

Joint Meeting HIT Steering Committee/Stakeholder Work Groups
October 2, 2008
Jamestown Hospital Room 446
Jamestown, ND

On-Site participants:

Chair - Lynette Dickson, Center for Rural Health
Marlene Miller, Center for Rural Health
June Herman, American Heart Association
Don Schott, BCBS
Alan Okerson, Trinity Health System, Minot
Nancy Willis, St. Alexius, Bismarck
Laurie Peters, HIMA/Northland Healthcare Alliance

Attendees by video conference:

Dana Halvorson, Senator Conrad's Office, Washington DC
Dr. Cathy Houle, West River Medical Center, Hettinger
Bruce Levi, NDMA
Howard Anderson, ND Board of Pharmacy
Ann Rathke, Telepharmacy Program, NDSU
Dean Haas, General Council, NDMA
Becky Hansen, SW Healthcare Services, Bowman
Maren Swofford and Stacy Ramberg, Mountrail County Medical Center, Stanley
Lisa Feldner, Jeff Swank, Art Bakke, ITD
Jenny Witham, Dept. of Human Services
Kimber Wraalstad, Presentation Medical Center, Rolla
Darren Meschke, NDDoH
Don Larson, UND School of Medicine & Health Sciences

Attendees by phone:

Mary Wakefield, Center for Rural Health
Vonnie Ereth and Paula Flanders, Missouri Slope Public Health, Bismarck
Tami Wahl, Governor's Office

Background – Proposed HIT Grant Program

The HIT Steering Committee was invited to present to the ND State Legislative IT Interim committee again on October 6th.

Since our last meeting the Funding/Resources workgroup followed up on ideas presented at the statewide meeting held in June and reviewed nine state HIT grant programs. Best practices were pulled together from the varying states and used to develop a proposal/draft guidance for review. We also have received permission to use MN guidelines and legislative language. Two levels of grants are suggested from the work group and a third added from Lynette Dickson based on research, examples from other states and conversation with other steering/stakeholder members.

The HIE work group sent an inquiry asking for feedback on what percent of rural/urban providers are needed before embarking on a statewide HIE. There were limited responses. However, they agreed with Funding and Resource group recommendation to develop an HIT grant program as described above. They also agreed with the 75/25 match from the applicant should be part of the grant program.

Legislative Processes/Suggestions

Bruce Levi was asked to share his perspective on approaching the interim committee (for October 6th meeting) and discuss how that segways into the draft legislation proposed. Suggestion for next steps – Interim committee isn't going to play a role introducing legislation as a committee; if Monday is their last meeting they don't have a bill draft prepared under their policy. Monday (Oct 6th) will be a good touch point for legislators – if there is testimony it will be included in their notes and information for all; good opportunity to update members who are in-tune with IT – knowledgeable in this area; building champions in those committee members. The goal for Monday is ensuring we use the 35 minutes to educate about the needs of ND, survey findings, some of the conclusions and recommendations and the challenges. This will serve as a backdrop for legislation proposed in upcoming session. We have two prominent state senators involved (Judy Lee/Larry Robinson). Decide how to move a bill into session – bipartisan? Who supports/introduces the bill? Where does the grant program come from – ITD, health department? Then move into details of grant program and how it would work, be administered, etc. Treat the two opportunities separately. Need time to develop strategy around legislation.

Question was raised as to where this stands with the Governor's office. Lynette shared that she met with Tami Wahl and Ryan from the Governor's office following the 2007 Session and at that time they recommended following the process we did last Session. We have inquired a number

of times on our monthly conf calls and have been told it was too late; and were advised to go the route we are currently going.

Question raised if there is an opportunity within their budget. ITD advised that their deadline was July 15th and is complete with hearing on Wednesday. They can ask but suspect not a viable option – they would probably recommend we do it through a separate bill. Discussion included Department of Human Services whose budget is due October 15th. Jenny Witham advised that if the Governor wanted to do this, he we would but it is very late in the process; they are finalizing budget now with OMB; if Tami wanted to work with OMB to have an OAR in their appropriation request it would need to come from their office.

Another option proposed was through the Health department – their deadline was August 15th – others say it is in validation process so perhaps a possibility if it goes through the Governor's office.

The group agreed to share a broad brush approach with the IT Interim Committee on Oct 6th of the grant program. Nancy Willis stated - At the last meeting Lynette gave a nice summary of activities to date and federal dollars received to support different HIT projects. Committee at that time was very interested in results of the pending surveys, to see where the gaps exist in the health care industry in ND as far as IT is concerned. Give the committee an understanding of what level everyone is at and what they need to do to get there. This is definitely the intent.

