SB

133

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/2/09

FURTHER: (Finance)

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/27/09

Health and Social Services 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** SB 133 (HSS)

[ ] 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/MAA	3/13	✓			1

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
Jon Thomas	Thomas	✓			
Joe Parkinson	Parkinson	X			
CHAIR: Kelly A Davis	DAVIS	X			

26-LS0489\S
Mischel
3/25/09

CS FOR SENATE BILL NO. 133( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS PASKVAN, Davis

A BILL

FOR AN ACT ENTITLED

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

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature to create a secure electronic health information exchange system that

(1) ensures that the confidentiality of individually indentifying health information of a patient is secure and protected;

(2) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

(3) promotes wellness, disease prevention, and management of chronic illnesses by increasing the availability and transparency of information related to the health

care needs of an individual for the benefit of the individual;

(4) ensures that appropriate information needed to make medical decisions is available in a usable form at the time and in the location that the medical service is provided;

(5) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(6) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services; and

(7) improves the coordination of information and the provision of health care services through an effective infrastructure for the secure and authorized exchange and use of health care information.

*** Sec. 2.** AS 18.23 is amended by adding new sections to read:

Article 4. Electronic Health Information Exchange System.

Sec. 18.23.300. Creation of health information exchange system. (a) The department shall establish and implement a statewide electronic health information exchange system and ensure the interoperability and compliance of the system with state and federal specifications and protocols for exchanging health records and data.

(b) The system established under this section must

(1) include infrastructure planning that involves

(A) the designation by the commissioner of a qualified entity or combination of qualified entities in the state that

(i) has an advisory or governing body made up of health system stakeholders that include members identified under (d) of this section;

(ii) applies for available federal and state funding for planning and implementation of the system authorized by the commissioner;

(iii) submits an annual budget for approval of the commissioner;

(iv) complies with nondiscrimination and conflict of

interest policies;

(v) meets and complies with federal and state health information policies and standards;

(vi) provides cost and cost saving data associated with the development and use of the system to the department;

(B) the development of statewide infrastructure to support the electronic health information exchange system established under this section and to connect electronic health records to the infrastructure;

(C) the development of a statewide technology plan, with the participation of identified stakeholders, to promote the implementation and sustained use by public and private health care payors and providers of electronic health records and the system established under this section in order to ensure interoperability among government-operated health information systems and other public and private health information and reporting systems;

(D) the development of policies and standards, consistent with federal and state law, to safeguard the privacy and security of health information;

(E) the development of a training and workforce development plan for implementing and serving the system;

(F) an estimate of costs of the hardware, software, services, and support needed to implement and maintain the technical infrastructure; and

(2) include implementation measures that

(A) provide for installation and training on the use of the system;

(B) set out a plan to encourage health care provider, payor, and patient use of electronic records over a sustained period of time;

(C) provide support to providers for workflow redesign, quality improvement, and care management services;

(D) provide for participation by all identified stakeholders in the planning and implementation of the system;

(E) comply with federal and state health information policies;

and

(F) provide for periodic evaluation and improvement of the system.

(c) The department may enter into contracts, seek and accept available federal and private funds and equipment, and adopt regulations necessary to carry out the purposes of this section.

(d) The designee under (b)(1)(A) of this section may be the state or a private for-profit or nonprofit entity or entities under contract with the state or a combination of the state and one or more entities under contract with the state. The advisory or governing body of the designee must include

(1) the commissioner; and

(2) eight other individuals, each of whom represents one of the following interests:

(A) hospitals and nursing home facilities;

(B) private medical care providers;

(C) community-based primary care providers;

(D) federal health care providers;

(E) Alaska tribal health organizations;

(F) health insurers;

(G) health care consumers;

(H) employers or businesses.

Sec. 18.23.305. Department; duties. In carrying out its duties under AS 18.23.300, the department shall

(1) in accordance with federal recommendations, determine the manner in which the system is developed and operated;

(2) provide oversight and technical assistance needed for planning and implementing the system;

(3) authorize and facilitate applications for available federal funding for planning and implementing the system;

(4) ensure compliance with applicable federal and state health information policies and standards;

(5) ensure compliance with federal and state law and standards that safeguard the privacy and security of health information.

Sec. 18.23.310. Confidentiality and security of information. (a) The department shall establish appropriate security standards to protect the transmission and receipt of individually identifiable information contained in the system established under AS 18.23.300. The standards must

(1) include controls over access to and collection, organization, and maintenance of records and data that protect the confidentiality of the individual who is the subject of a health record;

(2) include a secure and traceable electronic audit system for identifying access points and trails;

(3) meet the most stringent applicable federal or state privacy law governing the protection of the information contained in the system.

(b) A person may not release or publish individually indentifying health information from the system for purposes unrelated to the treatment or billing of the patient who is the subject of the information. Use or distribution of the information for a marketing purpose is strictly prohibited.

(c) The department shall establish procedures for a patient who is the subject of a health record contained in the system to

(1) opt out of the system;

(2) consent to the distribution of the patient's records contained in the system;

(3) be notified of a violation of the confidentiality provisions required under this section;

(4) on request to the department, view an audit report created under this section for the purpose of monitoring access to the patient's records.

Sec. 18.23.315. Health information exchange system report to the legislature. The department shall provide to the legislature, on or before December 31 of each year, an annual report on the progress of the health information exchange system in the state, including a specific set of recommendations for long-term participation and financial support by the state.

Sec. 18.23.320. Contract conditions. A contract entered into to carry out the purposes of AS 18.23.300 must require that the contractor meet applicable federal and state requirements for protecting health information privacy and security and nationally recognized standards for interoperability of health information technology.

Sec. 18.23.325. Definitions. In AS 18.23.300 - 18.23.325,

(1) "commissioner" means the commissioner of health and social services;

(2) "department" means the Department of Health and Social Services;

(3) "system" means the statewide electronic health information exchange system established under AS 18.23.300.

*** Sec. 3.** This Act takes effect July 1, 2009.

ALASKA STATE LEGISLATURE

Senator Joe Paskvan

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Senate District E – Fairbanks, AK

MEMORANDUM

DATE: **March 5, 2009**

TO: **Senator Bettye Davis, Chair**
Senate Health & Social Services Committee

FROM: **Senator Joe Paskvan**

RE: **Hearing Request for SB 133 – Electronic Health Info Exchange System**

I am requesting that Senate Bill 133 be scheduled for a hearing in the Senate Health and Social Services Committee at your earliest convenience.

This bill establishes an electronic health information exchange system within the Department of Health and Social Services. It also provides privacy protection standards in addition to those already required in Federal Law and regulation. When implemented, this system is estimated to save Alaska's healthcare system approximately $250 million annually while also improving the safety and quality of healthcare for Alaskans.

Included in this packet:

- Sponsor Statement
- A current version of SB 133 – 26-LS0489\E
- Background Information
- Letters of Support

Other backup will be forthcoming as required. Thank you.

Please contact Jake Hamburg – 465-2872 with any questions regarding SB 133.

ALASKA STATE LEGISLATURE

Senator Joe Paskvan

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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.

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					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	557.6		557.6	557.6	557.6	557.6	557.6
Travel	10.0		10.0	3.0	3.0	3.0	3.0
Contractual	56.4		56.4	3,356.4	3,356.4	3,356.4	3,356.4
Supplies	15.6		12.0	12.0	12.0	12.0	12.0
Equipment	30.0						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**669.6**	**0.0**	**636.0**	**3,929.0**	**3,929.0**	**3,929.0**	**3,929.0**
CAPITAL EXPENDITURES	**27,275.0**						
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	25,150.1		572.4	2,135.0	2,135.0	2,135.0	2,135.0
1003 GF Match	2,794.5		63.6	1,794.0	1,794.0	1,794.0	1,794.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**27,944.6**	**0.0**	**636.0**	**3,929.0**	**3,929.0**	**3,929.0**	**3,929.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	**6.0**		6.0	6.0	6.0	6.0	6.0
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 133 proposes to create a secure statewide electronic health information exchange system. It would mandate the department to create the system by 1) infrastructure planning that includes the designation of a qualified nonprofit entity in the state that has an advisory body made up of health system stakeholders; 2) implementating 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.

