

SB

133

<target><bill>SB 133</bill><subject>SB
133</subject><comm>SFIN26</comm></target>

ALASKA STATE LEGISLATURE

Senator Joe Paskvan

State Capitol Building, Room 7
Juneau, Alaska 99801-1182
<http://paskvan.aksenate.org/>



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Senate District E – Fairbanks, AK

Sponsor Statement SB 133

Alaska health care providers and patients continue to rely on an outdated healthcare infrastructure, with many providers using only paper based systems, which contributes to dangerous drug interactions, missed diagnoses, costly delays, duplicate testing and administrative overhead. According to national studies, these problems contribute to approximately 5% of health care expenditures or \$250 million annually in Alaska and unnecessarily degrade the quality of health care for all Alaskans.

SB 133 modernizes Alaska's healthcare IT infrastructure by developing a secure electronic Health Information Exchange (HIE) system to improve the *safety, cost effectiveness, and quality of healthcare* in Alaska. This standards-based electronic health network will allow individual Alaskans to have their own personal health record and to authorize their health care providers to exchange electronic medical records in a timely, secure manner.

The use of such technology requires careful and strict privacy protection measures. Current Federal and State laws already provide a number of standards protecting a patient's privacy and personal information. The privacy and security rules contained in the Health Insurance Portability and Accountability Act (HIPAA) most directly and extensively impact the HIE system. HIPAA establishes individuals' right to review and obtain a copy of their health information, requires notice of privacy practices, limits the use of records and the disclosure of information, and institutes strict security standards.

SB 133 establishes further strict standards to secure and protect the confidentiality of individually identifying health information of a patient. These standards include a secure and traceable electronic audit system to allow patients to see who has viewed their record, restrictions on how information may be used, patient consent requirements, an ability to opt out of the health information exchange system, and notification of confidentiality violations.

When complete, the Health Information Exchange System will have the capability to provide any Alaskan with a secure Personal Health Record, including authorization for their health care providers on the network to have access to electronic records required for continuity of care, such as hospitalization records, prescription information, vaccinations, allergies, imaging records, laboratory results, etc. The Network will support telemedicine services, the transfer of high resolution images for patient care, video conferencing, and Voice over Internet applications for providers.

Over 300 health organizations in Alaska are eager to participate in the electronic Health Information Exchange system.

I urge your support for SB 133.

SENATE FINANCE COMMITTEE REPORT

DATE: 3/30/09

FURTHER:

DATE TURNED
IN TO OFFICE: 4/13/09

Finance Committee considered SENATE BILL NO. 133

SB 133 ELECTRONIC HEALTH INFO EXCHANGE SYSTEM

"An Act creating a statewide electronic health information exchange system; and providing for an effective date."

and recommends:

- be replaced with SCS or CS SB133 (FIN)
- adopt previous SCS or CS ()
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

SENATE BILL:
 Same Title
 New Title

HOUSE BILL:
 Same Title
 Technical Title Change
 New Title w/ SCR # _____


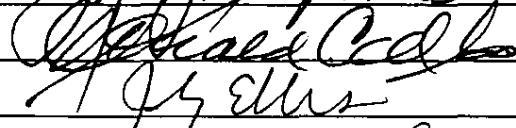
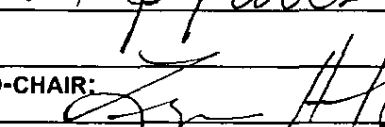
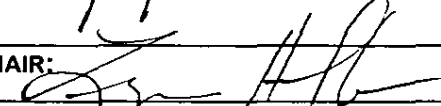
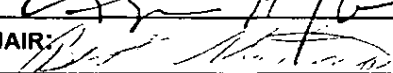
NEW FISCAL NOTE(S):

| Department | Date | Fiscal | Indet. | Zero | FN# |
|------------|---------|--------|--------|------|-----|
| DHS | 4/10/09 | ✓ | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

PREVIOUS FISCAL NOTE(S):

| Department | Date | Fiscal | Indet. | Zero | FN# |
|------------|------|--------|--------|------|-----|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

APPROPRIATION - no fiscal note

| SIGNATURES AND RECOMMENDATIONS: | PRINTED LAST NAME | DO PASS | DO NOT PASS | NO REC | AMEND |
|---|-------------------|---------|-------------|--------|-------|
|  | Thomas | ✓ | | | |
|  | OLSON | | | ✓ | |
|  | ELLIS | ✓ | | | |
| CO-CHAIR:  | Hottman | ✓ | | | |
| CO-CHAIR:  | STEINHILBER | ✓ | | | |

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB 133
() Publish Date: _____

Identifier (file name): SB 133-DHSS-MAA-03-13-09 Dept. Affected: Health & Social Services
Title: Electronic Health Info Exchange System RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Paskvan, Davis
Requester: Senate HSS Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

| | Appropriation Required | | Information | | | | |
|-------------------------------|------------------------|------------|--------------|----------------|----------------|----------------|----------------|
| | FY 2010 | FY 2010 | FY 2011 | FY 2012 | FY 2013 | FY 2014 | FY 2015 |
| OPERATING EXPENDITURES | | | | | | | |
| Personal Services | 232.2 | | 232.2 | 232.2 | 232.2 | 232.2 | 232.2 |
| Travel | 10.0 | | 10.0 | 3.0 | 3.0 | 3.0 | 3.0 |
| Contractual | 18.8 | | 18.8 | 2,118.8 | 2,118.8 | 2,118.8 | 2,118.8 |
| Supplies | 9.2 | | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Equipment | 10.0 | | | | | | |
| Land & Structures | | | | | | | |
| Grants & Claims | | | | | | | |
| Miscellaneous | | | | | | | |
| TOTAL OPERATING | 280.2 | 0.0 | 265.0 | 2,358.0 | 2,358.0 | 2,358.0 | 2,358.0 |

| | | | | | | | |
|-----------------------------|-----------------|--|--|--|--|--|--|
| CAPITAL EXPENDITURES | 27,275.0 | | | | | | |
|-----------------------------|-----------------|--|--|--|--|--|--|

| | | | | | | | |
|-----------------------------|--|--|--|--|--|--|--|
| CHANGE IN REVENUES (| | | | | | | |
|-----------------------------|--|--|--|--|--|--|--|

FUND SOURCE (Thousands of Dollars)

| | | | | | | | |
|----------------------------|-----------------|------------|--------------|----------------|----------------|----------------|----------------|
| 1002 Federal Receipts | 24,799.7 | | 238.5 | 1,281.3 | 1,281.3 | 1,281.3 | 1,281.3 |
| 1003 GF Match | 2,755.5 | | 26.5 | 1,076.7 | 1,076.7 | 1,076.7 | 1,076.7 |
| 1004 GF | | | | | | | |
| 1005 GF/Program Receipts | | | | | | | |
| 1037 GF/Mental Health | | | | | | | |
| Other Interagency Receipts | | | | | | | |
| TOTAL | 27,555.2 | 0.0 | 265.0 | 2,358.0 | 2,358.0 | 2,358.0 | 2,358.0 |

Estimate of any current year (FY2009) cost: _____

POSITIONS

| | | | | | | | |
|-----------|-----|--|-----|-----|-----|-----|-----|
| Full-time | 2.0 | | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

ANALYSIS: (Attach a separate page if necessary)

SB 133 proposes to oversee creation of a secure statewide electronic health information exchange system. It would mandate the department oversee 1) infrastructure planning by a qualified nonprofit or for-profit entity; 2) implementation measures that include installation and training, a plan to encourage use of the system, support to providers, and compliance with federal and state health information policies. The fiscal note assumes federal stimulus funding is available for the first five years of the project; it assumes those funds will create a number of new private sector jobs with those funds, and that the project promotes cost efficiencies across the public and private health delivery systems. The project assumes that when federal stimulus funds are gone, the electronic exchange system will be self-sustaining afterward from a combination of public and private sources that utilize the system. (continued on next page)

Prepared by: William J. Streur, Deputy Commissioner Phone 334-2520
Division: Health Care Services Date/Time 4/10/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner Date 4/10/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB 133

ANALYSIS CONTINUATION

Given the size and complexity of the task, the department has chosen to pursue funding in both the operating and capital budgets. The department believes that this approach enhances the overall success of the project.

The Division of Health Care Services estimates that it will need a total of 2 FTE's for the planning and administration of the electronic health information exchange system.

Operating Budget :

Administrative costs

1 Project Manager, \$150.0, 1 Accountant III \$82.2, All personal services costs include benefits. Assumes \$9.4 per FTE annually for office space, phones, and other contractual costs. Assumes \$2.6 one time costs per FTE for computers and software. Assumes \$5.0 one time costs per FTE for Office equipment. Assumes \$2.0 per FTE annually for supplies. Assumes \$10.0 for travel for first 2 years and \$3.0 for remaining years.

Maintenance

Assumes \$1,800.0 per year for hosted service maintenance costs beginning in FY2012.

Assumes \$300.0 annual maintenance costs for broadband support beginning in FY2012.

Capital Budget:

Planning

Assumes approximately \$1,500.0 will be needed for infrastructure planning, Statewide Technical planning, policy and standard planning, training and workforce development planning, and health information policy compliance.

Implementation

Assumes \$13,000.0 one time costs will be needed for contractual services to upgrade broadband support statewide for the electronic health information exchange system to be interactive, responsive, and less subject to frequent breakdowns especially in rural parts of the state. Assumes \$7,000.0 one time costs will be needed for hardware and software updates for the system. Assumes \$5,775.0 one time costs will be needed for Health Electronic Records repository, patient and provider portals.

Fund Source

Assumes 90% federal for FY2010 and FY2011

Assumes 54.34% federal for 2012 and beyond

Adopted
4/13

26-LS0489\P.2
Mischel
4/10/09

AMENDMENT 1

S. Thomas

OFFERED IN THE SENATE
TO: CSSB 133(HSS)

1 Page 4, line 7:

2 Delete "the state or"

3

4 Page 4, lines 8 - 9:

5 Delete "or a combination of the state and one or more entities under contract with the
6 state"

7

8 Page 5, line 2, following "information":

9 Insert ";

10 (6) ensure that the health information exchange system becomes self-
11 sustaining through a combination of user fees and other private and public funding
12 sources."

CSSB 133(HSS) Amendment
Summary

This amendment does two things:

1. Deletes the designation of "the state" as an option for fully implementing and operating the HIE system
 - a. It is not necessary to have a big-government operation when there are private sector options – the state can just act in an oversight role.

2. Puts in statute the expectation that the designated entity must become self-sustaining through a combination of user fees and other private and public funding sources.

SB 133 - Electronic Health Info Exchange Questions and Answers

1. Impact of developed AeHN to sole practitioner
 2. Does North Sound Support?
 3. \$27 million fiscal note includes federal dollars - if we don't get the federal stimulus funding have we obligated the state to \$27 million general funds?
 4. Why does the fiscal note include 6 positions?
 5. What happens if this bill doesn't pass this year?
 6. What "strings" are attached to the stimulus funding?
 7. Do we need the state match?
-

1. Impact of developed AeHN to sole practitioner?

SB 133 does not mandate any provider to implement (Electronic Health Records) EHRs or to join the Health Information Exchange (HIE) system.

It is anticipated that any provider could join the network for a minimum membership fee of \$50/year. Additional fees would be charged for additional services such as practice work flow design and use of an ASP (application service provider) model EHR. By utilizing a shared network to exchange data, the cost to private providers is greatly decreased.

The real benefit to providers is in the connectivity. While the provider may be able to implement a local EHR, the real need is to have access to data in other provider EHRs. This is what will provide "meaningful use". Note that meaningful use is still being defined by CMS (Center for Medicare/Medicaid Services), but connectivity has been identified as one of the criteria.

2. Does Norton Sound support?

All of the regional organizations including Norton Sound have signed letters of agreement to participate in the FCC network build out for the non-profit AeHN and are participating in the ongoing health information exchange planning process.

The health information exchange does not provide the regional corporations with EHRs, but does connect the EHRs currently being installed at regional locations with the ANTHC EHR and the rest of the state.

3. \$27 million fiscal note includes federal dollars - if we don't get the federal stimulus funding have we obligated the state to \$27 million general funds?