Decision Point 1: Are we requesting appropriation for a HIT grant program only, or something else? **All participants agree that we move forward with a HIT grant program. Details to be worked on by the Funding/Resources workgroup.**

Grant program:

Questions asked as to whether the grant program will be a natural extension to the identified survey needs. The results reflect two tiers (those with EMR, those planning for the implementation of an EMR) – we need to make sure records will talk to each other down the road/exchange. Suggestion to add anticipated outcomes that connect the grant with the justification to the outcome (based on draft summary shared with the group prior to the meeting). Suggestion to sum up the connection along with timelines for short and long term goals. Suggestion to include concrete examples/illustrations to explain why each type of grant is important as the content can be nebulous. Some of this has already been done with specific examples shared at last interim committee meet. Suggestion that repetition for this group is okay due to new legislators to the committee. Question as to whether we are able to provide a description of ND in terms of what it will look like in 10 years if we continue along the road we've been going and in 10 years if we invest now – and include why this is timely.

New ideas:

- Do we want to create a 501c3 for a group that could apply for separate funding? Lynette advised that this is a forthcoming recommendation from the consultant group working on a ND Report.
- Start a committee that would take a look at different ways to share information and start to think through ways so people are assured that disparate systems will be compatible/interoperable in the long run. This group already exists – the HIE workgroup.
- We need to talk about identity management and exchange of records; BCBS is working on Medi-q home; this may take care of some of the issues. Also a fit for the HIE workgroup.

Decision Point 2: If we are requesting appropriations for a HIT Grant Program, is this for EHR, e-prescribing and telehealth pilot project?

To date discussion has included whether to limit the grant program to one area of HIT (e.g. EHR, e-prescribing, telehealth). Ultimately decision of the group was to leave the grant program open to varying HIT initiatives including the 3 proposed tiers.

Discussion around Point 2 included:

(Jeff) What is the problem statement for this? (Howard) As a statewide goal – we need to focus as everyone implements EHR, e-prescribing, and more – it is most important to share the information between facilities taking care of patients/residents – info should follow them anywhere that helps the provider take care of them no matter where they are. Not sure the state should buy hospitals an EHR – we should help them plan and be able to exchange information.

(Nancy) We need to help rural purchase equipment to get them to a place to be able to engage in information sharing – rural doesn't have the funds or the people to do this alone (Maren).

(Kimber) agrees with Howard; ultimate goal is to have information from health providers be electronic so we can share it wherever – we cannot get there if we don't have the information in an electronic format to exchange – yes we want this; but if public health units don't have their data electronically or hospitals, or others, then it's a “no-go”. Regarding including this in our cost report – 22/27 CAHs are losing money on operations – sounds good to include in our cost report. It will come at a cost to other things (can't purchase everything). The funding request (any of the 3 options) will not solve the problems – it will help us leverage other funding and get us started. We cannot do this independently – we have to work together as a state – this message has to be strong! And reinforced!

(Lisa) – sounds similar what we have with education and law enforcement; schools can't afford to run a student info system alone; technical people not available; state hosts the environment and schools pay a fee to use the system (system located at ITD) – it is successful and going “all-

schools” in next biennium. The state also has a program for law enforcement (\$25 a month) to use records management system. Do we want to go this route for health care? Not sure in health care if there will actually be repository of information at the state level – other states have an exchange box where everyone keeps their own data and can go into the “box” to exchange the information. Lisa – this is what happens for law enforcement – there is no central repository.

(Nancy) Ultimate long term goal: develop state infrastructure to have process to access all info for care of the patient – not a central repository. Info would be accessible for whoever has care of the patient.

Now – how can the state help the entities that aren’t involved in anything yet – get them to a level of assistance to start moving in the needed direction for the good of the state.

(Kimber) – There are network models trying to streamline and select similar solutions; sharing hardware (not software due to vendor restrictions) to make it more effective and efficient. We are trying to move into this scenario – shared relationships.

We need to have something in our documents of the examples of group organizations that have been pulled together (networks, 501c3). Promotes cost-effectiveness.

We need to state the problem – if we give funding to health facilities; we have to have some oversight so they pick something that will talk/exchange with others; a group with legislative support (not volunteer) that ensures it is working toward all options to exchange within the state and external. This would also ensure facilities don’t “waste funds”. There are so many projects going on (different regions in the state); many trying to do the same thing; working together and help each other. Don’t think these efforts are counter to each other. The varying grants received to date have increased the timing for others to move on this quicker.