Since this is a large and complex task to complete, 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.

Prepared by: William J. Streur, Deputy Commissioner
Phone 334-2520
Division: Health Care Services
Date/Time 3/13/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/13/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 133

ANALYSIS CONTINUATION

The Division of Health Care Services estimates that it will need a total of 6 FTE's for the planning, infrastructure development, installation, and administration of the electronic health information exchange system.

Operating Budget :

Administrative costs

1 Project Manager, $150.0, 1 Micro Network Specialist II, $95.0, 1 Research Analyst II, $72.9, 1 Medical Assistance Administrator III, $92.4, 1 Accountant III $82.2, 1 Accounting Technician II, $65.0. 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 $3,000.0 per year for hosted service maintenance costs beginning in FY2012.

Assumes $300,000 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 potals.

Fund Source

Assumes 90% federal for FY2010 and FY2011
Assumes 54.34% federal for 2012 and beyond

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

Prepared by:

Carolyn Heyman-Layne, Dorsey & Whitney LLP
Linda Boochever, Alaska EHR Alliance
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Submitted to:

Linda Dimitropoulos, Project Director
Privacy and Security Solutions for
Interoperable Health Information Exchange

Research Triangle Institute
P. O. Box 12194
3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

December 5, 2007

RTI INTERNATIONAL

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.

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.

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:

- 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 agreements and consumers, and
- 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 ofe lectronic 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.

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 *Minnesota Health Records Act*	**Rhode Island** *Rhode Island Health Information Exchange Act of 2008*
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: • 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 *Minnesota Health Records Act*	**Rhode Island** *Rhode Island Health Information Exchange Act of 2008*
Audit Log	RLS must maintain an audit log of providers who access a patient's information. The log must contain at least the following: 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.	Patients have the following rights: (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	(b) When requesting health records using consent, or a representation of holding a consent, a provider warrants that the request: 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.	Provides immunity to health care providers who rely in good faith upon information provided through the HIE in the treatment of a patient.
Penalties	An RLS is liable for inappropriate disclosures of information. Anyone who inappropriately discloses a patient's data is liable for compensatory damages caused by an unauthorized release, plus costs and reasonable attorneys' fees. Providers who violate the statute can face disciplinary action by the appropriate licensing board or agency.	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.

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 *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
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.

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

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
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			
	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.	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.	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.

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

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
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			
	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.	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.	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.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)			
	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
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			
	Chapter 6. Duties 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: (1) Compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). (2) Protection of information privacy. (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.	Sec. 182.104.AASecurity Compliance. The corporation shall: (1) establish appropriate security standards to protect both the transmission and the receipt of individually identifiable health information or health care data; (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; (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	Sec. 903. Health Information Technology (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.

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

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
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			
	Chapter 6. Duties Sec. 1. The corporation shall do the following:... (6) Promote the use of the statewide health information exchange system by doing the following: (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. (B) Recommending policies and legislation that advance the development and efficient operation of the statewide health information exchange system.... (10) Encourage and endorse interoperability standards.	Sec.A182.103. Privacy of Information. (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.	Sec. 903. Health Information Technology b) The health information technology plan shall: (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;... (6) incorporate the existing health care information technology initiatives in order to avoid incompatible systems and duplicative efforts; (7) integrate the information technology 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;

The New York Times

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."

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***

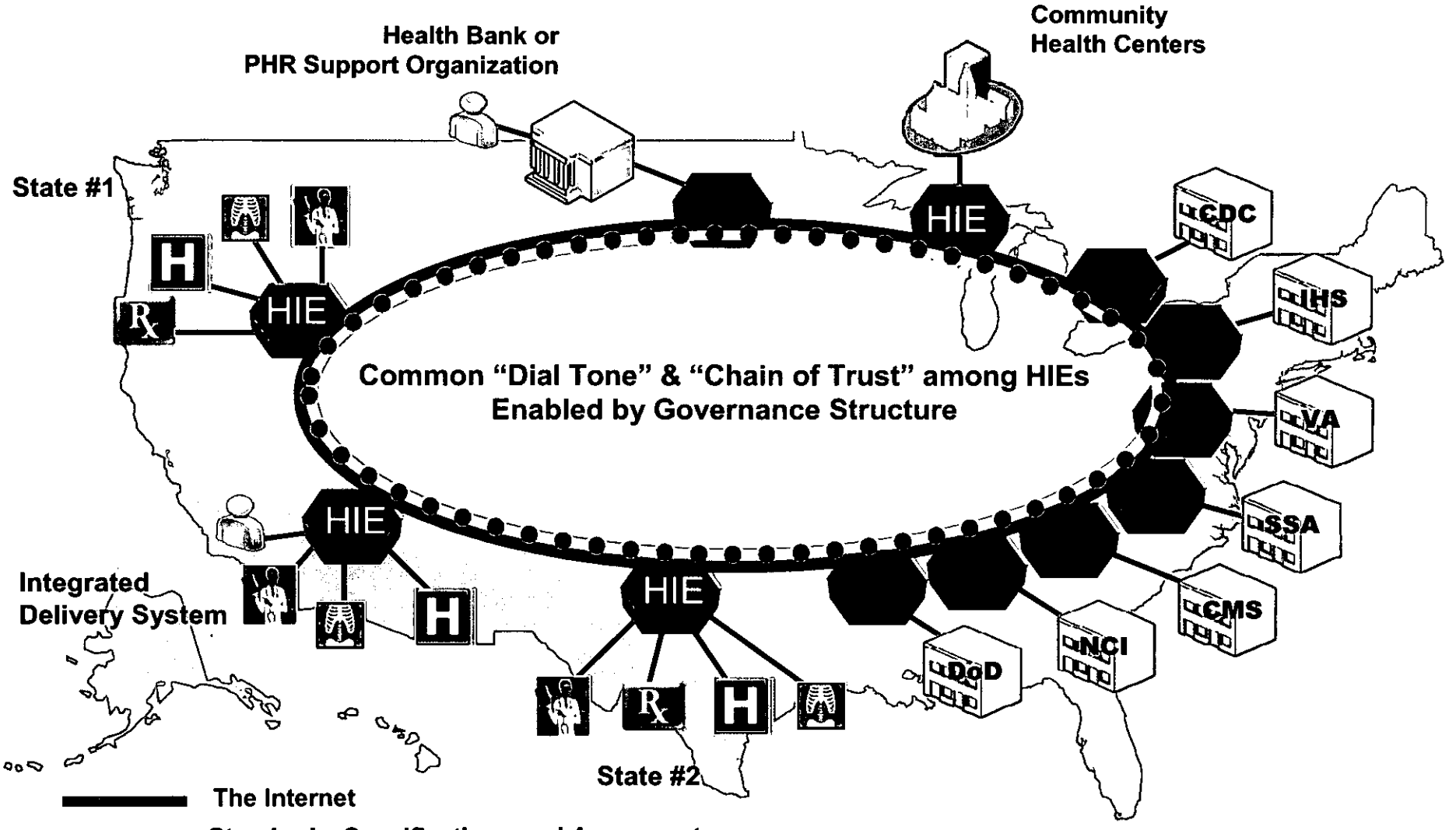
- Alaska's health care providers are aligned in support of creating a statewide ***Health Information Exchange*** network so patient records may be securely exchanged between providers for timely and safe patient care