The current fiscal note is based on a state-developed Health Information Exchange (HIE), with state employees. However, SB 133 allows the state to designate an entity other than itself to plan and implement the system. This approach would avoid costs of state employees and place the costs in a non-profit, user supported entity.

Below may be considered alternative fiscal note summary language which would identify the actual costs to the state based on the cost estimates prepared by the non-profit AeHN:

2010 \$1.3M (stimulus match) plus \$65K (1 FTE for a oversight position)
2011 \$1.0M (stimulus match) plus \$65K (1 FTE for a oversight position)
2012 \$1.0M (Operations membership fee) plus \$65K (1 FTE for a oversight position)
2013 \$1.0M (Operations membership fee) plus \$65K (1 FTE for a oversight position)
2014 \$1.0M (Operations membership fee) plus \$65K (1 FTE for a oversight position)

The AeHN Business Plan shows the cost being borne by all of the stakeholders not just the state. The State's ongoing bill is \$1M. This amount is offset by a potential savings to Medicaid of \$10M.

4. Why does the fiscal note include 6 positions?

The state is projecting the entire project cost in the fiscal note if the state were to fully implement it on its own. With SB 133, the state has the option to designate another entity while maintaining oversight.

The state oversight may be handled by 1 FTE. A second position may be required for Finance. The other positions are part of the HIE and would be covered in the sustainable model by revenues generated through user fees.

5. What happens if this bill doesn't pass this year?

Passing this bill would cement the state's involvement in the HIE project, demonstrate the state's commitment to HIE, require a standards based approach, and solidify privacy standards on Alaska's terms. Other states are moving forward with a similar approach. With the availability of stimulus funds, and additional competitive grants, passing this bill would put a designated entity in a better position to be awarded additional funding.

If it doesn't pass, the HIE project would not have the match required to apply for regular grants, stimulus grants or the stimulus match required funds. Essentially, the existing work done to bring Alaska along with the rest of the nation for health information exchange would be severely impacted and momentum to complete this project would be lost.

SB 133 ensures that progress toward HIE completion is done on Alaska's terms. It outlines additional privacy standards not currently existing in Federal and State law.

AeHN will continue to look for additional funds from other funders (Denali, Rasmuson and others), and will do this whether there are stimulus funds or not. However, the guarantee for success is much higher with a state match. The \$10 million FCC project which is already approved by the feds would also be placed on hold.

6. What "strings" are attached to the stimulus funding?

There are no strings attached according to the Office of the National Coordinator (ONC) staff and the speakers at a recent HIMSS Conference. All the federal agencies are feeling the push from the Obama administration to get stimulus funds released. In particular, agencies are focusing on the money that will be given directly to states. But all agencies are gearing up for an increased number of competitive grants as well. There are still unanswered questions regarding the release of funds, but each day brings additional clarity as agencies meet with consumers.

The HIMSS Conference in Chicago was attended by over 30,000 people representing most of the states. Almost every state is approaching electronic health network system development similarly as proposed in SB 133—partnership organization with a state designated, shareholder based entity. Speakers from Congress, federal agencies, HIE Directors, providers and consumers all spoke about the need to include private providers, state agencies, federal agencies, consumers and payors.

7. Do we need the state match?

Yes. The language in ARRA is clear, and requires a 90/10 match. The state is a key player in the health information exchange process. Without state commitment, this project will move much slower and cost the state more over time. The non-profit, AeHN, which has already made significant progress, will continue to pursue other revenue sources whether the state money is awarded or not.

There will be stimulus funds available very soon in the form of competitive grants from federal agencies such as HRSA, FCC, and NTIA to anyone. If a non-profit has the \$1.3M, they can use it as match for other funds as well. They can apply for these funds with or without the governor's approval of the stimulus \$\$ for states. State match will be necessary to apply for these funds as well.

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

MEMORANDUM

DATE: April 9, 2009
TO: Senator Bert Stedman
Chair, Senate Finance
FROM: William J. Streur
Deputy Commissioner
SUBJECT: SB 133

Chair: No, I'm under the assumption that we're looking at 6 FTE and capital expenditures of 27.9 of which 25.1 is federal. I mean we don't *have to* take action on this bill. So, I guess I'm struggling with the timing issue because we are going to be out of session apparently when the administration decides or doesn't decide to accept any of the stimulus funding.

Does it put us in any jeopardy if we just set this aside until January when you make your decision?

DHSS: To answer your question regarding a delay until next year, it may jeopardize our ability to realize the full benefits as envisioned under the bill. The ARRA Stimulus Funds anticipated come from two pots of money; the Provider pot for provider enhancements to encourage expansion of HIT/HIE/EHR activities. This money requires no match and is intended to be provided on a first come first served basis until gone. With this funding, we also face the potential ire of providers who would like to access that funds source for their efforts. CMS believes we may place the provider incentives in jeopardy as well as potential good will if we do not request the money. The money could potentially not be available once we are approved to request the funding and the authority to spend it. The second pot is more straightforward and, with the Legislature/Governor's approval, we will be able to request the funding from CMS through an Advance Planning Document (APD) much as we do when planning for Medicaid expenditures on an annual/biannual basis.

My concern is with our spending limits. In the past couple of years we have taken significant cuts in the Medicaid budget and our federal authority has been cut right along with our GF authority. So, I do not have enough authority on the books right now to spend the money even if I am able to submit the APD to request the funds.

CMS does not believe enough is known on the larger 90/10 match funds and how aggressive the states will be in their efforts to go after the money. They believe if there is significant interest, there may be less funds available in the second year, but that remains an unknown.


We continue to look carefully at the elements of the legislation and also the planning funding contained in the ARRA to determine what the state's role should/could be, particularly in this current revenue situation with over \$1 billion in revenue shortfall for the next fiscal year.



Deploying a Health Information Exchange for Alaskans



Paul Sherry, President
Alaska eHealth Network
March 2009



Medical Care: **From Paper to Electronic**

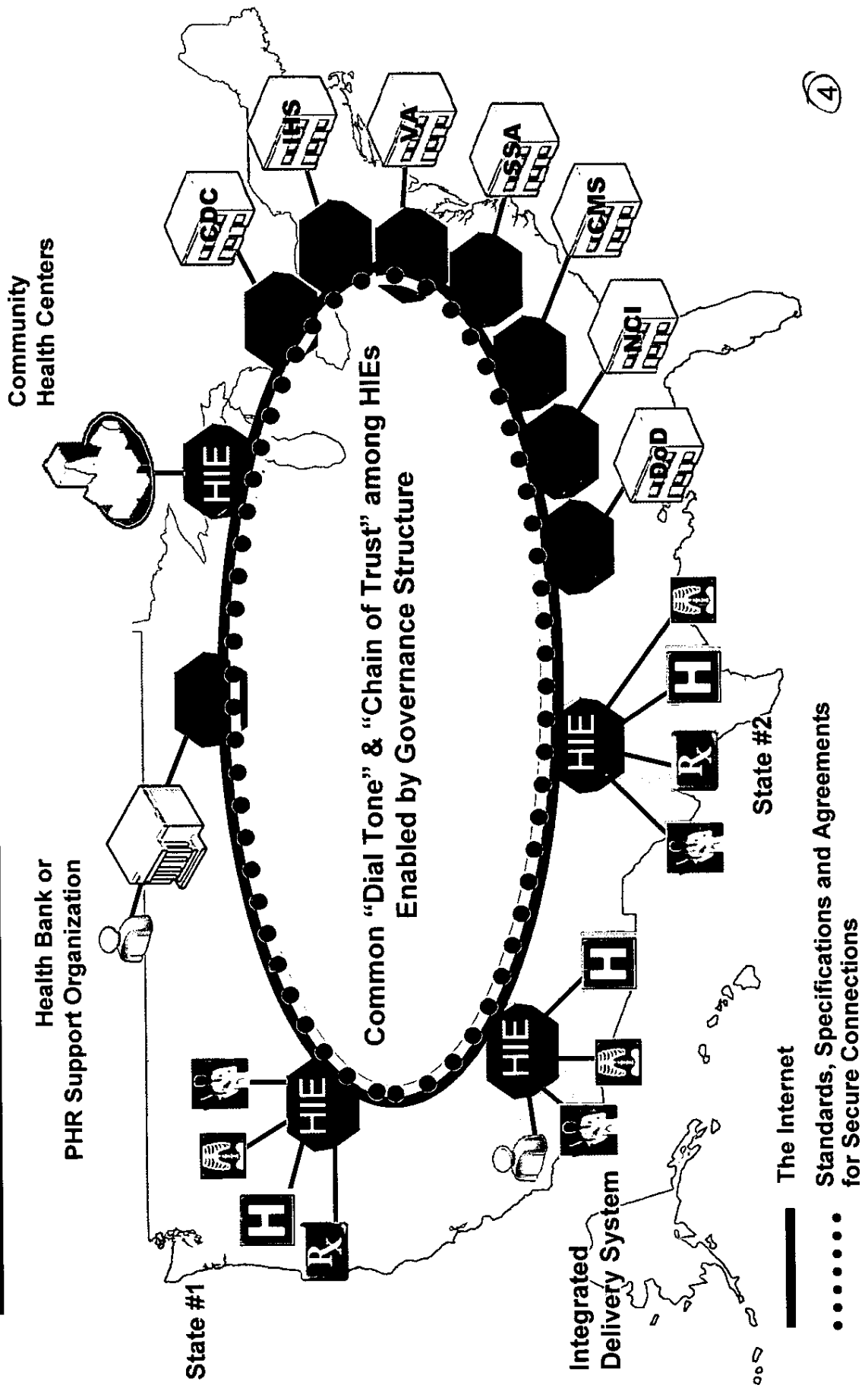
- Alaska's health care providers are now making major investments (\$100M+) in moving from paper records to **Electronic Medical Records**
- Alaska's health care providers are aligned in support of creating a statewide **Health Information Exchange** network so patient records may be securely exchanged between providers for timely and safe patient care
- State of Alaska plays a **key role as a partner** in Alaska's developing Health Information Exchange



Health Information Exchanges: **National effort: State Solutions**

- Statewide and regional health information exchanges have developed over the last 10 years in other states
- “National Health Information Network” concept created in Bush administration and enhanced in Obama administration through ARRA 2009 stimulus
- Successful State Models:
 - DHIN - Delaware Health Information Network
 - CalRHIO – California, Los Angeles County
 - FHIN – Florida Health Information Network
 - Regenstrief – Indiana Eight County Network

NHIN "Network of Networks"



Health Information Exchanges: **Providing timely, safer care**

- Provide rapid access by authorized providers to critical patient information at the point of care
 - medical history allergies
 - medication status laboratory reports
 - immunization status imaging reports
- Reduce redundancy in medical testing and procedures
- Improve patient safety through reducing medication reconciliation errors
- Reduce provider administrative costs for data management
- Expedited response to public health emergencies



Health Information Exchanges: Respecting Patient Privacy

- Do not require centralized patient health record repositories: health providers continue to own their records
- Facilitate connectivity with patient's Personal Health Record choices
- Respect patient decisions to opt-out of network participation
- Provide significant penalties for data breaches



Health Information Exchanges:

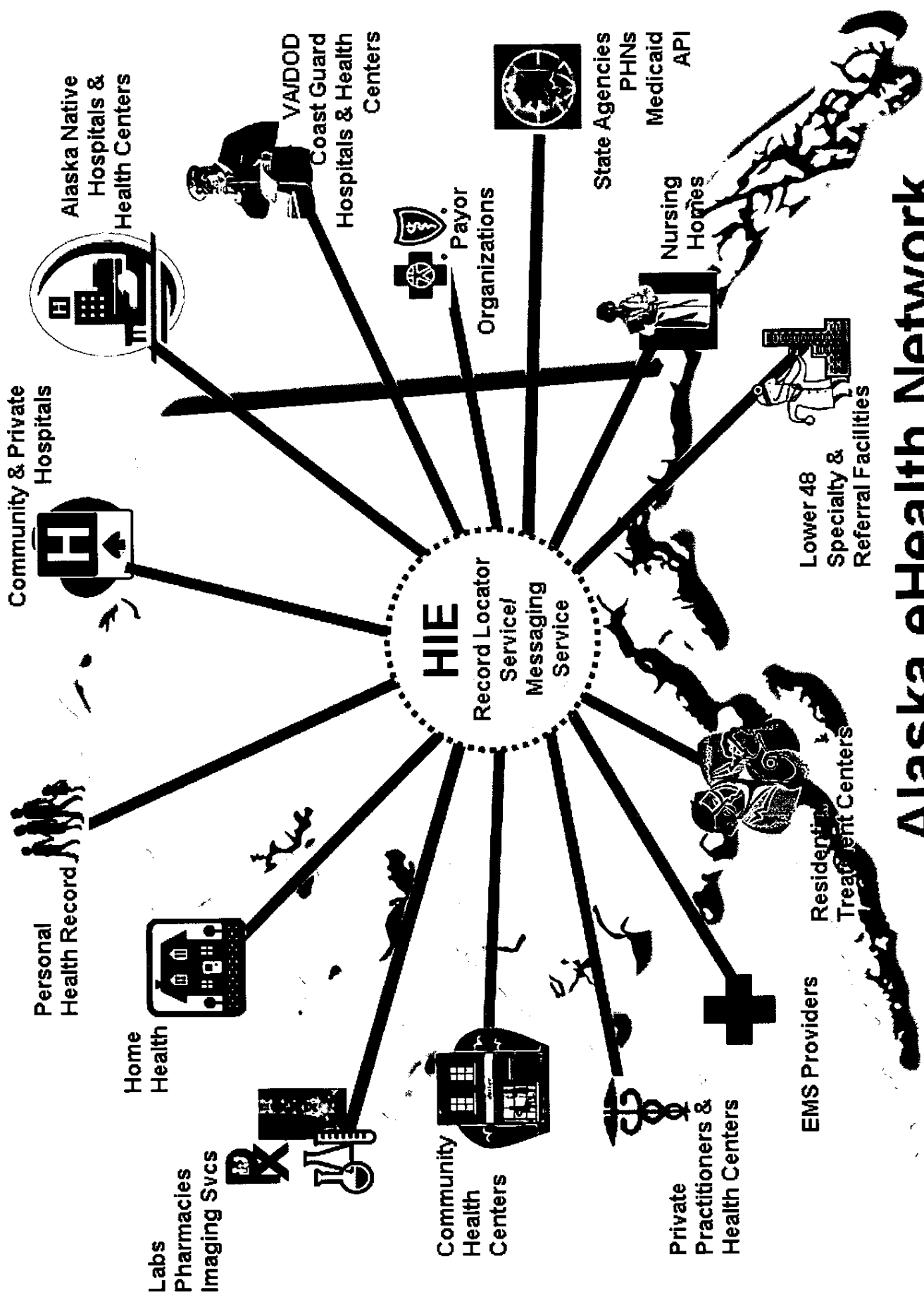
Saving money

- Federal and private research projects 5% savings in annual U.S. health care expenditures from full deployment of inter-operable electronic medical records
- For Alaska's \$5B health care industry, annual savings could reach \$250M.
- For the State of Alaska's \$250M GF Medicaid expenditures, annual savings could exceed \$10M



Alaska eHealth Network

- **5 year \$35 million project** to deploy a secure network supporting the exchange of electronic health records between all Alaska health care providers
- **\$12.0 million currently awarded** through 2008 from Federal Communications Commission, US Dept. of Health and Human Services, State of Alaska, Alaska Federal Health Care Partnership



Alaska eHealth Network

COX, COURTNEY (DOB: 5/19/1965; ID: 1002) 40 year old woman

File Edit View Help Know Lock

Demographics | Summary Sheet | Most Recent Encounter | Past Encounters | Imported Items | Account Information

Encounter changes will be saved to this date:
Monday November 7, 2005 08:59 AM Change Date

Use a past encounter as template for this visit: Don't overwrite CC, HPI, ROS
Overwrite current CC, HPI, ROS

Physical Exam vs note Pictures 115 lb 64 in 170 / 90 88 12 19.7

| Date | Weight lb | Height in | Temp F | BP | Pulse | RR | BMI |
|------------|-----------|-----------|--------|--------|-------|----|-----|
| 11/02/2002 | | | | | | | |
| 10/02/2002 | 122.0 | | 99.7 F | 120/80 | 130 | | |

WNVVD NAD. Mucosa pink & moist. Inferior turbinates erythema bilaterally but nares patent. Pharynx without injection or exudate. Neck supple shotty bilat. nodes. TMs clear bilaterally. Maxilla/Front/Eth sinus without tenderness. Chest CTA nor l/E. Cor PRR S1S2 s M/T/R Ext no C/C/E

Search Database: Search ICD9s

Problem List

Assessment:
 Remove Reminder get an ekg next visit.
 # URI / UPPER RESPIRATORY ILLNESS (465.9): The risk of antibiotic use for what is likely a viral infection was discussed and the need to let me know if fever, chills, or feeling any worse, or if not improving over next few days.
 # PALPITATIONS (785.1): likely from the suddated. Advised she stop this and will check EKG just to be safe.

Plan:
 Add Updated Med List to Plan

Prescriptions
 Order Tests
 Forward Chart
 Sign Chart

Chief Complaint:
 I want to quit smoking

History of Present Illness:
 Doing well. Getting married next month and feeling nervous. Promised her fiance she'd quit and did 10-10-321.

Review of Systems:
 Patient notes lowgrade temp without rigors. No SOB or DDE. No hemoptysis. Sick coworkers with similar symptoms. Some palpitations too since taking suddated.

Past Medical History:
 Generalized Anxiety
 No PMH/PSH reported
 GIPD

Social History:
 Tobacco: 1 ppd. No recreation drugs.
 EtOH: Only when out with friends
 Living situation: Married. Both are actors.

Family History:
 Mother: Depression
 Father: HTN
 No Siblings.

Allergies:
 NKDA

Current Medications:
 LOESTRAIN 21 1/20 TABLET COMBO, 1 po qd

JONATHAN 11/7/2005

40 year old woman last seen 3 years ago (11/02/02) by Jonathan Berman, MD

Alaska eHealth Network

- Incorporated non-profit August 2008
- Partners:
 - Alaska Native Tribal Health Consortium (designated lead partner)
 - Alaska State Hospitals and Nursing Homes Association
 - Alaska Primary Care Association
 - Premera Blue Cross/Blue Shield
 - State of Alaska DHSS
 - Alaska Federal Health Care Partnership (DOD, VA, USCG, Indian Health Service)
 - University of Alaska
 - Alaska E.H.R. Alliance (private physicians)
 - American Association of Retired Persons



Alaska eHealth Network
Board of Directors

- Alex Spector
- Jeff Davis
- Garth Hamblin
- Jay Butler, M.D.
- Jerome List, M.D.
- Tom Nighswander,
M.D.
- Joel Gilbertson
- Marilyn Walsh-Kasmar
- Pat Luby
- Paul Sherry
- Rod Betit



Progress to Date: 2007-2008

- Participation in determining national privacy standards and technology interoperability standards
- Contract for technical network design awarded to GCI; determining requirements for needed broadband connectivity for Alaska health providers
- FCC grant funding is now available for health provider network technology acquisitions in 2009 and 2010



Next Steps: 2009-2010

- Complete network design and assist providers with connectivity
- Secure AeHN designation as Alaska's qualified Health Information Exchange organization
- Secure \$20M+ from \$19B available federal ARRA funding to acquire Health Information Exchange software

Next Steps: 2009-2010

- Secure \$1.3M for FY2010 and \$1.0M in FY2011 from State of Alaska for network development
 - Ensures match for federal stimulus funds
- Engage contractor/vendors to deploy Health Information "bridging" software to interconnect Alaska's various Electronic Medical Records systems
- Align the Health Information Exchange with State systems: MMIS, API, Public Health data
- Add Internet2 connectivity for telemedicine applications, teleconferencing, voice-over-internet, and consults from lower-48 academic/teaching hospitals

Sustainability: FY2011+

Establish the Alaska eHealth Network business structure to sustain network and software services through provider and payor contributions

AeHN Estimated recurring costs after FY11: \$5.0M

\$1.3M administration/business operations

\$3.7M contractual HIE technical/software services

Estimated recurring AeHN revenues after FY11: \$5.0M

- \$1.5M 1500+ physicians/clinicians
- \$0.5M 26 Hospitals
- \$0.5M Laboratories/Pharmacies/Imaging Centers
- \$1.0M State of Alaska
- \$1.0M Private Insurers
- \$0.5M Alaska Federal Health Care partners

SB133 Facilitates HIE development

- Positions Alaska for substantial stimulus funding
- Demonstrates state commitment to support and participate in Alaska's Health Information Exchange development
- Provides for DHSS oversight, engagement, and long-term participation plan
- Provides framework for designation of a qualified state Health Information Exchange entity
- Ensures privacy protections



Alaskan's support
Health Information Exchange

- Partner organization support: hospitals, physicians, tribal health, insurers, citizens, community health centers, employers, federal health providers
- Alaska Health Care Commission short term priority area
- Strong Congressional delegation support

Summary recommendations

- A. Passage of SB133
- B. State DHSS oversight, support, and designation of HIE organization
- C. Provide stimulus match of \$1.3M in FY10 and \$1.0M in FY11



The outcomes:

- Timelier access to safer health care for Alaskans
- \$1M annual State investment yields ~5% savings in future State expenses for Medicaid, employee health care, state-operated health care programs

ALASKA STATE LEGISLATURE

Finance Committee
•
Health & Social Services Committee
•
Legislative Council
•
Committee on Committees



While in Session
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Fax: (907) 465-2529

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Anchorage, AK 99501
(907) 269-0169
Fax: (907) 269-0172

SENATE MAJORITY LEADER
JOHNNY ELLIS

FREQUENTLY ASKED QUESTIONS

ABOUT UNEMPLOYMENT INSURANCE MODERNIZATION FUNDING IN THE FEDERAL STIMULUS

The American Recovery and Reinvestment Act of 2009, better known as the federal stimulus, has been the subject of intense scrutiny here in Alaska and around the country. Because of the amount of interest and complexity of the stimulus bill, there has been significant confusion about a number of specific points. In the interest of ensuring accuracy in the conversation around Senate Bill 170 and the unemployment insurance funds in the federal stimulus, this sheet attempts to address some of those common misconceptions around the specific changes proposed in this bill.

Q: What changes Alaska must make to our unemployment insurance program to be eligible for the modernization incentive? Many states are concerned that changes to the UI statutes will require significant expansions of eligibility requirements.

A: The US Department of Labor has certified that **Alaska already meets two of the three qualifications** for the unemployment insurance modernization incentive funds. The first third of the money is contingent on a state including an alternative base period to determine eligibility, which is the change SB170 proposes. The second two-thirds are based on a state allowing UI payments to be made to unemployed workers who fit at least two of the following four conditions: part-time workers, workers enrolled in training programs, workers who leave their jobs for compelling family reasons, and additional benefits for workers with dependents. Alaska already meets the final two categories, making further change unnecessary. Many other states need to make all three changes.

Q: Won't those changes mean increased numbers of people receiving UI benefits and increase business taxes over the long term?

A: The Alaska Department of Labor has determined that had the changes in SB170 been in effect in calendar year 2008, 1,300 additional people would have been eligible for \$1.9 million in payments. The amount necessary to keep the UI trust fund solvent, given the current balance of over \$350 million, is significantly less than the amount offered by the federal government. After seeing these calculations, the **National Federation of Independent Business – Alaska endorsed SB170** as “a relatively simple administrative change the cost of which will be born by stimulus funding. . . This is good for individual Alaskans, employers, and Alaska’s economy.”

Q: What is the effect on state government of accepting short-term federal money? Will we be forced to close down the existing programs or replace the federal dollars with state funds?

A: While the stimulus does not mandate that any federal funds be replaced, the unemployment insurance modernization funds provided are **more than enough to cover the costs of the expansion indefinitely**. The state Department of Labor is determining exactly how much of the

\$15.6 million Alaska would be eligible for if SB170 is adopted would need to be deposited in the UI trust fund to maintain solvency, but it is expected to be significantly less than the available total, freeing up the rest of the money to support job training and workforce development programs.

Q: If all the money is not necessary to shore up the UI trust fund, what will be done with it, and how can we be assured that it will not create a long-term growth in government?