(Lynette) reminded the group that we do have a statewide mission and vision and the grants do outline the need for compliance with CCHIT. During the June meeting, the HIE work group outlined a regional approach that moves toward statewide vision for HIE. This needs to be formalized moving forward.

(Laurie) Do not limit grants to EHR – upfront planning is needed for success; there are so many levels needed; facilities are in different places; flexibility would be beneficial.

(Don) Need to show some success stories for the state to see (e.g. BCBS grants); there are good examples (Park River – CT scanner); e.g. showcase efficiency, patient care, cost savings. ROI can be difficult to show financially; but quality of care is the issue – all grants need to focus on evaluation – showing outcomes and ROI – networking.

For the Implementation grants - Would these applicants have to demonstrate a planning process has taken place in order to apply for implementation grants? Yes, that has been included in the DRAFT guidance.

A lot of the focus is on rural due to needs; however focus on urban connection and benefit to all needs to be highlighted – NDHA won't support it otherwise. Has to be rural and urban. **Need to review grant to ensure we are specific in guidance to connection and partnership with urbans.** St. Alexius's is supportive of rural acquisition of grants because they are coming to urban for assistance and we don't have the capacity to help them all. **Make sure NDHA is well aware of urban/rural benefits.**

Decision Point 3 – What funding level will we be requesting? Is this for one biennium or more?
Total funding request – will continue to work on a bit more; get feel from legislators on what is a reasonable request.

CRH compiled all of the federal and nonfederal grants that have been awarded in ND for HIT over past 9 years (approximately \$10M).

Group reviewed three funding level options.

Types of grants (2009-2011) 2013) 2015):

- I. Readiness Assessment and Planning
- II. Implementation (EMR, e-prescribing)
- III. Implementation (telehealth)
- IV. Health information exchange collaboration grants

Who is eligible to apply? See draft description. (Kimber) suggests adding networks or 501c3s (currently says non-profits); other non-profits comprised of networks and eligibles. Note: A description of a network organization has been included in the DRAFT document.

Do we apply for maximum amount? Have some conversation ... are we in a position now to know the sense of legislators and where we might go with the specific dollar amount; it would be important to have one-on-one conversations with legislators to ask for their ideas; sense of their openness to varying amounts, etc. The Legislative and Policy work group will discuss next steps (Nancy).

Important when visiting with legislators to support the planning process. Ensuring tech people are available to ensure implementation of this goes smoothly – need to hone in on these discussions. [Center for Rural Health is doing scan of academic/tech supply side of IT support to get sense of current training availability of future IT experts to work in this area.]

Add input on dollar amounts listed in the spreadsheets – if we were to fund everyone what would it cost?

Add column to spreadsheet of number of facilities that could apply for each level of funding – shows justification of the number that could be benefited. Flip columns (potential # facilities and # grants). Add in-kind column to reflect facility contributions. Change “potential” to “minimum” numbers of facilities served.

Proposed funding per grant (*each grant would require a minimum of 3 facilities working together*):

\$45,000 for Readiness/planning based on going rate for consultants to provide this service

\$900,000 for Implementation based on current CAH HIT Network Implementation Grant

\$50,000 for telehealth appropriate per NDSU Telepharmacy program

\$500,000 for HIE collaborative seems reasonable based on tertiary experience.

We’ll hold these numbers for now and work through Funding/Resource work group.

Question related to the number of participants, particularly the planning grant. Might be low as currently as is; suggestion was made that planning grants should be doubled (\$900K). How would legislators view the lesser amount on planning grants given what we’re saying about the importance of these?

Discussion related to administration of these grants; Arizona has a line item for a grant program and is administered by a Project Management Organization within the Tech Dept. that manages this and other state initiatives. They have 1 ½ FTE.

Question – Is it reasonable to include in the request funds for the operation of the Steering Committee; or a statewide HIT symposium/summit similar to last Session? If this committee is going to be part of the grant process as an advisory group and making awards then yes, this committee should be funded and looked at for continuity. Last year we requested about \$80K which also would have supported the environmental scan, writing the report, committee meetings – that was denied. The Steering committee has not discussed this. This is also a question for Dr. Dwelle. Legislative and Policy committee will also share this with him.