- 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

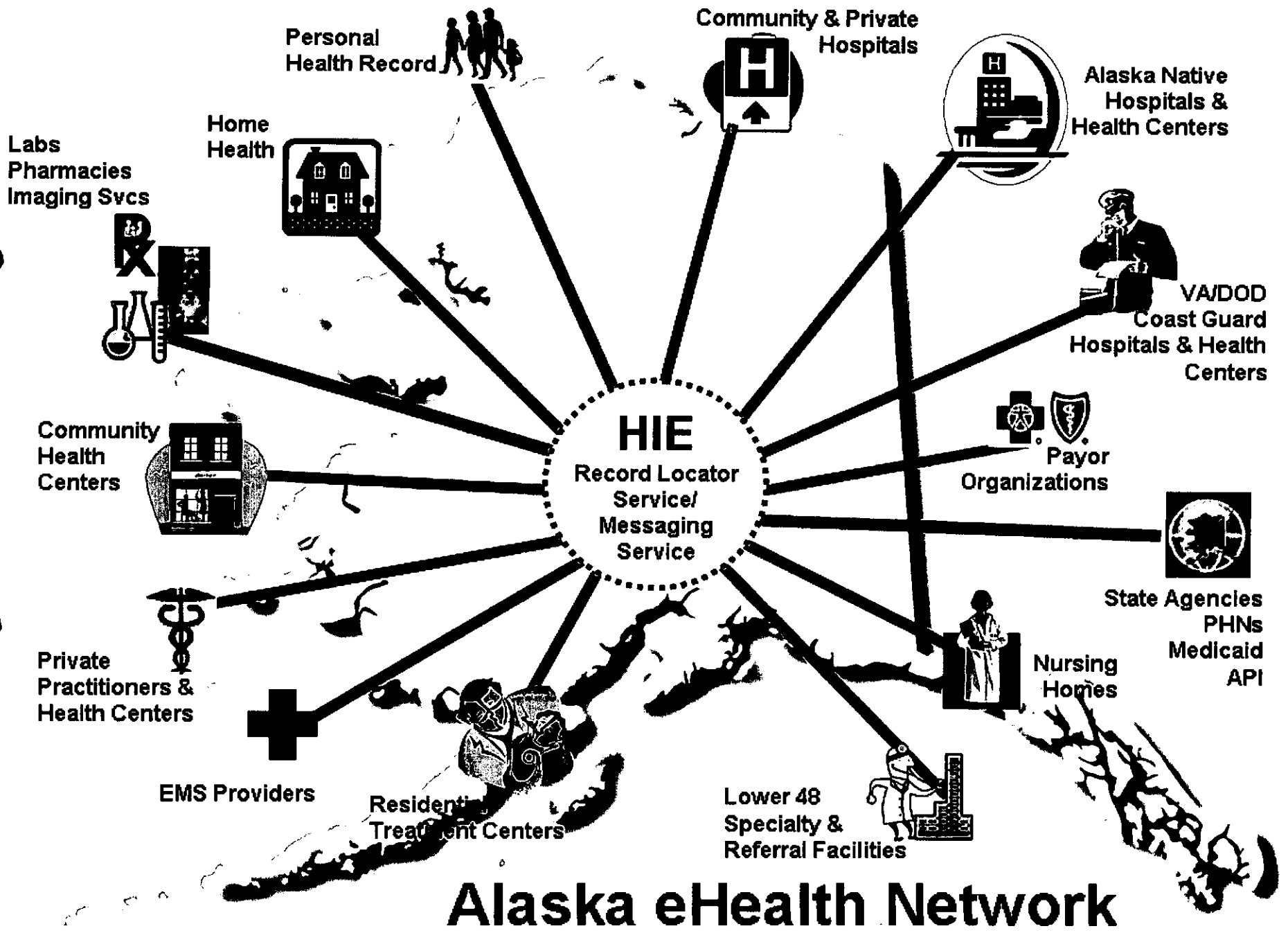
Health Information Exchanges: Saving money

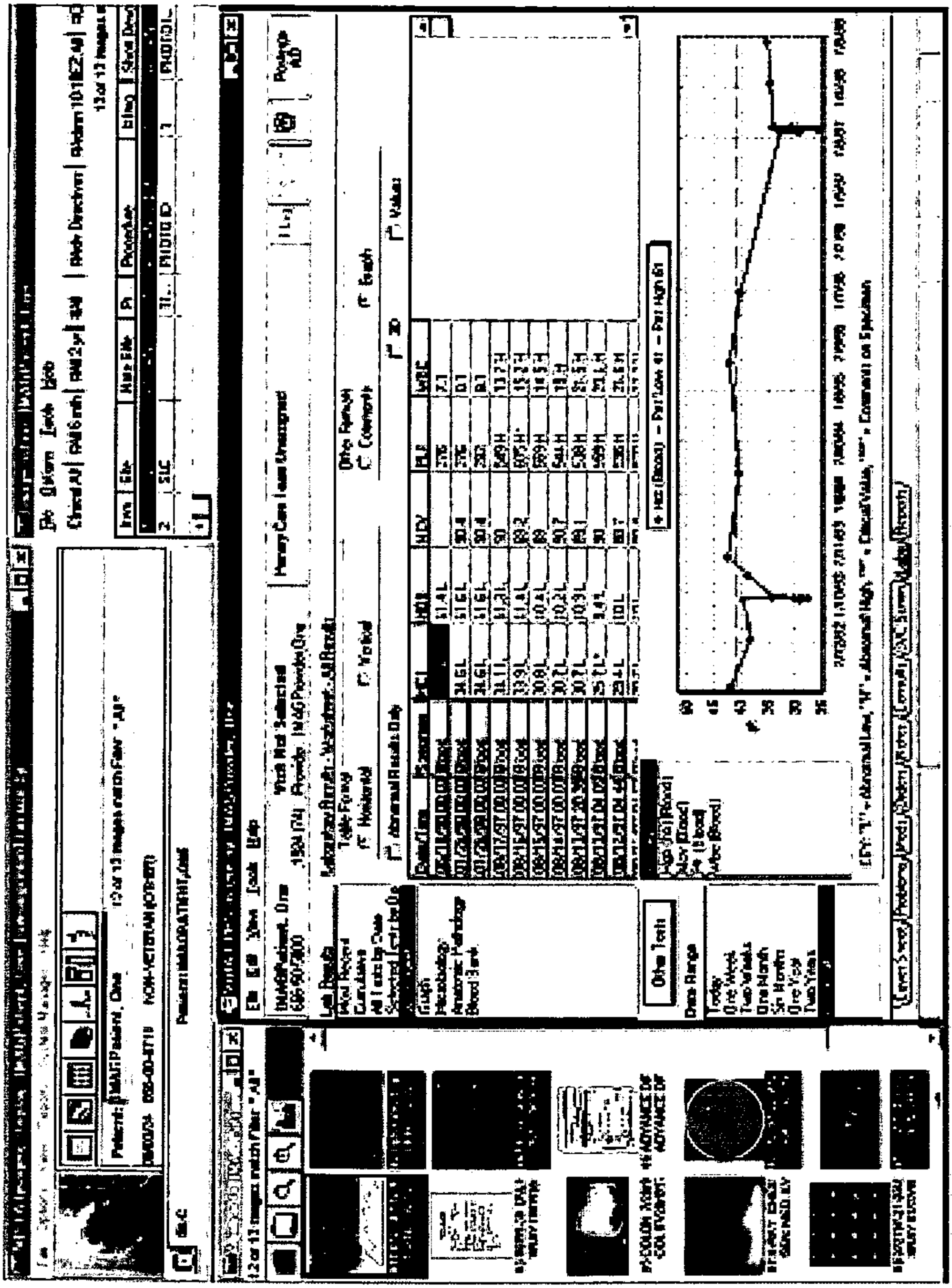
- Federal and private research projects 5% savings in annual U.S. health care expenditures from full deployment of inter-operable electronic medical records
- For Alaska's $5B health care industry, annual savings could reach $250M.
- For the State of Alaska's $250M GF Medicaid expenditures, annual savings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