A: The UI modernization incentive funds are eligible to be used for three purposes: paying UI benefits, administering the UI program, or job training programs. It is our intent that funding in excess of the amount required to pay benefits without increasing taxes would be appropriated to support job training. Alaska is currently facing the highest unemployment rates in a generation, and we are facing a massive shortage of qualified workers as we approach construction on a natural gas pipeline. The confluence of these two events makes the timing perfect for a **highly targeted short term expansion of workforce development programs**, the need for which will decline as the federal money runs out.

Q: Are these stimulus funds a backdoor approach to increasing state spending through the requirement of a state match?

A: There are some stimulus programs that require a state match component to participate, but the UI modernization is not one of them. It is also worth noting that other stimulus programs serve to reduce state spending, either by increasing federal reimbursement levels or eliminating state match components altogether.

Q: Some are concerned about the impact of the federal stimulus package on the overall federal debt. Many of these criticisms portray the stimulus package as burdening the future and passing debt on to future generations.

A: The federal debt is a very serious issue, and significant action must be taken to undo the fiscal impacts of the last eight years and return to the surpluses left by the Clinton Administration. Unfortunately, **state action on the stimulus cannot have any impact**. All funds have already been appropriated by the federal government, and any moneys not accepted by Alaska will be re-routed to other states that are willing to take advantage of them – many of which have already stated their willingness to do so due to the hardships caused by the current economic downturn.

Q: A major consideration for some has been potential strings attached to federal funds, and what a change in statute now means for the future.

A: Any changes to state statute that are made to maximize federal funding are done freely, after a detailed examination of the positive and negative attributes of the package. While the unemployment insurance section of the stimulus explicitly prohibits sunset clauses or temporary provisions, there is **no prohibition on future legislatures re-examining the program** and making whatever changes they see fit.

Q: Doesn't increasing our reliance on federal funding create a potential loss of state sovereignty? Many are concerned that the stimulus funds represent a marked increase in moneys contingent on compliance with federal mandates.

A: The fiscal year 2010 operating budget contains approximately \$2.8 billion in federal funds, almost all attached to highly specific instructions on how it may be spent. Since its inception, the state of Alaska has received tens of billions of dollars from the federal government, and our delegation to Congress, most notably Sen. Ted Stevens, has made careers out of maximizing the number of federal dollars that flow into our state.

ALASKA STATE LEGISLATURE

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CS for SB 133

Explanation of Changes

Added Flexibility

The CS reflects new language to provide the department with some added flexibility while maintaining the integrity of multiple stakeholder participation. (*Page 4, Lines 7-10*)

The department now has the option to designate one entity or a combination of entities to fulfill the purposes of Section 2. The department may designate the state, an outside vendor, and/or a nonprofit to fulfill the purposes of Section 2.

Any and all entities designated must meet the same requirements which include:

- Have an advisory or governing body made up of health system stakeholders
- Apply for available federal and state funding for planning and implementation of the system
- Meet the most stringent applicable federal or state privacy law governing the protection of the information contained in the system.
- Submit an annual budget for approval of the commissioner
- Provide cost and cost saving data associated with the development and use of the system

Clear Responsibilities

Section 18.23.305 was added in the CS to more clearly establish the Department's duties. (*Page 4, Line 22 – Page 5, Line 2*)

- in accordance with federal recommendations, determine the manner in which the system is developed and operated
- provide oversight and technical assistance needed for planning and implementing the system
- authorize and facilitate applications for available federal funding for planning and implementing the system
- ensure compliance with applicable federal and state health information policies and standards
- ensure compliance with federal and state law and standards that safeguard the privacy and security of health information

Clarification of Board Membership

The CS places specific advisory/governing board membership requirements. (*Page 4, Lines 11-21*)

Interoperable Statewide Health Information Exchange (HIE)

State Medicaid General Fund and Alaska Health Care System Cost Savings Projections

| Annual Medicaid State General Funds | Net Value Percentage | Annual Net Value of HIE* | |
|-------------------------------------|----------------------|--------------------------|--------------------------------------|
| \$248,544,000 | 4.68% | \$11,631,859 | Based on standard cost benefit model |
| \$248,544,000 | 3.69% | \$9,171,274 | Based on high-cost HIE model |
| \$248,544,000 | 5.70% | \$14,167,008 | Based on low-cost HIE model |

| Annual AK Health Care Spending | Net Value Percentage | Annual Net Value of HIE* | |
|--------------------------------|----------------------|--------------------------|--------------------------------------|
| \$5,294,000,000 | 4.68% | \$247,759,200 | Based on standard cost benefit model |
| \$5,294,000,000 | 3.69% | \$195,348,600 | Based on high-cost HIE model |
| \$5,294,000,000 | 5.70% | \$301,758,000 | Based on low-cost HIE model |

*Full Annual Net Value realized beginning 2013

Assumptions:

Fully standardized and fully implemented statewide interoperable Health Information Exchange State Medicaid GF budget based on Gov 09 Request for Medicaid Services Component only State Medicaid GF budget remains flat Annual AK Health Care Spending remains flat Based on national cost benefit model (see Sources):

Cost savings: 5.68% of annual health care expenditures, minus cost: 1% of annual health care expenditures
 National cost benefit model calculates projected cost savings based on projected efficiencies in laboratory testing, imaging procedures, interactions between outpatient providers and pharmacies, provider to provider connectivity, provider to public health agency connectivity, and provider-payer transactions

Sources:

Institute for Social and Economic Research, UA Research Summary No. 6, March 2006
http://www.iser.uaa.alaska.edu/Publications/researchsumm/RS6_06.pdf
 Walker, J, et al, The Value of Health Care Information Exchange and Interoperability, Health Affairs, January 2005.
<http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.10/DC1>

Implementation Project Summary and Impact Analysis

State of Alaska Report

Subcontract No.
RTI Project No. 9825

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December 5, 2007



Alaska HISPC Implementation Project Summary and Impact Analysis Report

Executive Summary:

Alaska, like the rest of the United States, faces challenges in addressing increasing health care costs, improving access to medical care, and ensuring and improving quality medical care for patients. Timely access to essential medical information by providers at the point of care is critical to good outcomes for the patients. A statewide initiative is working to address these challenges by promoting the expansion of the use of electronic health records by Alaska's medical providers and by establishing a statewide electronic health information exchange delivery system to provide critical information when and where it is needed.

Alaska health care leaders and members of the Alaska Telehealth Advisory Council formed the Alaska Regional Health Information Organization to look at innovative technology solutions targeted toward lowering costs and preventing medical errors. To accomplish this goal the Alaska RHIO, with the support of the Alaska Governor's office, successfully competed for a national contract to focus on issues of security and privacy as related to health information exchange. In January 2007, the Alaska RHIO was reorganized as Alaska ChartLink.

The Health Information Security and Privacy Collaboration (HISPC) is part of a national effort to encourage wider adoption of Electronic Health Records (EHRs) and establish a Health Information Exchange (HIE) network in Alaska and throughout the United States. Participation in this national initiative gives a voice to Alaska specific issues, needs, and recommendations in the development of national policies as related to security, privacy and best business practices surrounding interoperability of health information exchange.

Phase I of the HISPC contract provided an assessment of the privacy and security climate in Alaska as it relates to health information exchange. The findings from this assessment determined a number of action steps that needed to be addressed in order for Alaskans to begin exchanging electronic health information. Key areas of action included:

- ~ Legal solutions for enacting legislation related to medical records and the electronic exchange of health information,
- ~ Standardized policies and procedures for use across participating organizations,
- ~ Participation agreements for use by participating organizations and consumers, and
- ~ Education and marketing tailored to consumers and providers encouraging use of electronic health records.

Alaska HISPC Implementation Project Summary and Impact Analysis Report

Phase II of the HISPC contract provided an opportunity for Alaska to implement selected solutions developed during Phase I and to participate in a national collaborative security and privacy think tank. In particular, the Alaska HISPC contract produced three products:

1. Five essential documents providing a standardized approach to the exchange of health information and addressing privacy and security concerns.
2. A Communications Plan and educational materials targeted toward patients, providers, and payers, that addressed the benefits of exchanging critical medical information in a secure manner that ensures patient privacy.
3. A collaborative report developed in conjunction with Guam, Iowa, New Jersey, North Carolina, North Dakota, Puerto Rico, and South Dakota addressing multi-state inter-organizational agreements for health information exchange.

Volunteers from across the state participated in the HISPC project. Over 250 Alaska citizens participated in stakeholder meetings held in both urban and rural locations. Participants included; healthcare consumers, public, private and federal providers, payers, state and municipal workers, healthcare professionals, lawyers and employers. These dedicated individuals provided valuable insights into the needs, desires and fears associated with electronic health information. The documents created through the exchanges with the citizens of Alaska provide a sound basis for the ongoing development of health information exchange in Alaska.

Alaska HISPC Implementation Project Summary and Impact Analysis Report

V. Conclusion

Phase I of the HISPC contract provided an assessment of the privacy and security climate in Alaska as it relates to health information exchange. The findings from this assessment determined a number of action steps that needed to be addressed in order for Alaskans to begin exchanging electronic health information. Key areas of action included:

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- ~ Standardized policies and procedures for use across participating organizations,
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- ~ Education and marketing tailored to consumers and providers encouraging use of electronic health records.

Phase II of the HISPC contract provided an opportunity for Alaska to implement selected solutions developed during Phase I and to participate in a national collaborative security and privacy think tank. In particular, the Alaska HISPC contract produced three products:

1. Six essential documents providing a standardized approach to the exchange of health information and addressing privacy and security concerns.
2. A Communications Plan and educational materials targeted toward patients, providers, and payers addressing the benefits of electronic health records, personal health records, and exchanging critical medical information in a secure manner that ensures patient privacy.
3. A collaborative report developed in conjunction with Guam, Iowa, New Jersey, North Carolina, North Dakota, Puerto Rico, and South Dakota addressing multi-state inter-organizational agreements for health information exchange.

Alaska HISPC Implementation Project Summary and Impact Analysis Report

In addition to the products developed during the HISPC contract, the Alaska partners received additional benefits:

The HISPC project has helped to increase awareness of electronic health records and health information exchange in both consumers and providers throughout the state. Processes are now in place to continue this awareness campaign.

Prior to this project there was no coordinated statewide approach to addressing issues of privacy and security. Standardized policies, procedures, and participation agreements are now available for use statewide.

The collaborative process initiated by HISPC facilitated the exchange of ideas and lessons learned between many states. It was an opportunity for Alaska's Core Team to share and receive "best practice" solutions to privacy and security issues.

The HISPC project created an opportunity for Alaska to advance the HIE and EHR initiatives within Alaska and has opened the door to potential future grant opportunities.

UPDATING PRIVACY LAWS TO FACILITATE HEALTH INFORMATION EXCHANGE

Consumer and provider concerns about privacy and security are inhibiting adoption of health IT. Consumers are concerned about the consequences of disclosure of sensitive health information related to dire or stigmatized diseases, such as the loss of health coverage or employment. Providers, concerned about varying interpretations of state and federal privacy laws and the liability for violations, often are reluctant to exchange data. State updates to health privacy laws can help alleviate these and other concerns. Trends identified in enacted legislation include the following.

Comprehensive Reform

Key policy decisions for states that want to update privacy laws to allow for health information exchange include structuring patient consent, addressing provider concerns and establishing accountability mechanisms.

Structuring Patient Consent

States face key questions on the issue of patient consent. Under what circumstances should patient consent be required? How should consent be structured (opt-in, opt-out)? Will patients have to choose between including all their information for exchange or none? Or will patients be able to choose specific information to share? As states set policy on consent, a number of competing issues must be balanced, including: patients' desire to control data, providers' concern about having access to all relevant information for treatment, and implementation costs for providers and health information exchanges.

Provider Concerns

Providers, understandably, want access to all relevant patient information at time of treatment. They are concerned about liability if they treat a patient based on incorrect or missing data obtained from a health information exchange. Providers also are concerned about the cost of implementing privacy rules and their effect on practice workflows.

Accountability

States need to structure regulations and penalties so that patient, provider and health information exchange needs are balanced.

