policy – Privacy & Security, State Laws, P&P, Oversight of HIE, and enforcement

OPERATIONAL PLAN COMPONENTS

The Operational Plan shall include details on how the Strategic Plan will be carried forward and executed to enable statewide HIE. It must also include a project schedule describing the tasks and sub-tasks that need to be completed in order to enable the statewide HIE. The implementation description shall identify issues, risks, and interdependencies within the overall project.

General Topic Guidance

Coordinate with ARRA Programs

Coordinate with Other States

Domain Requirements

Governance – Governance and Policy Structures

Finance – Cost Estimates and Staffing Plans; Controls and Reporting

Technical Infrastructure – Standards and Certification; Architecture; Technical Deployment Business and Technical Operations – Current HIE Capacities; SOP for HIE

Legal/Policy – Establish Requirements; Privacy & Security Harmonization;

Federal Req

A self-assessment checklist has been developed by the AHIMA Foundation at www.slhie.org

FUNDING FORMULA DESCRIPTIONS

Base Allocation – For all states, DC, and Puerto Rico = \$4 Million

Equity Adjustment – Applies to states, DC, and Puerto Rico

Additional funds will be added to the base to account for differences in existing health care delivery environment. These additional funds will be determined by formula using the following equity factors and weights:

PCP Populations – 40% of total allocation

Short-Term (Acute) Care Hospitals – 30% of total allocation

Medically Underserved and Rural Providers – 25% of total all.

State Population – 5% of the total allocation

** Needs based adjustment Removed additional 10% to be redistributed to four equity factors above

MATCHING STATE REQUIREMENTS

Fiscal Year of Funding	Match Required
2010	None
2011 (October 1, 2010)	\$1 for each \$10 federal dollars
2012 (October 1, 2011)	\$1 for each \$7 federal dollars
2013 (October 1, 2012)	\$1 for each \$3 federal dollars

** Matching requirements can be provided through cash and/or in-kind contributions

CONTENT AND FORM OF APPLICATION

Letter of Intent
Project Abstract
Project Narrative (25-40 pages)
Current State
Proposed Project Summary
Required Performance Measures and Reporting
Project Management
Evaluation
Organizational Capability Statement
Required Plans (Strategic and Operational if available)
Collaborations and Letters of Commitment from Key Organizations
Budget Narrative / Justification

TIMELINES

First Draft	October 2, 2009
Internal Review/Validation	October 8, 2009
Letters of Commitment Due	October 9, 2009
Final Draft Available	October 12, 2009
Proposal Finalized	October 15, 2009
Submission Date	October 16, 2009

Dan presented information on the Regional Center.

Overview (from HHS Aug 27th)

- The purpose of the Regional Centers is to furnish assistance, defined as
- **education,**
- **outreach,** and
- **technical assistance**
- to help providers in their geographic service areas
- **select,**
- **successfully implement,** and
- **meaningfully use**
- certified EHR technology to improve the quality and value of health care.

Priority

- Priority shall be given to providers that are primary-care providers (physicians and/or other health care professionals with prescriptive privileges, such as physician assistants and nurse practitioners) in any of the following settings:
 - o individual and small group practices (ten or fewer professionals with prescriptive privileges) primarily focused on primary care;
 - o public and Critical Access Hospitals;
 - o Community Health Centers and Rural Health Clinics; and
 - o other settings that predominantly serve uninsured, underinsured, and medically underserved populations.
- Applicants must propose to serve a minimum of 1,000 priority primary-care providers over the initial two year budget period. The number of providers to be served must represent at a minimum 20% of the total primary-care providers in the proposed service area.

Services That Must be Offered

- Education and Outreach:
 - National Learning Consortium:
 - Local Workforce Support :
 - Practice and Workflow Redesign:
 - Functional Interoperability and Health Information Exchange:
 - Vendor Selection & Group Purchasing:
 - Privacy and Security Best Practices:
 - Implementation and Project Management:
 - Progress Towards Meaningful Use:
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- Education and Outreach:

- Disseminate knowledge about the effective strategies and practices to select, implement, and meaningfully use certified EHR technology to improve quality and value of healthcare
- National Learning Consortium:
 - Participate in the National Learning Consortium facilitated by the HITRC and share tools and materials developed through the cooperative agreement with other Regional Centers, interested stakeholders, and the public.
- Local Workforce Support :
 - Partner with local resources, such as community colleges, to promote integration of health IT into the initial and ongoing training of health professionals and supporting staff.
- Practice and Workflow Redesign:
 - Support for practice and workflow redesign necessary to achieve meaningful use of EHRs
- Functional Interoperability and Health Information Exchange:
 - Assist priority primary-care providers in connecting to available health information exchange infrastructure(s).
- Vendor Selection & Group Purchasing:
 - Help providers select the highest-value option -- the option that offers the greatest opportunity to achieve and maintain meaningful use of EHRs and improved quality of care at the most favorable cost of ownership and operation, including both the initial acquisition of the technology, cost of implementation, and ongoing maintenance and predictable needed upgrades over time.
 - Each Regional Center will offer unbiased advice on the systems and services best suited to enable the priority primary-care providers to become meaningful users of EHRs. Regional Centers will avoid entering into business arrangements creating an actual or apparent conflict of interest with the Regional Center’s obligation to act solely in the best interests of advancing meaningful use of certified health IT by providers it serves.
 - Applicants are required to submit a Conflict of Interest Certification with the vendors that that they’ve identified. If vendors have not yet been identified applicant can leave the vendor portion of the certification blank for the moment.
- Privacy and Security Best Practices:
 - Support providers in implementing best practices in the privacy and security of personal health information.
- Implementation and Project Management:
 - Support end-to-end project management over the entire EHR implementation process, including individualized and on-site coaching, consultation, troubleshooting.
- Progress Towards Meaningful Use:
 - Participate in program training and be able to provide their clients effective assistance in attaining meaningful use.

Motion by Randy Moses, seconded by Holly Arends to recess. Motion carried.

Tuesday morning 8:30 am. The meeting began with Kevin providing news of upcoming events. SD HIT Conference in Ft Pierre at the America Inn on October 8th. Discussion followed on the date for the Spring meeting which will be March 17 and 18th, 2010 at Chamberlain.

Legal Group report provided by Rick Puetz. His group reviewed the Roadmap goals, talked about two strategies. Step by step wise changes or wait a year to see what develops. Randy Moses took it upon himself to develop some legislature which he submitted to the Department of Health.

Kevin commented that there were general ideas for legislature received from Randy. The floor was given to Laurie Gill and she presented information from the DOH. DOH thought they should step back and wait to develop legislature that would give the authority to develop less detailed rules. Their experience show that detailed legislature can hamper the ability to move forward. Also guidelines are just coming out, maybe this group could develop legislature for 2011.

Rebekah Cradduck asked how the waiting would affect the time lines? Kevin thought we would be okay to wait. Rebekah also stressed the need for an educational push as Mike Rounds will not be our champion in 2011.

Motion by Randy Moses, seconded by Lynn Beck to adjourn the meeting. Motion carried.