Personal Health Record
Community & Private Hospitals
Alaska Native Hospitals & Health Centers
Home Health
Labs Pharmacies Imaging Svcs
VA/DOD Coast Guard Hospitals & Health Centers
HIE
Record Locator Service/ Messaging Service
Community Health Centers
Payor Organizations
State Agencies PHNs Medicaid API
Private Practitioners & Health Centers
Nursing Homes
EMS Providers
Residential Treatment Centers
Lower 48 Specialty & Referral Facilities
Alaska eHealth Network



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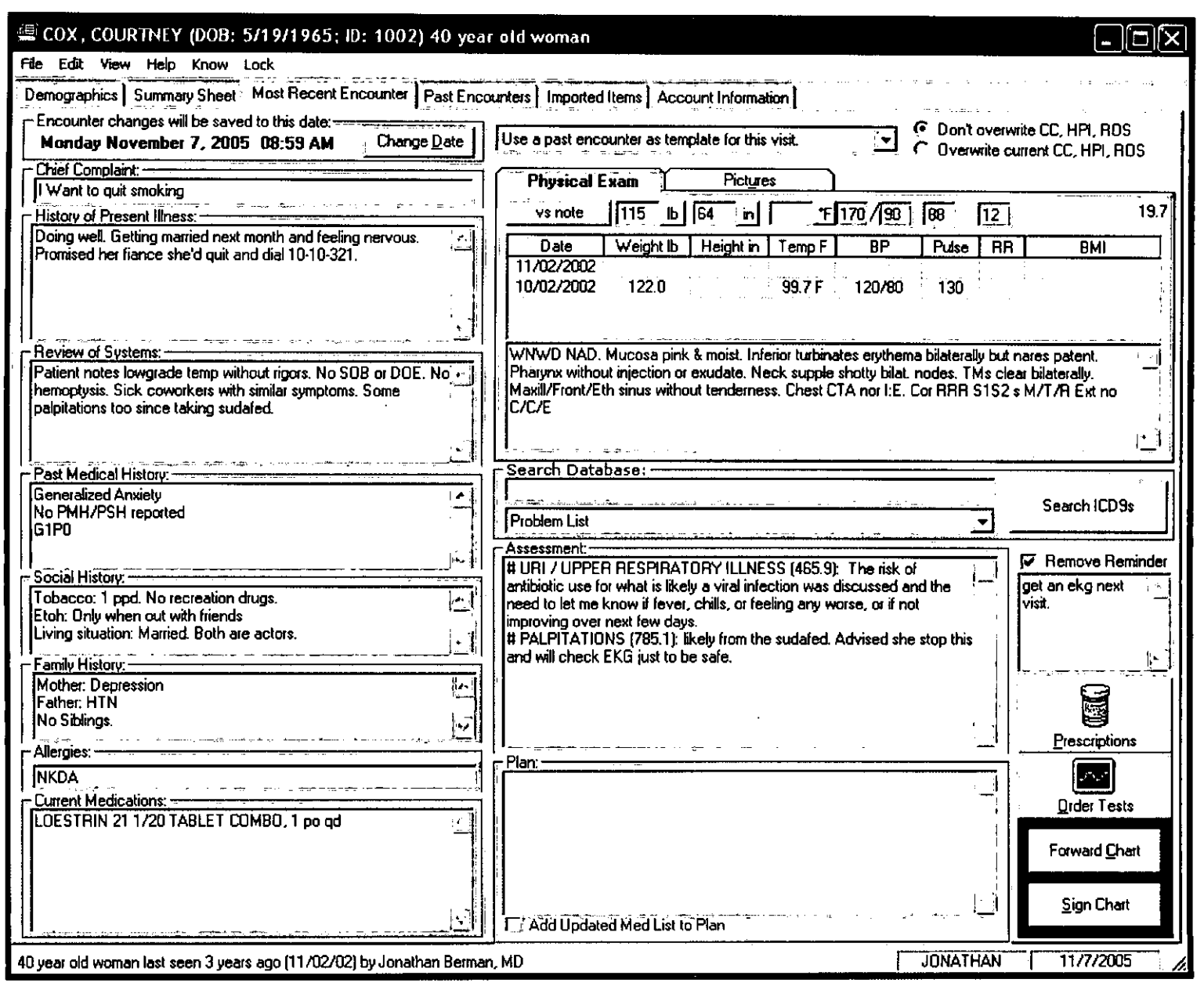

COX, COURTNEY (DOB: 5/19/1965; ID: 1002) 40 year old woman

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

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 dial 10-10-321.

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

Past Medical History:
Generalized Anxiety
No PMH/PSH reported
G1P0

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:
LOESTRIN 21 1/20 TABLET COMBO, 1 po qd

Physical Exam | Pictures

vs note | 115 lb | 64 in | °F | 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		

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

Search Database:
Problem List
Search ICD9s

Assessment:
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 sudafed. Advised she stop this and will check EKG just to be safe.

Remove Reminder
get an ekg next visit.

Prescriptions

Order Tests

Plan:

Add Updated Med List to Plan

Forward Chart

Sign Chart

40 year old woman last seen 3 years ago (11/02/02) by Jonathan Berman, MD | JONATHAN | 11/7/2005

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 eHeath 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

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800-478-5201
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
Ekuk
Ekwok
Goodnews Bay
Igiugig
Iliamna
Ivanof Bay
Kanatak
King Salmon
Knugank
Kokhanok
Koliganek
Levelock
Manokotak
Naknek
New Stuyahok
Newhalen
Nondalton
Pedro Bay
Perryville
Pilot Point
Platinum
Port Heiden
Portage Creek
South Naknek
Togiak
Twin Hills
Ugashik

To promote health with competence, a caring attitude &

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

BRISTOL BAY AREA HEALTH CORPORATION
P.O. Box 130
6000 Kanakanak Road
Dillingham, Alaska 99576

TOLL FREE: 1-800-478-5201 (In Alaska Only)
PHONE: 1-(907)-842-5201
FAX: 1-(907)-842-9354

PLEASE DELIVER THE FOLLOWING PAGES TO:

Name: Anna Mae — Hard Copy To Follow: Yes U No ____
Department: ____ — Phone: ____
Company: ____ — Fax: 842-5105

From: Holly Akelkok — Phone: 842-5201
Department: Administration — Fax: 842-9543

Comments: Please include this information in the hearing today at 1:30 p.m. Would you be able to send to the SHSS Committee as well as Edgmon, Hoffman & Dept Stevens? Thank you.

Date: 3-16-09 Pages: 2 Sent By: Holly Akelkok

3-16-09 11:40am

AARP

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 16, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 133 (Paskvan)—Support

Dear Chair Davis:

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

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

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

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

AARP

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

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.

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Thank you for your consideration.

Sincerely,

Marie Darlin

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

Lynda Zaugg

From: Amory Lelake
Sent: Tuesday, March 24, 2009 9:37 AM
To: Lynda Zaugg
Subject: FW: SB 133 Electronic Health Network

From: Sherry, Paul [mailto:psherry@anthc.org]
Sent: Tuesday, March 24, 2009 8:43 AM
To: Amory Lelake
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner; linda.zaugg@legis.state.ak.us
Subject: RE: SB 133 Electronic Health Network

Thanks Amory. We will review her comments and provide a response to you today.