Minnesota and Rhode Island passed health privacy updates as part of comprehensive health IT measures. A comparison of the privacy portion of the bills illustrates the differing paths states take as they attempt to capture the benefits of mobile health data and temper the associated risks (Table 1).

| Table 1. Comparison of Privacy Provisions from Minnesota and Rhode Island | | |
|---|---|---|
| | Minnesota <i>Minnesota Health Records Act</i> | Rhode Island <i>Rhode Island Health Information Exchange Act of 2008</i> |
| Bill | 2007 HB 1078 | 2008 HB 7409 |
| Status | Enacted 5/25/07 | Enacted 7/10/2008 |
| Summary | Allows creation of record locator services (RLS). An RLS is an electronic index of patient identifying information that directs providers to the location of patient health records held by providers and group purchasers. | Establishes a statewide health information exchange (HIE) under state authority. Designates the Rhode Island Quality Institute as the governance body or regional health information organization (RHIO) for the HIE. |
| Putting Patient Data into the System | An RLS can be created without patient consent. Patients have the right to opt-out of the RLS in total or can exclude specific provider contacts from the system. | Patients must opt in for their data to be included in the HIE. |
| Consent for Access | Consent is required to search an RLS for the location of a patient's records except in an emergency. To facilitate the real-time exchange of data, one provider can electronically represent patient consent to another. To do so, a provider must have a signed and dated patient consent form authorizing the release. In addition, the provider releasing the record shall document: 1) the provider requesting the health records; 2) the identity of the patient; 3) the health records requested; and 4) the date the health records were requested. | Patients who opt in can choose which providers have access to their data. If a patient opts in their authorization is not required for release to: <ul style="list-style-type: none"> • public health authorities for specified functions; • health care providers for diagnosis or treatment in an emergency; and • the RHIO for operation and administrative oversight of the HIE. |

| Table 1. Comparison of Privacy Provisions from Minnesota and Rhode Island (continued) | | |
|--|--|---|
| | Minnesota <i>Minnesota Health Records Act</i> | Rhode Island <i>Rhode Island Health Information Exchange Act of 2008</i> |
| Audit Log | <p>RLS must maintain an audit log of providers who access a patient's information. The log must contain at least the following:</p> <ol style="list-style-type: none"> 1) the identity of the provider accessing the information; 2) the identity of the patient whose information was accessed by the provider; and 3) the date the information was accessed. | <p>Patients have the following rights:</p> <ol style="list-style-type: none"> (a) to obtain a copy of their health care information from the HIE; (b) to obtain a copy of the disclosure report pertaining to their health care information; (c) to be notified of a breach of the HIE security system; (d) to terminate participation in the HIE; and (e) to request to amend their information through the provider participant. |
| Provider Liability | <p>(b) When requesting health records using consent, or a representation of holding a consent, a provider warrants that the request:</p> <ol style="list-style-type: none"> 1) contains no information known to the provider to be false; 2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and 3) does not exceed any limits imposed by the patient in the consent. | <p>Provides immunity to health care providers who rely in good faith upon information provided through the HIE in the treatment of a patient.</p> |
| Penalties | <p>An RLS is liable for inappropriate disclosures of information.</p> <p>Anyone who inappropriately discloses a patient's data is liable for compensatory damages caused by an unauthorized release, plus costs and reasonable attorneys' fees.</p> <p>Providers who violate the statute can face disciplinary action by the appropriate licensing board or agency.</p> | <p>The bill establishes civil and criminal penalties for violations of the statute. Attorneys' fees may be awarded by the court to the successful party in any action under this chapter.</p> |

Source: National Conference of State Legislatures, 2008.

Other Strategies

Make HIPAA the Rule

Nevada specifies that the Health Insurance Portability and Accountability Act (HIPAA) shall preempt any more stringent state laws related to the electronic exchange of health information by covered entities. The bill allows patients to not participate in electronic transmission of individually identifiable health information, with an exception for Medicaid and SCHIP patients and when required by HIPAA or state law.

Nevada SB 536 Section 1 1. *"If a covered entity transmits electronically individually identifiable health information in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which govern the electronic transmission of such information, the covered entity is, for purposes of the electronic transmission, exempt from any state law that contains more stringent requirements or provisions concerning the privacy or confidentiality of individually identifiable health information."*

Address Varying Interpretations of State and Federal Privacy Laws

To address differing interpretations and application of federal and state privacy laws, the Oklahoma Legislature ordered the State Board of Health to create a standard authorization form for exchange of health information. Providers who use the form and follow the board's instructions are immunized from liability under state privacy laws that may arise from the exchange of health information. Use of the form is not required. (Oklahoma SB 1420)

Data Breach Notification

California AB 1298 expands the state's data breach notification law to include unencrypted medical information and health insurance information. The bill also expands the definition of provider of health care under the state's Confidentiality of Medical Information Act to cover third-party vendors of personal health records such as Google and Microsoft. HIPAA and most state health privacy laws do not cover personal health records maintained by third-party vendors.

E-prescribing

A few states prohibit e-prescribing systems from influencing provider prescribing practices. New Hampshire passed the most comprehensive of these bills, which included the following language to prohibit use of prescription information by certain parties:

New Hampshire HB 134 *"(e) No person who has access to electronic prescription information solely by transmitting or facilitating the transmission of prescriptions between the licensed prescriber generating the prescription and the pharmacy receiving the prescription, or any intermediary, shall retain the prescription or any information it contains for longer than is mandated by federal or state law, after which time the prescription information shall be destroyed. No such person shall sell, use, or otherwise make available the prescription information for any purpose other than transmission of prescriptions, prescription refills, and clinical information displayed to the prescriber or pharmacist."*

PROMOTING HEALTH INFORMATION EXCHANGE

States are working to advance health information exchange by promoting interoperable health IT tools and by establishing and sustaining health information exchange organizations and infrastructure. Interoperability, combined with state initiatives to create health information exchange organizations is essential to states efforts to achieve quality improvements and reduce duplicative tests. Trends identified in the enacted legislation include the following.

Interoperability

Interoperability allows different systems to share information in an understandable format. Uniform data standards are essential to achieving this capability among health IT systems. At the national level, the Healthcare Information Technology Standards Panel is establishing standards, and the Certification Commission for Healthcare Information Technology certifying products. State approaches to encourage interoperability vary. Some states adopted these standards by reference, while others designated a state agency or outside group to establish standards. To encourage use of the standards, states can require agencies to purchase only standards-based systems. States also can require specific functions for health IT systems sold within their borders.

Require Purchase of Certified Systems

Minnesota mandated interoperable electronic health records by 2015 for all hospital and health care providers. To meet the interoperability standards set by statute, providers must use an electronic health records system certified by the Certification Commission for Healthcare Information Technology or its successor. An exception is included in the legislation for specialists whose practice setting the Certification Commission for Healthcare Information Technology doesn't certify electronic health records for. (Minnesota SB 3780)

Use State Agency Purchasing Requirements

Virginia HB 2198 requires that electronic health records systems or other tools that interact with electronic patient information purchased by state agencies meet interoperability standards or be certified by a recognized certification body. The bill also requires state agencies that provide grants available to other entities for such systems ensure that the systems meet interoperability standards or be certified by a recognized certification body.

Create Standards and Require Use to Exchange Data

Utah HB 47 authorizes the Department of Health to adopt standards for electronic health information exchange. Payers and providers must use the standards adopted by the department to electronically exchange health information between health care systems. Payers and providers are not required to use the standards if they electronically exchange health information within a health care system.

Require Certain Functions

Texas SB 204 requires that electronic medical record systems sold to Texas health care providers who administer immunizations be able to interface with the state immunization registry.

Create or Designate a State-level Health Information Exchange

Many early health information exchange efforts began in the private sector, and state governments were asked to join. The current wave of health information exchanges, by contrast, is as likely to originate at the state level. Texas and Indiana created bodies to run the state-level health information exchange; and Connecticut, Vermont and Rhode Island designated existing independent nonprofit entities. Whether they create new entities or bless existing activities, statutes that define a state-level health information exchange confer formal status and authority, charge the health information exchange to promote health IT in both private and public sectors, define governance to include state agencies, and determine that they may receive and disburse funds on behalf of statewide health IT initiatives. Beyond these broad elements, various models have been adopted, reflecting existing activity in the state. Statutes that create these entities typically are comprehensive measures that, among other things, include: start-up support for a designated group, a state governance role, ongoing funding, and unique state-level responsibilities.

Appendix A compares legislation from Indiana, Texas and Vermont that creates or designates a state-level health information exchange.

ADVANCING ADOPTION AND USE

States are drawing on a wide range of policy levers to expand the use of health IT. These include mandates, incentives and leveraging state purchasing power. Trends identified in the enacted legislation include the following.

Mandates

Minnesota and Massachusetts have enacted mandates for the use of health IT tools. A few other states considered such mandates but did not enact them.

Mandate Purchase

Minnesota enacted two mandates for the purchase of health IT systems. The first requires hospitals and health care providers to have interoperable electronic health records systems by 2015. (Minnesota HB 1078) The second requires that, by 2011, all providers, group purchasers, prescribers and dispensers establish and maintain e-prescribing systems. (Minnesota SB 3780)

Tie Facility Licensure to Health IT System Implementation

Massachusetts tied implementation of computerized physician order entry and electronic health records to facility licensure standards for hospitals and community health centers. The Department of Public Health is charged with adopting regulations to require implementation of computerized physician order entry by Oct. 1, 2012, and of electronic health records by Oct. 1, 2015. The systems are to be certified by the Certification Commission for Healthcare Information Technology or its successor. (Massachusetts SB 2863)

Require health IT competency for physician licensure.

(Massachusetts SB 2863) *"The board shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board."*

Incentives

Link Medical School Loan Repayment to Health IT Competency

Massachusetts created a workforce loan repayment assistance program for graduates of medical or nursing schools who specialize in areas where practitioners are in short supply. Among other eligibility requirements for the program is demonstration of competency with certain health IT tools. (Massachusetts SB 2863)

Offer Tax Credits

Wisconsin SB 40 creates a tax credit for providers who purchase electronic medical records. Providers can claim up to 50 percent of the cost of the system, to a maximum of \$10 million per year.

Leverage State Purchasing Power

States are leveraging their role as a purchaser and provider of care to drive adoption and use of health IT.

Offer Incentive Payments for Electronic Health Records Use

New York SB 6808 allows providers who meet certain standards set by the Department of Health to receive supplemental payments for the increased cost of using electronic health records. To receive the payments, a provider must have an operating electronic health records system, and a set percentage of patients must be on Medicaid or uninsured.

Provide Targeted Reimbursement

Colorado SB 196 provides medical assistance program reimbursement for home and community services delivered via telemedicine.