Question was raised - How is all of the committee work being paid for to date? (Lynette) shared that volunteer hours from all have been estimated (over 2000); the SORH, Flex, SHIP federal grant programs (Center for Rural Health) have contributed the majority of the support, since 2006 approximately \$55,000; June, 2008 meeting supported, in part, by BCBSND (\$3500); HIMA, ND Healthcare Review, BCNSND have supported travel to out of state meetings. Creating and maintaining a website – minimum of \$5K a year. This does not include conducting all of the surveys. This was all referenced in the presentation to the Interim Committee;

Funding and Resource work group will fine-tune grant guidance and spreadsheet of funding levels.

Legislative and Policy work group will move forward with strategy on connecting with legislators and informing others.

Decision Point 4 – What will be presented to the IT Interim Committee – October 6. We have 35 minutes. Nice to do Power Points but probably not as efficient as the committee always seems to be running late.

- General overview of results from surveys (students, clinics, LTC, hospitals, supply of IT techs?)
- General overview of current activities related to grant program and forthcoming request for funding; do not share any handouts related to grant program yet – can make general overarching statements that refer to the idea
- Focus on justification of need
- Lynette hopes to have report available – Phase I is being worked on by John Snow Inc. If it is not ready to go by Monday; it will be mailed to legislators with a cover ltr.
- Education: have examples shared of what/why this is needed and so important; and answer questions.
 - Focus on small and large facilities
 - Providers, students, administrators

Presenters include:

- Kimber will present on rural perspective; hospitals, long term care, clinics, etc.
- Nancy will attend – discuss further with Lynette re agenda.
- Nancy will check on provider representation.
- Howard will share compelling story about lack of pharmacy and success of tele-pharmacy project. Example: because there is no connection to EMR, they have to fax, scan records back and forth; rather than access e-record. This very issue puts up a roadblock to moving forward with vision of HIT in the state.
- Lynette will present on environmental scan.

In general, we need to be sensitive to how legislators look at amount and source of grant funds already accessed. Caution that federal funds are not guaranteed; ND has received a number of grants in the past and may not be a future focus if other states are more in need. Some federal grants are not available to ND (e.g. CMS Demonstration incentive project - ND did not have enough providers currently using EHR to qualify)

Next steps

HIT 101 for Legislators – perhaps in December or during legislative session. Some very basic education – mini EMR demo; CR – digital image; pharmacy. Walk them through continuum of care (with and without IT to show the difference). Ann Rathke very supportive of this – good way to learn and make it real for them. Talk with Senator Robinson about best vehicle to get their attention. Perhaps Senators Lee and Robinson might want to host/invite the session for counterparts. Communication/Education work group will work on planning this.

Suggestion - Look into video-taping legislative demos and load onto website for further use.

Education of facilities (hospitals, clinics, LTC) – how do we share talking points with those in the field so they are informed and know how to approach their own legislators and what to say?

- Funding and Resource work group - clean up grant program documents.
- Legislative/Policy work group - strategize around approach
- Communication/Education work group - work on message, F&Q and dissemination; plan HIT 101 Demo Day
- HIE work group – using the 2015 as a timeline, calculate the overall cost of implementing EHR across the state; the development of the regional information hubs, and eventual statewide HIE. Create a visual to share with legislators to demonstrate this.

OTHER BUSINESS

AHRQ Grant opportunities

- 3 new opportunities recently released
 - o <http://www.ahrq.gov/fund/grantix.htm>
- None of these have been funded in North Dakota
- Montana received 3 last round
- Not rural-only focused

Other IT related requests for funding by others?

(June) American Heart Association – honed in on a stroke registry request; have had meetings with the Governor’s office and the Health Department; hope to pursue some basic technology support; licensing – to put coordinators out there to assist the hospitals with the technology learning piece and funds for assistance with some of the data entry.

(Kimber) NDHA - There has been loose discussion regarding potential request for capital for hospitals through NDHA – not sure where this is at. At one time it also included funds for IT – Kimber not thinking this is going through. There is a small group of CAHs to share information related to issues – average age plant and limited ability to put money into infrastructure and ability to access those funds; conversation is occurring but no official proposal.

(Paula) – The Center has conducted an electronic survey, collaboration with Dept of Health and their public health liaison – results not yet available. Their group recently met; public health

group from administrator's group has requested funding for electronic equipment – going in through a request in the Governor's budget – other things included (home visits for emergency preparedness and some for electronic records - \$20K for each unit). There are 28 local public health units. No idea yet if the Governor will put in this budget. Dependent Health Dept's budget; may need to also go to legislators separately on this bill.