Paul Sherry

From: Amory Lelake [mailto:Amory_Lelake@legis.state.ak.us]
Sent: Tue 3/24/2009 8:30 AM
To: Sherry, Paul
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner; linda.zaugg@legis.state.ak.us
Subject: FW: SB 133 Electronic Health Network

Here are the concerns our constituent Dr. Illona Farr has about electronic health records in reference to SB 133. Since the bill will be heard again on Friday, maybe we can try to set up a time to discuss her concerns.

Thanks!

Amory

From: Ilona Farr [mailto:afmc4045@gmail.com]
Sent: Monday, March 23, 2009 8:46 PM
To: Amory Lelake
Cc: afmc4045@yahoo.com
Subject: Re: SB 133 Electronic Health Network

Amory,

I just got back into town yesterday and just got your email. As a Family Practice Physician these required electronic medical records will force me to stop seeing medicare and medicaid patients because of the added time and cost associated with these records. I tried electronic medical records(EMRs) for 6 months. I went from seeing patients 5 hours a day with 3 hours of paperwork to seeing patients 3 1/2 hours a day and doing work on the computer 5 hours a day. My costs went through the roof and I started loosing long time patients because they could no longer get into see me. (that 4 MD clinic spent $240,000 on EMRs , lost lots of money and terminated the system after one year.) I went back to solo practice with hand written notes and just scan these into the computer in a word file so my patients can get a copy on disc of their word document medical file if they desire.(so I do have a form of EMR) I

have estimated the costs to my office of $65,000.00 per year for these new required medical electronic records (where I have to type or dictate into an approved system) plus add 2 more hours a day to my work schedule, forcing me to decide between family or patients.

Studies have shown that electronic medical records add 1-2 hours of work a day for each MD. Electronic medical records are beneficial in large institutions but will do nothing but be detrimental in my practice as 99% of what I do will never need to be viewed again. I recently talked to a physician from Tanana Valley Clinic. They spent 2 million dollars converting to electronic medical records, lost 1-2 million in revenues (for 35 MDs and Approx 40,000 patients) and recently had to be taken over by the hospital to keep them in business.

The technology is not there to guarantee security on internet, nor are the EMRs currently efficient for most of us in primary care. Only 17-19% of MDs do EMRs in spite of this technology being available for 20 years because it is not time or cost effective yet. There are not enough MDs in primary care seeing medicare and medicaid patients now so why force those of us who are still seeing them to stop seeing them by adding more costs to our practices when we already loose money ($100/Patient) seeing these patients now.

EMRs Will increase the costs to my patients of between $25 to $65 per visit. In this age of increasing medical care costs I see this as a needless expense for most primary care MDs in small practices which will force many into early retirement.(when there is already an MD shortage) We should not be forced into doing things that are detrimental for our practices. Let individual practices decide what is best for the individual situations (as with the unreliability of electricity in the bush records like this will be a nightmare for the healthaides.) Do you really want your records available on the internet to the 600,000 organizations that will potentially have access to them?

I hope this information helps. Please forward to Berta and others as needed.

Ilona Farr MD

On Tue, Mar 17, 2009 at 9:18 AM, Amory Lelake <Amory_Lelake@legis.state.ak.us> wrote:

Hi Ilona

My name is Amory I met you recently at the District 24 pizza party. I'm writing because today Senate Bill 133 came before Senator Ellis in the H&SS Committee: "An Act creating a statewide electronic health information exchange system; and providing for an effective date".

Senator Ellis mentioned to the committee that he had recently met with a constituent who had a number of reservations regarding the costs that such a system would create for small private practices. Senator Ellis knows you are very busy, but is hoping you could put your concerns in writing so that we can pass them on to the people involved with the bill.

Thanks!

Amory Lelake

Legislative Aide

Senator Johnny Ellis

State Capital Building, Rm 103

Juneau, Alaska 99801

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

USA TODAY

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Hospitals far from paperless

By Janice Lloyd, USA TODAY

Adoption of electronic health records in hospitals lags behind previous estimates and is expected to be more costly and difficult than predicted, says a study out Wednesday in *The New England Journal of Medicine*.

Many medical experts agree that eliminating paper records would help save lives and make health care more efficient and less costly. But a survey of nearly 3,000 hospitals found only 1.5% have comprehensive electronic records in all units. An additional 7.6% have a basic system in one unit that includes physicians' or nurses' notes.

BETTER LIFE: News on what affects when the doctor can see you ...

Earlier reports estimated the portion of hospitals adopting electronic records ranged from 5% to 59%. This survey was conducted by researchers at the Harvard School of Public Health, Biostatistics Center at Massachusetts General Hospital, the Brigham and Women's Hospital, the VA Boston Healthcare System, the Institute of Health and the Department of Health Policy at George Washington University. It had a 63% response rate and is the first reliable data, the researchers say.

To rank as having comprehensive health information technology (HIT), 24 functions were required in a hospital's major clinical units. These functions range from doctors' notes to diagnostic test images to computerized provider entry for medications. Eight functions had to be present in at least one major clinical unit for the basic program. Only 12% of the hospitals had physicians' notes.

"If we want to improve health care, I think we're really going to need to see much more widespread deployment of a lot of the key functions that are at low rates," says the report's lead author, Ashish Jha of Harvard. "Certainly in those ways it seems that we have a long ways to go."

The numbers from the survey "validated what we've been hearing," says Don May of the American Hospital Association. "We've heard some have stepped up but mostly we've heard some are on the path. They're doing a little but not enough for the whole package."

Better recordkeeping part of Obama overhaul

The study's release follows on the heels of a plan by President Obama to upgrade the record-keeping system as a key part of an effort to overhaul the health care system. Obama set aside $19 billion in the economic stimulus package to help with costs and pledged to spend $50 billion over five years.

Progress will not be easy, says David Blumenthal, director of the Institute for Health Policy and an author of the study. Blumenthal was recently named national coordinator for Health Information Technology by the U.S. Department of Health and Human Services, a post he assumes in mid-April.

"We are at a very early stage in adoption, a very low stage compared to other countries," says Blumenthal, but that suggests "an enormous upside in that respect for stimulating the adoption.

"The Congress and the administration showed enormous foresight and commitment to the goal of increasing adoption rates through the provisions of the stimulus bill," he says. "It's clear they want to see results in health care."

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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,

Barbara B. Russell

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

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DORSEY
DORSEY & WHITNEY LLP

CAROLYN Y. HEYMAN-LAYNE
(907) 257-7870
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

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

Sincerely,

DORSEY & WHITNEY LLP

Carolyn Heyman-Layne

Carolyn Y. Heyman-Layne

cc: R. Madison (via email)

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,

Marilyn Walsh Kasmar, RNC, MBA
Executive Director.

Phone 907-929-2722 Fax 907-929-2734 www.alaskapca.org alaskapca@alaskapca.org
903 West Northern Lights Blvd, Suite 200 Anchorage AK 99503-2400

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,

Barbara Starr for

Jerome List, DDS, MD

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.

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

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

cc: Rebecca Madison

Bristol Bay Area
Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
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800-478-5201
FAX (907) 842-5354

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- Twin Hills
- Ugashik

To promote health with competence, a caring attitude &

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

ARRA Update:

Providers can receive up to $44,000 reimbursement for EHR systems. Incentives give early adopters a means to recover expenses.

Here are some tips to help you come quickly up-to-speed with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 and the section of ARRA relating to Health Information Technology (HITECH).