Leverage State Employee Health Plan

Minnesota HB 548 creates a pilot program to provide a consumer-owned portable personal health record to members of the state employee health plan.

| Appendix A. Comparison of Health Information Exchange Legislation in Three States | | | |
|--|--|---|--|
| | Indiana <i>Indiana Health Informatics Corporation</i> | Texas <i>Texas Health Services Authority Corporation</i> | Vermont <i>Vermont Information Technology Leaders</i> |
| Bill | 2007 IN S 551 | 2007 TX H 1066 | 2007 VT H 229 |
| Status | Enacted 5/2/07 | Enacted 6/15/07 | Enacted 6/5/07 |
| Project's Role within State Health IT Activities | | | |
| | Chapter 5. General Powers Sec. 1. The corporation shall encourage and facilitate the development of health informatics functions in Indiana. Sec. 2. The corporation is granted all powers necessary or appropriate to carry out the corporation's public and corporate purposes under this article. Chapter 7. Expiration Corporation will expire on June 30, 2015. | Section 182.051 (a) Created to promote the establishment of a voluntary statewide network for the communication of electronic health information and to foster a coordinated public-private initiative for the development and operation of the health information infrastructure in the state. | Amends the scope of work of the Vermont Information Technology Leaders (VITL, a non-profit organization incorporated in 2005). Section 903 (c) VITL shall develop the states health information technology plan. Designates VITL to operate the statewide health information exchange network. |
| Organizational Structure | | | |
| | Chapter 3. Indiana Health Informatics Corporation Sec. 2. (a) The corporation is a body politic and corporate, not a state agency but an independent instrumentality exercising essential public functions. | Sec.A182.051. Texas Health Services Authority; Purpose. ... (b) The corporation is a public nonprofit corporation and, except as otherwise provided in this chapter, has all the powers and duties incident to a nonprofit corporation under the Business Organizations Code. | VITL is a nonprofit corporation. |

| <p align="center">Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)</p> | | | |
|--|---|---|--|
| | <p>Indiana <i>Indiana Health Informatics Corporation</i></p> | <p>Texas <i>Texas Health Services Authority Corporation</i></p> | <p>Vermont <i>Vermont Information Technology Leaders</i></p> |
| Bill | 2007 IN S 551 | 2007 TX H 1066 | 2007 VT H 229 |
| Status | Enacted 5/2/07 | Enacted 6/15/07 | Enacted 6/5/07 |
| Board Membership | | | |
| | <p>Chapter 4. Corporation Board Sec. 1. The corporation shall be governed by a board. Sec. 2. (a) The board is composed of the following nine (9) members, none of whom may be a member of the general assembly: (1) The secretary of family and social services, or the secretary's designee. (2) The state health commissioner, or the state health commissioner's designee. (3) Seven (7) individuals appointed by the governor, of which at least: (A) one (1) individual must be a licensed physician who is actively engaged in the practice of medicine; and (B) one (1) individual must be engaged in the administration of a hospital licensed under IC 16-21.</p> | <p>Sec.A182.053.AA Composition Of Board Of Directors. (a) The corporation is governed by a board of 11 directors appointed by the governor, with the advice and consent of the senate. (b) The governor shall also appoint at least two ex officio, nonvoting members representing the Department of State Health Services. (c) The governor shall appoint as voting board members individuals who represent consumers, clinical laboratories, health benefit plans, hospitals, regional health information exchange initiatives, pharmacies, physicians, or rural health providers, or who possess expertise in any other area the governor finds necessary for the successful operation of the corporation.</p> | <p>Sec. 903. Health Information Technology (d) The following persons shall be members of VITL: (1) the commissioner, who shall advise the group on technology best practices and the state's information technology policies and procedures, including the need for a functionality assessment and feasibility study related to establishing an electronic health information infrastructure under this section; (2) the director of the office of Vermont health access or his or her designee; (3) the commissioner of health or his or her designee; and (4) the commissioner of banking, insurance, securities, and health care administration or his or her designee.</p> |

**Appendix A. Comparison of Health Information Exchange
Legislation in Three States (continued)**

| | Indiana <i>Indiana Health Informatics Corporation</i> | Texas <i>Texas Health Services Authority Corporation</i> | Vermont <i>Vermont Information Technology Leaders</i> |
|------------------|---|--|--|
| Bill | 2007 IN S 551 | 2007 TX H 1066 | 2007 VT H 229 |
| Status | Enacted 5/2/07 | Enacted 6/15/07 | Enacted 6/5/07 |
| Financing | | | |
| | <p>Chapter 5. General Powers Section 11 The corporation may request appropriations from the general assembly to: 1) carry out the corporation's duties under this article; and 2) fund the effort to develop and operate a statewide health information network. Section 12. (a) The Indiana health informatics fund is established. ...the corporation shall deposit the following in the fund: (1) All appropriations made by the general assembly to the corporation (2) All funding received from nonprofit entities under IC 5-31-6-2(4). (3) All other contributions received by the corporation from a nonprofit entity, as long as the nonprofit entity does not otherwise have an interest in the decisions of the corporation or board.</p> | <p>Sec. 182.107 (a) The corporation may be funded through the General Appropriations Act and may request, accept, and use gifts and grants as necessary to implement its functions. (b) The corporation may assess transaction, convenience, or subscription fees to cover costs associated with implementing its functions. All fees must be voluntary but receipt of services provided by the corporation may be conditioned on payment of fees. (c) The corporation may participate in other revenue-generating activities that are consistent with the corporation's purposes.</p> | <p>Sec. 903 (a)(8)(g) By July 1, 2007, shall prepare a plan for achieving self-sustainable funding, including an analysis of the costs, benefits, and effectiveness of any pilot projects. (i) VITL is authorized to seek matching funds...In addition, it may accept any and all donations, gifts and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof, and from any person, firm or corporation for any of its purposes and functions under this section and may receive and use the same, subject to the terms, conditions, and regulations governing such donations, gifts, and grants.</p> |

| Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued) | | | |
|---|---|---|---|
| | Indiana <i>Indiana Health Informatics Corporation</i> | Texas <i>Texas Health Services Authority Corporation</i> | Vermont <i>Vermont Information Technology Leaders</i> |
| Bill | 2007 IN S 551 | 2007 TX H 1066 | 2007 VT H 229 |
| Status | Enacted 5/2/07 | Enacted 6/15/07 | Enacted 6/5/07 |
| Privacy and Security | | | |
| | <p>Chapter 6. Duties</p> <p>Sec. 3. The corporation's plan to create the statewide health information exchange system must provide for procedures and security policies to ensure the following:</p> <p>(1) Compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).</p> <p>(2) Protection of information privacy.</p> <p>(3) Use of information in the statewide health information exchange system only in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) and as required by public health agencies.</p> | <p>Sec. 182.104.AA Security Compliance.</p> <p>The corporation shall:</p> <p>(1) establish appropriate security standards to protect both the transmission and the receipt of individually identifiable health information or health care data;</p> <p>(2) establish appropriate security standards to protect access to any individually identifiable health information or health care data collected, assembled, or maintained by the corporation;</p> <p>(3) establish the highest levels of security and protection for access to and control of individually identifiable health information, including mental health care data and data relating to specific disease status, that is governed by more stringent state or federal privacy laws; and</p> | <p>Sec. 903. Health Information Technology</p> <p>(f) The standards and protocols developed by VITL shall be no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments. In addition, the standards and protocols shall ensure that there are clear prohibitions against the out-of-state release of individually identifiable health information for purposes unrelated to treatment, payment, and health care operations, and that such information shall under no circumstances be used for marketing purposes. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail.</p> |

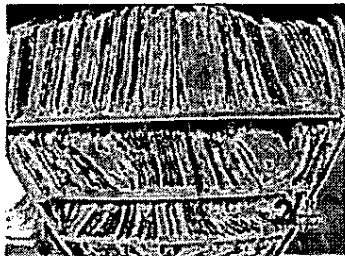
**Appendix A. Comparison of Health Information Exchange
Legislation in Three States (continued)**

| | Indiana <i>Indiana Health Informatics Corporation</i> | Texas <i>Texas Health Services Authority Corporation</i> | Vermont <i>Vermont Information Technology Leaders</i> |
|-----------------------|--|---|--|
| Bill | 2007 IN S 551 | 2007 TX H 1066 | 2007 VT H 229 |
| Status | Enacted 5/2/07 | Enacted 6/15/07 | Enacted 6/5/07 |
| Data Standards | | | |
| | <p>Chapter 6. Duties Sec. 1. The corporation shall do the following:...</p> <p>(6) Promote the use of the statewide health information exchange system by doing the following:</p> <p>(A) Encouraging and facilitating users of the statewide health information exchange system and other interested parties in developing and adopting standards for the statewide health information exchange system.</p> <p>(B) Recommending policies and legislation that advance the development and efficient operation of the statewide health information exchange system....</p> <p>(10) Encourage and endorse interoperability standards.</p> | <p>Sec.A182.103. Privacy of Information.</p> <p>(c) The corporation shall develop privacy, security, operational, and technical standards to assist health information networks in the state to ensure effective statewide privacy, data security, efficiency, and interoperability across networks. The network 's standards shall be guided by reference to the standards of the Certification Commission for Healthcare Information Technology or the Health Information Technology Standards Panel, or other federally approved certification standards, that exist on May 1, 2007, as to the process of implementation, acquisition, upgrade, or installation of electronic health information technology.</p> | <p>Sec. 903. Health Information Technology</p> <p>b) The health information technology plan shall:</p> <p>(3) promote the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;...</p> <p>(6) incorporate the existing health care information technology initiatives in order to avoid incompatible systems and duplicative efforts;</p> <p>(7) integrate the information rechnology components of the blueprint for health established in chapter 13 of Title 18, the global clinical record, and all other Medicaid management information systems being developed by the office of Vermont health access, information technology components of the quality assurance system, the program to capitalize with loans and grants electronic medical record systems in primary care practices, and any other information technology initiatives coordinated by the secretary of administration pursuant to section 2222a of Title 3;</p> |

<<Back



Medical offices gradually switching to electronic records



by Ashton Goodell
Tuesday, March 17, 2009

ANCHORAGE, Alaska -- Visiting the doctor's office you can expect two things: paperwork and a wait time.

But a new record system might do away with one of those two things. Doctors say it's a wonder offices still use paper charts.

Doctors are hoping to transition patient records from this ... (Daniel Hernandez/KTUU-TV)

"If this were the banking industry or any other industry we would be bankrupt," Dr. Tom Nighswander said.



The Alaska eHealth Network is designing a system to exchange medical records. The network would allow you and your doctor to access your medical information anywhere.

... to this, a computerized database. (Daniel Hernandez/KTUU-TV)

"The No. 1 reason is for patient safety," said Rebecca Madison director of the Alaska eHealth Network. "You've probably heard horror stories (about people) who had drug interactions or have tests done by mistake just because there's not a way to transfer records."



The network won't have a central database where patient information is stored. All the data will be in your doctor's office and will stay there, but offices will share the information through a network.

Rebecca Madison director of the Alaska eHealth Network (Daniel Hernandez/KTUU-TV)

"It's less time consuming as far as the time it takes to make a chart," said Yanira Williams, a doctor's office administrator.



Patients have raised concerns about privacy. They are worried someone could potentially hack the system or get into private records.

Dr. Jerome List (Daniel Hernandez/KTUU-TV)

"A lot of people are nervous about their stuff being scanned into the system, so they are a little bit hesitant about identity theft," Williams said.

Some doctors say paper databases aren't necessarily safer.

"Paper charts have just always been messy and difficult to organize, difficult to gather information from, easy to lose," Dr. Jerome List said.

Electronic records could replace the bulk of paper records, and a patient has full control over who accesses their health records.

Electronic records work kind of like an ATM -- the information you see on the screen isn't transmitted and can't be pulled up by someone else after it's closed.

You might go home or to the office and look at your bank statement online -- the same applies for the e-network. You can look up your information at any time to see who last touched the record.

"You can see who actually looked at your record for how long and for what purpose," Nighswander said.

The e-network is voluntary, so it's up to you whether you want to be on the system, and if so who you'll allow access to your records.

Some doctors have already switched to electronic records, but they said it wasn't easy.

"Early on document scanning was very difficult," List said. "Scanning did not get saved and so on and so forth, so yes, I had some bumps along the road to show for it."

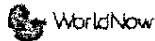
The goal now is to exchange those records between offices, probably two years down the road.

A move toward electronic record keepers will eliminate jobs in doctors' offices. The eHealth Network says the system would cut jobs but would also cut other costs like the mailing of records.

They say that savings would pass along to patients.

The e-network says it needs \$20 million to finish the system. Some of the state's stimulus money could go toward the project.

Contact Ashton Goodell at agoodell@ktuu.com



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The New York Times



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March 1, 2009


UNBOXED

How to Make Electronic Medical Records a Reality

By STEVE LOHR

IN the world of technology, inventors are hailed as heroes. Yet it is more subtle forms of innovation that typically determine the impact of a technology in the marketplace and on society. Clever engineering, smart business models and favorable economics are the key ingredients of widespread adoption and commercial success.

History abounds with evidence. For years, much of what was known as "Yankee ingenuity" was, in fact, the American ability to pursue commercial applications of British inventions, from the Bessemer steel process to the jet engine. Even in computing, which we regard as made-in-America technology, the first stored-program computer, simple programming language and reusable code were pioneered in Britain.




But, of course, computer technology and the industry really flowered in the United States. That happened in no small part because the federal government nurtured the market with heavy investment, mainly by the Defense Department, and by choosing standards, like the Cobol programming language.

Today, Washington is about to embark on another ambitious government-guided effort to jump-start a market — in electronic health records. The program provides a textbook look at the economic and engineering challenges of technology adoption.

In its economic recovery package, the Obama administration plans to spend \$19 billion to accelerate the use of computerized medical records in doctors' offices. Medical experts agree that electronic patient records, when used wisely, can help curb costs and improve care.