"Meaningful use of EHR" is a .new concept introduced in HITECH. Incentives will require both Medicare and Medicaid eligible professionals to demonstrate meaningful use of certified EHR technology by:

- Using e-prescribing as determined to be appropriate by HHS
- Using EHR technology which provides exchange of information to improve quality of health care, such as promoting care coordination
- Reporting of clinical quality measures and other measures selected by HSS

Adoption demonstration may require attestation, submission of claims with appropriate coding, survey response, reporting on measures or other means specified by HHS. Provision is given for alternative reporting means for group practice providers.

Additional requirements may include:

- Contact information of eligible professionals who are meaningful users to be posted on the HHS web site
- To the extent possible, incentive payments will be coordinated across multiple practices for a given EP, and to avoid duplicative requirements under Medicaid
- Payment may be in a single consolidated payment or periodic installments
- Significant hardship exception may be granted up to 5 years
- Comparable incentives and adjustments are provided for professionals providing substantial services through Medicare Advantage plans

The maximum amount of the incentive is $44,000 depending on when an EHR is acquired. Note that the incentives include an "adjustment" of the full reimbursement for Medicare patients after 2015. This sanction would occur after the targeted goal for all Americans to have an EHR by 2014. The payment structure includes:

Payment Year	**Amount of Incentive or Adjustment subject to per physician cap of 75% of Medicare allowable charges in any year**
First year if implemented in 2011 or 2012	$18,000
First year if implemented before 2013	$15,000
Second year	$12,000
Third year	$8,000
Fourth year	$4,000
Fifth year	$2,000
Succeeding payment years	$0
If practice is in a health professional shortage area	Above amount increases by 10%
IF EHR is adopted after 2014	$0
IF not using EHR by 2015	99% of reimbursement
If not using EHR by 2016	98% of reimbursement
If not using EHR by 2017 and beyond	97% of reimbursement
If <75% use EHR by 2018	1% less than preceding year but not less than 95%

	reimbursement

ARRA provides for payments to those States that have approved Medicaid plans and implement programs to encourage adoption and use of certified EHR technology. Program payments cannot be more than 85% of the average allowable costs for certified EHR technology, capped at $25,000 for first year and $10,000 for subsequent years, reduced by 2/3 for pediatricians. Eligible professionals include physicians, dentists, certified nurse mid-wives and nurse practitioners, who are not provider-based with at least a 30% Medicaid patient load, pediatricians who are not provider-based with at least a 20% Medicaid patient load, and physician assistants practicing in a federal qualified health center or rural health clinic with at least 30% load of patients classified as "needy," which is broader than Medicaid beneficiaries requirements.

Lynda Zaugg

From: Amory Lelake
Sent: Wednesday, March 25, 2009 10:32 AM
To: Lynda Zaugg
Cc: Jake Hamburg; Sen. Johnny Ellis
Subject: FW: SB 133 Electronic Health Network
Attachments: ARRA Update.doc

Hi Lynda,

Just wanted to make sure you had Mr. Sherry's response to Dr. Farr's email and the attached ARRA.

From: Sherry, Paul [mailto:psherry@anthc.org]
Sent: Tuesday, March 24, 2009 11:13 AM
To: Amory Lelake
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner;
Subject: RE: SB 133 Electronic Health Network

Hi Amory and all:

Thank you for sharing the comments you received from Dr. Farr, and the opportunity to address them.

The main point is that SB133 does not require any physician or other health care provider to use electronic medical records (EMR). The legislation focuses on the development of a secure network so that providers who do elect to use them can exchange patient records when they are referred or seen by new providers.

The network plans to provide information to physician offices in whatever format the office is capable of receiving including faxing, printing, or regular mail.

While some other states have enacted legislation requiring medical providers to use electronic records, this legislation does not take that step, nor are we recommending that the State do so.

Dr. Farr is not alone in having difficulties with the transition from paper to medical records. Early adopters nation-wide experienced a myriad of problems, including high implementation costs and software systems that were not easy-to-use. As the EMR industry matures, the cost is gradually coming down and the solutions are improving. For example, there are now several versions of "EMR-lite" that require substantially less investment and are more user-friendly.

Federal legislation requires physicians to have some form of EMR by the year 2014 or accept decreased Medicare payments for services. Our e-Health Network plans to provide assistance to physicians and other providers to find software, e-prescribing systems, training, and other tools to make this transition easier. We are working closely with the Alaska EHR Alliance, a physician-based group that has this activity as their main focus.

The American Recovery and Reinvestment Act (ARRA) provides new incentives for physician investments in electronic medical records. An individual physician can receive up to $44,000 for such an

investment. Those providers who were early adopters will benefit first from this funding, which becomes available in 2010. The attachment provides more information on this federal provision.

Both our network director Rebecca Madison and I live in Fairbanks and have recently received feedback from providers at the Tanana Valley Clinic. While they have gone through a painful learning curve, most say they would never go back to paper, that their charting time has been reduced by half, and that they are waiting for our network to be deployed so that they can connect with others around the state.

Hopefully these observations address the concerns brought forward by Senator Ellis at the hearing. If additional information is required regarding the deployment of EMR's or the national research that has clearly demonstrated their efficacy and cost-reductions, we would be pleased to provide such to you.

Thank you again.

Paul Sherry, President
Alaska e-Health Network

From: Amory Lelake [mailto:Amory_Lelake@legis.state.ak.us]
Sent: Tue 3/24/2009 8:30 AM
To: Sherry, Paul
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner; linda.zaugg@legis.state.ak.us
Subject: FW: SB 133 Electronic Health Network

Here are the concerns our constituent Dr. Illona Farr has about electronic health records in reference to SB 133. Since the bill will be heard again on Friday, maybe we can try to set up a time to discuss her concerns.

Thanks!

Amory

From: Ilona Farr [mailto:afmc4045@gmail.com]
Sent: Monday, March 23, 2009 8:46 PM
To: Amory Lelake
Cc: afmc4045@yahoo.com
Subject: Re: SB 133 Electronic Health Network

Amory,

I just got back into town yesterday and just got your email. As a Family Practice Physician these required electronic medical records will force me to stop seeing medicare and medicaid patients because of the added time and cost associated with these records. I tried electronic medical records(EMRs) for 6 months. I went from seeing patients 5 hours a day with 3 hours of paperwork to seeing patients 3 1/2 hours a day and doing work on the computer 5 hours a day. My costs went through the roof and I started loosing long time patients because they could no longer get into see me. (that 4 MD clinic spent $240,000 on EMRs , lost lots of money and terminated the system after one year.) I went back to solo practice with hand written notes and just scan these into the computer in a word file so my patients can

get a copy on disc of their word document medical file if they desire.(so I do have a form of EMR) I have estimated the costs to my office of $65,000.00 per year for these new required medical electronic records (where I have to type or dictate into an approved system) plus add 2 more hours a day to my work schedule, forcing me to decide between family or patients.

Studies have shown that electronic medical records add 1-2 hours of work a day for each MD. Electronic medical records are beneficial in large institutions but will do nothing but be detrimental in my practice as 99% of what I do will never need to be viewed again. I recently talked to a physician from Tanana Valley Clinic. They spent 2 million dollars converting to electronic medical records, lost 1-2 million in revenues (for 35 MDs and Approx 40,000 patients) and recently had to be taken over by the hospital to keep them in business.

The technology is not there to guarantee security on internet, nor are the EMRs currently efficient for most of us in primary care. Only 17-19% of MDs do EMRs in spite of this technology being available for 20 years because it is not time or cost effective yet. There are not enough MDs in primary care seeing medicare and medicaid patients now so why force those of us who are still seeing them to stop seeing them by adding more costs to our practices when we already loose money ($100/Patient) seeing these patients now.