The proof is seen in large medical groups, with hundreds or thousands of physicians. They sift, sort and analyze the data from digital records, for example, to better manage the health of patients with costly, chronic conditions like diabetes and heart disease. These larger groups have the scale to invest in information technology, and they are often insurers as well as providers, so they benefit directly from the cost savings.

Yet these large groups are the exceptions in American health care. Three-fourths of the nation's doctors practice in small offices, with 10 doctors or fewer. For most of them, an investment in digital health records looks like a cost for which they are not reimbursed.



It is scarcely surprising, then, that only about 17 percent of the nation's physicians are using computerized patient records, according to a government-sponsored survey published last year in The New England Journal of Medicine.

"This is really not a technology problem," observed Erik Brynjolfsson, an economist at the Sloan School of Management at the Massachusetts Institute of Technology. "It's a matter of incentives and market failure."

That market failure is a principal target of the Obama administration's plan. A main feature of the legislation calls for incentive payments of more than \$40,000 spread over a few years for a physician who buys and uses electronic health records. But the technology is just a tool, one that needs to be used properly to improve health care.

So the legislation states that physicians will be paid only for the "meaningful use" of digital records. The government has not yet defined that term precisely. While the long-term goal is better health for patients, that can take years to measure. Consequently, many health experts predict that the meaningful use will be a requirement to collect and report measurements that can be closely correlated with improved health. Examples would be data for blood glucose, cholesterol and blood pressure levels for diabetes patients.

The legislation, health experts say, seems thoughtfully put together, but the obstacles to success will be daunting. "What's underappreciated is the implementation challenge," said Dr. Blackford Middleton, chairman of the Center for Information Technology Leadership, a research arm of Partners Healthcare in Boston.

A crucial bridge to success, according to experts, will be how local organizations help doctors in small offices adopt and use electronic records. The new legislation calls for creation of "regional health I.T. extension centers." In a letter to the White House and Congress last month, Dr. Middleton and 50 other experts emphasized the importance of these centers and pointed to the Primary Care Information Project in New York City as a model.

The New York project's brief history, beginning two years ago with \$27 million in financing, offers a glimpse of the challenges of wiring small physician practices. The New York team, headed by Dr. Farzad Mostashari, an assistant commissioner in the city's health department, started by bringing in decision-support experts in medicine to study how doctors work, so the technology would be easier to use. Team members considered writing their own software for simple, Web-based electronic health records, but abandoned that idea once they understood that patient records would have to be tightly linked to billing — a physician's financial lifeblood.

The project's 50-member staff provides centralized technical support and education for doctors and others. "There's no way small practices can effectively implement electronic health records on their own," Dr. Mostashari said. "This is not the iPhone."

The staff worked closely with its software supplier, eClinicalWorks, to tweak and tailor the system. They began rolling out the records a little more than a year ago. They are now used by more than 1,000 physicians, mainly in poorer neighborhoods, whose workplaces include two hospital outpatient clinics, 10 community health centers, 150 small group physician practices and one women's jail, serving a total of one million patients. The rollout is progressing, and the government plan promises to accelerate adoption.

"Our experience here is that it's just hard," Dr. Mostashari said. "It's not impossible."



DEPARTMENT OF VETERANS AFFAIRS
Alaska VA Healthcare System and Regional Office
2925 DeBarr Road
Anchorage, Alaska 99508-9998

• March 4, 2009

In Reply Refer To: 463/00

Senator Joe Paskvan
State Capitol
Juneau, Alaska

Subject: Alaska e-Health Network

Dear Senator Paskvan:

I recently read with interest Senate Bill #133 that advocates creating a statewide electronic health information exchange system. The Alaska Veteran Affairs Healthcare System is a strong advocate of such a system. The VA has had an electronic medical record since the 1980's and has seen the benefits of improving quality patient care and safety, reducing healthcare costs, coordinating care and improving emergency services. Increasing the ability to exchange information with private sector providers would further enhance these benefits for Alaska veterans.

The Alaska VA Healthcare System has a strong relationship with providers throughout Alaska. Last year the Alaska VA purchased approximately \$40m of healthcare services from hospitals, clinics and doctor's offices throughout the state. Allowing instantaneous exchange of vital information can do nothing but improve the quality of care for Alaskans. Reducing duplication of tests, x-rays, medications and procedures would surely drive down costs for everyone. We are excited about the possibilities of a statewide network. As such, I am a member of the Board of the Alaska e-Health Network to assure federal providers are included as a stakeholder in any system developed in our state.

The Alaska VA Healthcare System seeks the same solutions as you do. We would be glad to work with all parties to assure such a system is comprehensive in its scope.

Good Luck in your efforts.

Sincerely,

Alex Spector
Director
Alaska VA Healthcare System

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 17, 2009

Honorable Joe Paskvan
Alaska State Senate
Capitol, Room 7
Juneau, Alaska

RE: SB 133 – Electronic Health Information Exchange System

Dear Senator Paskvan:

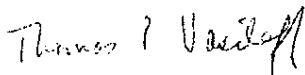
The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

We in Alaska need the ability to electronically transmit patient health information securely and flawlessly between the various facilities and health care professionals involved in the treatment process. The transfer of such information in a uniform manner is important in providing the best care for our injured or ill citizens. Additionally, this system also needs to mesh with similar systems outside of Alaska as well. This facilitates the timely and best care for patients in Alaska who reside elsewhere in the United States and Alaskan patients who require care while in another state.

ASMA has been engaged as a stake holder in this process for sometime being represented by Dr Jerome List, an ASMA past president. He currently is on the board of Alaska e-Health Network. Additionally, ASMA was one of the founders of the Alaska Electronic Health Record Alliance and is represented on its board by Dr. List and Jim Jordan, ASMA Executive Director. This entity is engaged in developing pilot programs to get electronic health records deployed in the office of solo or small number physician practices. It needs the uniform interoperability to maximize patient care through the ability to send and receive health information involving all in the care of a patient.

ASMA supports SB 133 and urges its passage.

Sincerely,



By: Thomas Vasileff, MD, President
For: The Alaska State Medical Association

3/9/09



Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: SB 133

Dear Senator Paskvan:

Premera Blue Cross Blue Shield of Alaska is pleased to offer this letter of support for Senate Bill No.133. Benefits to Alaskans will be significant. Health information exchange networks have been successful in improving patient care and safety, reducing healthcare costs and enhancing emergency response to public health emergencies.

A non-profit organization which is independent, widely representative of the major stakeholders, and operates transparently is crucial to the success of this effort. We feel this is necessary to win and maintain the trust of Alaskans. Your bill truly meets these important criteria.

Premera feels a deep commitment to improving the health and welfare of the citizens of Alaska while creating efficiencies in the health care system. This organization is willing to work with other stakeholders to seek out best practices and solutions for a statewide healthcare network infrastructure enabling the secure exchange of health care data.

Premera supports this plan. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for our patients. We see this as a next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,

A handwritten signature in black ink that reads "Barbara B. Russell". The signature is written in a cursive style.

Barbara B. Russell, CLU
Vice President, Alaska Sales
Premera Blue Cross Blue Shield of Alaska

2550 Denali Street
Suite 1404
Anchorage, AK 99503

tel 907.258.5065
fax 907.258.1619

www.premera.com

An Independent Licensee of the
Blue Cross Blue Shield Association

ALASKA PRIMARY CARE ASSOCIATION, INC.

"... Uncompromising in the pursuit of access to primary care for all Alaskans."



March 6, 2009

Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: Alaska e-Health Network Appropriation Request

Dear Senator Paskvan:

The Alaska Primary Care Association (APCA) is pleased to offer this letter of support for Senate Bill No.133. Irrefutable research shows that health information exchange (HIE) networks are successful in improving patient care and safety, reducing healthcare costs and enhancing emergency response to public health emergencies. Thus, there is no question that benefits to Alaskans as a result of this bill will be significant.

APCA holds a deep commitment to improving the health and welfare of the citizens of Alaska while creating efficiencies in the health care system. APCA's mission, purpose and programs revolve around increasing access to primary care for all Alaskans. APCA is committed to working with other stakeholders to seek out best practices and solutions for a statewide healthcare network infrastructure enabling the secure exchange of health care data, as it will help our constituents (Alaska's community health centers and other safety net providers) in providing quality health care more effectively.

Healthcare organizations in Alaska have a track record of working together with other leaders and stakeholders here to improve health services for our patients. APCA sees this plan for the continued development of an HIE as a next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Walsh Kasmir".

Marilyn Walsh Kasmir, RNC, MBA
Executive Director.



Alaska Ear Nose & Throat, Inc.
Jerome List, DDS, MD

3841 Piper Street
Suite T4-348
Anchorage, Alaska 99508

Tel: (907) 261-3096
Fax: (907) 261-3094

March 3, 2009

Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: Alaska e-Health Network appropriation request

Dear Senator Paskvan:

Alaska Ear Nose & Throat, Inc. is pleased to offer this letter of support for Senate Bill No. 133. Benefits to Alaskans will be significant. Health information exchange networks have been successful in improving patient care and safety, reducing healthcare costs and enhancing emergency response to public health emergencies.

A non-profit organization which is independent, widely representative of the major stakeholders, and operates transparently is crucial to the success of this effort. We feel this is necessary to win and maintain the trust of Alaskans. Your bill truly meets these important criteria.

Alaska Ear Nose & Throat, Inc. feels a deep commitment to improving the health and welfare of the citizens of Alaska while creating efficiencies in the health care system. This organization is willing to work with other stakeholders to seek out best practices and solutions for a statewide healthcare network infrastructure enabling the secure exchange of health care data.

With the geography in Alaska, exchange of medical information is critical. Telemedicine has been a huge cost savings to the Native Health System not to mention numerous other benefits. We need to expand our interconnectivity to allow exchange of medical data among all Health Care Providers for all patients when appropriate & needed.

Alaska Ear Nose & Throat, Inc. supports this plan. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for our patients. We see this as a next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,


Jerome List, DDS, MD



Bristol Bay Area Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
800-478-5291
FAX (907) 842-9354

Bristol Bay Area Health Corporation is a tribal organization representing 34 villages in Southwest Alaska:

- Aleknagik
- Chignik Bay
- Chignik Lagoon
- Chignik Lake
- Clark's Point
- Dillingham
- Egegik
- Skuk
- Ekwok
- Goodnews Bay
- Igluvig
- Iliamna
- Ivanof Bay
- Kanatak
- King Salmon
- Krugank
- Kokhanok
- Kolliganok
- Laydlock
- Manokotak
- Naknek
- New Stuyahok
- Newhalen
- Nondalton
- Pedro Bay
- Perryville
- Pilot Point
- Platinum
- Port Heiden
- Portage Creek
- South Naknek
- Tagiak
- Twin Hills
- Ugashik

March 16, 2009

To Whom It May Concern:

The Bristol Bay Area Health Corporation (BBAHC) has begun implementation of a Electronic Health Records EHR system at our Kanakanak Hospital and hopes to secure additional funding to do so with our 28 village clinics.

It is our hope that we can electronically communicate our EHR's and receives EHR's from all patients using our system and other health facilities throughout the state and elsewhere.

With our different system's we need a way to all talk to each other. We are excited about the possibility of SB No. 133 "An Act creating a statewide electronic health information exchange systems; and providing for an effective date. By senators PASKVAN, Davis introduced on 3.2.09.

We are members of several statewide groups who are supportive of an HIE as proposed, as we have seen how well it works in the lower 48.

This should be a high priority of the state and is an area that President Obama's stimulus package supports.

Thank you for you support.

Robert J. Clark
President/CEO

To promote health
with competence,
a caring attitude &



Alaska State Hospital and Nursing Home Association

426 Main Street
Juneau, AK 99801
907-586-1790

March 4, 2009

The Honorable Joe Paskvan
Alaska State Senator
State Capitol
Juneau, Alaska 99801

Re: SB 133 and the Alaska e-Health Network (AeHN) Budget Request

Dear Senator Paskvan:

The Alaska State Hospital & Nursing Home Association (ASHNHA) is pleased to offer this letter of support for Senate Bill No.133. ASHNHA has been – and is – a long standing and strong supporter of the efforts of the AeHN. Indeed, I have seat on the newly formed board of directors for the AeHN, in part as a reflection of the Association's keen interest in this important project, but primarily because ASHNHA's members believe that the benefits to Alaskans from the outcome of the AeHN initiative will be significant. Health Information exchange (HIE) networks in other parts of the country have been successful in improving not only the quality of patient care but patient safety, as well. As a result, HIE's contribute to reducing healthcare costs while enhancing emergency response to public health emergencies.