EMRs Will increase the costs to my patients of between $25 to $65 per visit. In this age of increasing medical care costs I see this as a needless expense for most primary care MDs in small practices which will force many into early retirement.(when there is already an MD shortage) We should not be forced into doing things that are detrimental for our practices. Let individual practices decide what is best for the individual situations (as with the unreliability of electricity in the bush records like this will be a nightmare for the healthaides.) Do you really want your records available on the internet to the 600,000 organizations that will potentially have access to them?

I hope this information helps. Please forward to Berta and others as needed.

Ilona Farr MD

On Tue, Mar 17, 2009 at 9:18 AM, Amory Lelake <Amory_Lelake@legis.state.ak.us> wrote:

Hi Ilona

My name is Amory I met you recently at the District 24 pizza party. I'm writing because today Senate Bill 133 came before Senator Ellis in the H&SS Committee: "An Act creating a statewide electronic health information exchange system; and providing for an effective date".

Senator Ellis mentioned to the committee that he had recently met with a constituent who had a number of reservations regarding the costs that such a system would create for small private practices. Senator Ellis knows you are very busy, but is hoping you could put your concerns in writing so that we can pass them on to the people involved with the bill.

Thanks!

Amory Lelake

Legislative Aide

Senator Johnny Ellis

State Capital Building, Rm 103

Juneau, Alaska 99801

HITECH (ARRA 2009) Stimulus Provisions and Notes:

QUALIFIED STATE-DESIGNATED ENTITY:
To be qualified a State-designated entity must

- be designated by the state
- be a not-for-profit entity with broad stakeholder representation on its governing board
- demonstrate that its principal goal is to use IT to improve health care quality and efficiency through HIE
- adopt nondiscrimination and conflict of interest policies to include participation of stakeholders

IMMEDIATE FUNDING:
Immediate funding is available through a number of agencies within the U.S. Department of Health and Human Services (HHS). These include the Office of the National Coordinator for Health Information Technology (ONC), Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Indian Health Service. Funding is expected to start flowing within 2009 for:

- HIT architecture that supports nationwide electronic exchange and use of health information in a secure, private, and accurate manner
- Development and adoption of certified EHRs for providers not eligible for other support
- Training on and dissemination of best practices to integrate HIT, including EHR, into a provider's delivery of care
- Infrastructure and tools for telemedicine
- Promotion of interoperability of clinical data repositories or registries
- Promotion of technologies that enhance protection of health information
- Improvement and expansion of uses of HIT by public health department

One area of immediate funding will be in the area of HIT implementation assistance. Two resources are provided for:

Health Information Technology Extension Program: ONC, in consultation with other Federal agencies and National Institute of Standards and Technology (NIST), establish a HIT extension program to help providers adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information

Health Information Technology Research Center: Secretary of HHS creates this center to provide technical assistance and develop or recognize best practices to support and accelerate efforts to use HIT

- HIT Regional Extension Centers: housed within U.S.-based nonprofit institutions or organizations to gain broad participation, active dissemination of knowledge, participation in HIE, and integration of HIT and EHR into initial and ongoing training of health professionals
- Focus on regional assistance to public or not-for-profit hospitals or critical access hospitals; federally qualified health centers, entities located in rural and other underserved areas, primary care individuals and small group practices

STATE GRANTS & LOANS:
Through ONC, HITECH requires the establishment of a program to facilitate and expand electronic movement and use of health information among organizations according to nationally recognized standards through planning and implementation grants to States.

Activities expected to be performed with use of this money include:

- Participation in authorized and secure nationwide electronic use and exchange of health information
- Identify State or local resources and complement Federal programs

- Provide technical assistance
- Promote strategies to adopt and utilize HIT in medically underserved communities
- Assist patients in utilizing HIT
- Encourage clinicians to work with HIT Regional Extension Centers
- Support public health agencies' use of electronic health information
- Promote use of EHRs for quality improvement, including through quality measures reporting

Grants require a match of at least $1 for each $10 of Federal funds in 2011, $1 for each $7 of Federal funds in 2012, and $1 for each $3 of Federal funds for 2013 and following years. Prior to 2011, Secretary may determine whether any state match is required.

HITECH also provides the ability for ONC to award competitive grants and loans to States or Indian tribes:

- For establishment of programs for loans to providers to purchase certified EHR technology
- Enhance utilization of certified EHR technology
- Train personnel in use of EHR technology
- Improve the secure electronic exchange of health information

In using such grant and loan funds, providers must agree to:

- Submit reports on quality measures
- Demonstrate that certified EHR technology is used to exchange health information in a manner that improves quality of health care, such as promoting care coordination
- Comply with other requirements as the entity or Secretary may require
- Include a plan on how providers involved intend to maintain and support the certified EHR technology over time

So while the largest amount of funding through the incentive program (to be discussed next) rewards use, there still are ways to support acquisition.

Provisions of the competitive grant and loan program include that there be matching funds at the rate of $1 for each $5 of Federal funding, the interest rate charged must not exceed market rate, and the principal and interest payment must start within first year of award and be fully amortized not later than 10 years. First awards may be made by January 1, 2010.

Overall Package (Billions)

SPENDING	$ 506.0
• Health care	
– Assist states with Medicaid:	86.6
– Subsidize COBRA:	24.7
– Grants, loans, infrastructure, & incentives to modernize HIT:	19.0
– NIH facilities & research:	10.0
– Prevention/wellness:	1.0
	141.3
• Infrastructure	91.7
– Including to expand broadband	
• Education	87.3
• Aid to poor & unemployed	67.0
• Energy	41.2
• Direct cash payments	14.2
• Housing	9.5
• State block grants	8.8
• Science	5.6
• Law enforcement	4.0
• Homeland security	2.8
• Other	32.6

TAXES	$ 281.0
• New tax credit	$ 116.0
• Alternative minimum tax	70.0
• Renewable energy incentives	20.0
• Child tax credit	15.0
• College credit	14.0
• Home-buyer credit	6.6
• Bonus depreciation	5.0
• Earned income tax credit	4.7
• Auto sales	1.7
• Repeal bank credit	-7.0
• Other tax provisions	35.0

Sources: Associated Press, LA Times, Tribune

Alaska eHealth Network
Health Information Exchange Infrastructure Requirements
(in thousands)

	FY2007	FY2008	FY2009	FY2010	FY2011	Funding Source
Privacy/Security Assessment and Policy Development	$300	$300				*Office of the National Coordinator for Health IT* - grant to assess Alaska Privacy and Security laws, to develop policies and procedures for the secure/private exchange of health information, and to work with an 8 state collaborative to develop inter-organizational privacy agreements.
Network/Hardware						
Technical Network Design			$260			*FCC* – contract to assess and design a statewide healthcare network for secure data exchange.
			$50			*State FY09* – required FCC match
Technical Network Development			$10,000			*FCC* – contract to implement a statewide healthcare data exchange network.
			$450			*State FY09* – required FCC match
			$500			*AFHCP* – required FCC match
Software						
Health Information Exchange Software/Implementation				$13,000	$7,000	Stimulus – proposed funding based on the draft American Recovery and Reinvestment Act of 2009.
				$1,300	$1,000	*State FY10, FY11* – appropriation request from state to match FCC and stimulus funds.
				$500		*Rasmuson* - pending
TOTAL Annual Non-Recurring	**$300**	**$300**	**$11,260**	**$14,800**	**$8,000**	Annual non-recurring requirements to provide Alaska with infrastructure for the secure exchange of healthcare information.
TOTAL Project Non-Recurring	**$34,660**					**Total non-recurring project requirements**

Yellow – State FY09

Green – State FY10 and FY11

3/13/2009

Alaska eHealth Network (AeHN)
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			
$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