The AeHN is an independent, non-profit organization with representative of the major stakeholders within Alaska concerned for the development and provider and patient utilization of important health information technologies (HIT). In this day of heightened concern for the speed at which digital information is spinning out across the Internet, the purposeful and transparent actions and activities of the AeHN are viewed by ASHNHA as crucial to the success of this statewide effort to bring unity of purpose to this important cost-effective, public safety program. The AeHN Board of Directors feels strongly that it must conduct its business in the full view of the public in order to win and maintain the trust of Alaskans. Your bill truly ensures these important criteria.

ASHNHA and its individual members feel a deep and demonstrative commitment to improving the health and welfare of the citizens of Alaska, while also recognizing citizen call for the creation of more efficiencies within the health care system.

Page Two - The Honorable Senator Joe Paskvan - March 4, 2009

Our organization is most willing to work with other healthcare related stakeholders to seek out best practices and solutions as we move forward together to create a statewide healthcare network infrastructure enabling the secure exchange of personal health care data.

ASHNHA whole heartedly supports the approach outlined in SB 133. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for our patients. We see this legislation, its goals and intents, as the next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for sponsoring this important legislation.

Respectfully,



Rod Betit
President and Chief Executive Officer
Alaska State Hospital & Nursing Home Association

cc: Rebecca Madison



CAROLYN Y. HEYMAN-LAYNE
(907) 257-7670
FAX (907) 276-4152
heyman.carolyn@dorsey.com

March 9, 2009

VIA FACSIMILE

Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: SB 133

Dear Senator Paskvan:

As a mother and a health care lawyer, I am writing in support of Senate Bill No. 133. Health information exchange networks can be a great tool to improve healthcare and increase the efficiency and safety of health care services. In addition, they can assist in reducing healthcare costs and eliminating redundant services. As a mother, I want to make sure my daughter can receive the best health care with the least amount of pain or discomfort. As a health lawyer, I want to make sure clients can provide services quickly and in compliance with all laws and regulations. An independent non-profit organization representing the major stakeholders would help to facilitate these goals and is an important step towards a complete health care system. Senate Bill No. 133 is a major part of this goal.

Everyday, I encourage clients to adopt electronic health records and help them figure out the privacy and security of those records. Most clients are ready and willing to support health information exchange, if they know there will be support available and the infrastructure to make their efforts worthwhile. They also want to know that there are local laws that address and encourage the exchange of health information, so they can show patients that these efforts are backed by more than just a computer company selling a program, or a healthcare organization pushing its own agenda. This bill would be one step in the building blocks that form a health information exchange network.

Even with my daily interaction with health care providers, I did not realize how difficult coordination of records would be without an electronic health record and health information network until I had a baby. My daughter was born over a year ago, was happy and healthy, and yet we are still working out the bills and services provided during her birth. I can only imagine the difficulty that we would have had if she were not healthy and happy. By coordinating records and services electronically, and by helping families avoid redundant tests and paperwork, a health information exchange network can make it easier for parents to cope with a loved one's illness.

I strongly support this plan. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for patients - I see this happening everyday. This bill is the next logical step toward improving health care delivery and outcomes throughout Alaska.

DORSEY & WHITNEY LLP - WWW.DORSEY.COM • T 907.276.4557 • F 907.276.4152
1031 WEST FOURTH AVENUE • SUITE 600 • ANCHORAGE, ALASKA 99501-5907
USA CANADA EUROPE ASIA



Senator Joe Paskvan
March 9, 2009
Page 2

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,

DORSEY & WHITNEY LLP

Carolyn Y. Heyman-Layne

cc: R. Madison (via email)



Alaska Native Tribal Health Consortium

Administration · 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

March 10, 2009

Senator Joe Paskvan
Alaska State Capitol
Juneau, Alaska 99801

RE: Endorsement of SB133: Alaska Health Information Exchange

Dear Senator Paskvan:

The Alaska Native Tribal Health Consortium (ANTHC) hereby expresses our support for your introduction of SB133 for consideration by the Alaska State Legislature.

For the past two years our organization has been the managing partner for the development of the Alaska e-Health Network, organized to create a health information exchange serving all residents of the State of Alaska. Like most Americans, Alaskans receive medical care services from multiple providers, and the availability of an electronic network allowing rapid transfer of medical data will significantly improve medical care wherever patients seek services. We have been encouraged that all of the major health care provider organizations in Alaska are aligned and working together in support of development of such a network.

Our organization is making a significant investment in the process of transferring all of our paper medical records to electronic medical records. When this process is complete, the Alaska e-Health Network will allow us to exchange our records with other participating health care providers both within the Alaska Tribal Health System and with other governmental and private health care providers who also see our patients.

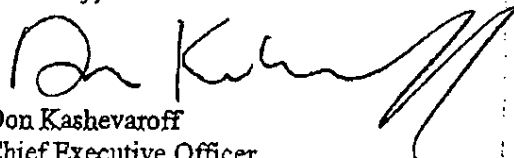
National research, and the experience of health information exchanges developed in the lower-48 states, have demonstrated that full deployment of interoperable electronic health records save the health care system nearly 5% of total annual costs, improve patient safety through reduction of medical errors, and improve the coordination of patient care.

The Alaska e-Health Network will ensure that patient privacy is protected and enhanced through the availability of a secure, encrypted network that is HIPAA compliant.

ANTHC urges the State of Alaska to take a leadership role in deploying health information exchange for Alaskans through passage of SB133 as enabling legislation, through a capital contribution to the development of the Network, and through a proportionate contribution for the long-term operations of the Network. The State will realize savings as a health care provider, as an employer, and as a major payor for health care services for Alaskans.

Please let me know how ANTHC can assist further in supporting your initiative.

Sincerely,



Don Kashevaroff
Chief Executive Officer
Alaska Native Tribal Health Consortium

cc: Governor Sarah Palin
Commissioner William Hogan, DHSS
Paul Sherry, Alaska e-Health Network



AARP Alaska
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March 6, 2009

The Honorable Joe Paskvan
Member of the Senate
Alaska State Capitol, Room 7
Juneau, AK 99801-1182

RE: SB 133 (Paskvan)—Support

Dear Senator Paskvan:

On behalf of the 97,000 members of AARP in Alaska, we are pleased to support SB 133, authored by you and co-sponsored by Senator Davis.

AARP has been collaborating with a group of organizations and medical leaders for several years to determine how Alaska can develop electronic medical record systems in medical offices and an electronic health record exchange network to connect clinics, hospitals, labs, pharmacies, insurers, the State of Alaska and other related health and medical providers that need to have quick access to accurate records.

SB 133 will establish an electronic health information exchange system.

AARP strongly supports this effort.

We believe electronic medical records will save overall costs as well as significantly reduce medical errors. In addition, electronic medical records will also lead to the more effective use of personal health records to increase consumers' engagement in their health care. Electronic records can take advantage of technology to facilitate patient education and self-management, permit secure messaging reminders, allow patients to maintain diaries, eg., of pain, symptoms and side effects, and to obtain prescription refills, schedule medical appointments online, and track medical test results. Ideally these personal health records will be connected to the electronic medical record system.

Even if all an electronic health information exchange accomplished was a reduction in medical errors, that goal alone is worth pursuing in Alaska.

Some proponents of setting up such an exchange system believe such a network could be the biggest advance in medicine since the discovery of penicillin. A network like this in Alaska has the potential to save hundreds, if not thousands, of lives and save millions of

dollars by eliminating duplicate tests, shortening hospital stays, improving care for chronically ill patients, and guaranteeing accurate prescribing.

The collaboration on this issue that we have already witnessed in Alaska gives us confidence that the system will work and work well. Some of our "best and brightest" are committed to accomplishing this for Alaska citizens and health consumers.

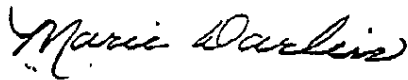
AARP members, more than any other age group, are consumers of health care. We believe SB 133 is in the best interests of our members as well as their families.

AARP is pleased to lend our strong support to SB 133.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Bettye Davis
Patrick Luby

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

SARAH PALIN, GOVERNOR

P.O. BOX 110693
 JUNEAU, ALASKA 99811-0693
 PHONE: (907) 465-3250
 FAX: (907) 465-1398

Alaska Commission on Aging

April 6, 2009

RECEIVED

APR - 7 2009

The Honorable Lyman Hoffman, Co-Chair
 The Honorable Bert Stedman, Co-Chair
 Senate Finance Committee
 Alaska State Capitol, Rooms 518 and 516
 Juneau, AK 99801-1182

Subject: Support for SB 133

Dear Chair Hoffman and Chair Stedman:

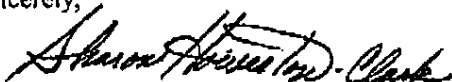
The Alaska Commission on Aging (ACoA) respectfully asks for your support of SB 133, a bill to establish a statewide electronic health information exchange system that would modernize the current paper-based system and allow health care providers quick access to patient health care records, reducing medical errors and enhancing cost effectiveness. This legislation is authored by Senator Joe Paskvan and co-sponsored by Senator Bettye Davis.

The benefits of an electronic health care information exchange system are significant and would contribute substantially to the State's goals to improve safety, cost effectiveness, and quality of health care in Alaska. An electronic information exchange system provides the means for individual Alaskans to have their own personal health records accessible to all health care providers so that providers can make medical decisions in a timely and secure manner in the location where medical services are delivered. The electronic exchange system will support telemedicine services including the transfer of high resolution images for patient care and video conferencing between providers and between providers and patients which are particularly important for patients living in rural Alaskan communities. SB 133 also provides for the implementation of a secure infrastructure that follows federal standards and requires patient consent to insure maximum protection of patient confidentiality and their medical records.

For older Alaskans, an electronic health information system will help to enhance the management of chronic diseases and improve health outcomes by increasing the availability of complete patient health information to ensure appropriate care and use of evidence-based health care services. An electronic health information system can also help to facilitate patient education in self-management of health conditions and potentially provide a means for personal health records to be connected to the electronic medical record system – including prescription records, lab results, schedules of medical appointments, and patient diaries of reported symptoms, side effects related to medicine, and other related information.

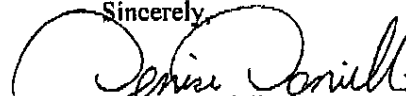
ACoA is pleased to support SB 133 and appreciates your consideration of this bill. We believe that an electronic health care information system will serve all Alaskans well, including older Alaskans who are among the largest consumers of health care services. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position or request assistance from our office. Thank you for your consideration of support for this important legislation.

Sincerely,



Sharon Howerton-Clark
 Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
 ACoA Executive Director

CC: Senator Johnny Ellis
 Senator Charlie Huggins

CC: Senator Donald Olson
 Senator Joe Thomas



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RECEIVED

APR - 7 2009

April 6, 2009

The Honorable Lyman Hoffman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 518
Juneau, AK 99801-1182

The Honorable Bert Stedman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 516
Juneau, AK 99801-1182

RE: SB 133 (Paskvan)—Support

Dear Co-Chairs Hoffman and Stedman:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Finance Committee to support SB 133, authored by Senator Joe Paskvan and co-sponsored by Senator Bettye Davis.

AARP has been collaborating with a group of organizations and medical leaders for several years to determine how Alaska can develop electronic medical record systems in medical offices and an electronic health record exchange network to connect clinics, hospitals, labs, pharmacies, insurers, the State of Alaska and other related health and medical providers that need to have quick access to accurate records.

SB 133 will establish an electronic health information exchange system.

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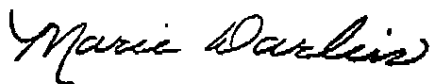
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AARP is pleased to lend our strong support to SB 133.

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Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Charlie Huggins
Senator Donald Olson
Senator Joe Thomas
Senator Johnny Ellis
Senator Joe Paskvan