Alaska eHealth Network (AeHN)
Interoperable Statewide Health Information Exchange (HIE)

Business Projection Based on Fee for Service

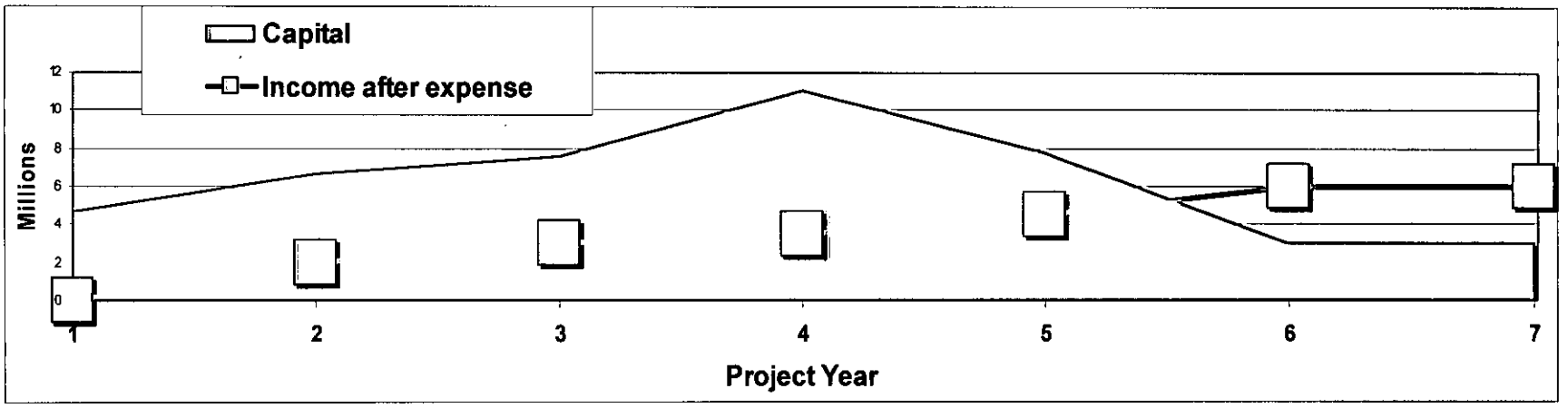
A review of more than 100 HIE projects in other states was conducted to guide the development of AeHN. Special lessons were drawn from intensive study of sustainable models in states with needs and goals similar to those of Alaska. The members of the business development team also identified the benefits and critical success factors of similar projects in other states.

A financial partnership has been created to fund development and implementation of AeHN. Capital support in varying levels is being sought from foundations, investors, state and federal agencies, tribal entities, consumer organizations, businesses, members of the AeHN Board of Directors (hospitals, employers, insurance companies, and the State Health Commission), physicians, and other caregivers.

Subscription fees and user charges will be assessed to sustain long-term operations. An 18-month rollout is planned, although early success in fundraising and availability of technology alternatives (e.g., outsourcing) could shorten the timeframe.

In summary, AeHN is designed to improve efficiency and effectiveness of healthcare in Alaska. Patient-controlled information will be accessible when and where it is needed most—complementing Alaska's national leadership in access with comparable accomplishments in cost and quality.

This graph provides an overview of the extensive business plan developed by partners of AeHN. It is expected that the project will break even in Year 5.



Paul Sherry
President
Work: (907) 729-1900
Cell: (907) 230-5572
psherry@anthc.org

February 23, 2009

Senator Lyman Hoffman, Co-Chair
Senator Bert Stedman, Co-Chair
Senate Finance Committee
State Capitol
Juneau, Alaska 99801

Re: Alaska e-Health Network appropriation request

Dear Senators Hoffman and Stedman:

On behalf of the Alaska eHealth Network, we are requesting that the State of Alaska include an appropriation of $1.3 million in FY2010 as state match for $13 million in federal stimulus funds to continue the build out of a health information exchange for Alaska.

The objective of the Alaska eHealth Network is to unify separate electronic health care networks that are being developed throughout the state and supply rural health providers with connectivity to referral providers both in Alaska and in the lower 48 states. This coordinated network will facilitate the exchange of critical health information between health providers. It will also support telemedicine services, the transfer of high resolution images for patient care, as well as videoconferencing and Voice-over-Internet applications.

Overall, an Alaska health information exchange network will improve patient's access to care, reduce unnecessary testing and procedures, improve patient safety, reduce health agency administrative costs, and enhance rapid response to public health emergencies.

In 2006 the Alaska Telehealth Advisory Council funded an effort to evaluate and recommend solutions for the electronic health information exchange for Alaska health care providers. Primary partners of this effort, now called the Alaska eHealth Network (AeHN), include the Alaska Federal Health Care Partnership, the Alaska Primary Care Association, the Alaska Native Tribal Health Consortium, the Alaska State Hospital and Nursing Homes Association, the Alaska Mental Health Trust Authority, Premera Blue Cross/Blue Shield, the University of Alaska, AARP Alaska, the State Department of Health and Social Services, and the EHR Alliance.

A business plan developed by the partners anticipates a total project cost of $35M for development of a health information exchange for Alaska over the next five years. The plan addresses the connectivity of Alaska's separate health care networks and the exchange of health information across Alaska's health care community. The plan calls for the generation of revenue through facility and provider user fees and

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a personal health record subscription fee. Break-even point for this extensive coordination of Alaska's health care information systems will occur in Year 6.

In August 2008, the Alaska eHealth Network partners elected to form a 501(c)(3) corporation. A list of the initial board members is enclosed. ANTHC has been designated by the partners to act as interim project manager for development of the Alaska eHealth Network.

The Alaska eHealth Network has as its mission: *To improve the safety, cost effectiveness, and quality of healthcare in Alaska through the promotion and facilitation of widespread implementation and use of secure and confidential electronic clinical information systems, including electronic health records, medical decision support, clinical data exchange capabilities and reimbursement mechanisms.*

To date we have secured $11.5 million in support of this initiative, primarily from federal sources (the Federal Communications Commission and the Alaska Federal Health Care Partnership. In FY2009 we received an appropriation of $500,000 in this year's capital budget. This funding has allowed the Alaska eHealth Network to proceed with planning and design of a statewide health information exchange initiative.

For FY2010 we are requesting that the State of Alaska include an appropriation of $1.3M for the state share of costs for the Alaska e-Health Network. We will be requesting an additional $1M in FY2011. We anticipate this funding will provide the match for the federal stimulus and will allow us to complete the infrastructure build out for health information exchange without any additional capital requests for FY2012 and beyond.

Please contact me at 907-230-5572 or at psherry@anthc.org if you have questions or require additional information. You may also contact project director Rebecca Madison at 907-729-3934 or at rebccam@akrivertracks.com.

Sincerely,

Paul Sherry
President
Alaska eHealth Network

Cc: Governor Sarah Palin

"Technology's Wonders" coming to a doctor's office near you ...if we act quickly.

Published 2/24/2009 in the *Fairbanks Daily News Miner* and *Juneau Empire*

By Rebecca Madison, Director, Alaska eHealth Network
[(907) 729-3934 ramadison@anthc.org]

In his inaugural speech, President Obama pledged to "wield technology's wonders to raise health care's quality and lower its costs." The recently enacted American Recovery and Reinvestment Act of 2009 includes $12 billion to bring these wonders from the world of rhetoric to the world of reality, right here in Alaska. The good news is, we are "shovel ready!"

This funding aims to accelerate the adoption of Health Information Technology systems—like the one already in the works in Alaska—while creating high-tech jobs in the process. Timing couldn't be better for Alaskans to obtain some of this funding, but competition in the national arena will be intense. We must act quickly.

The fact is, we have already made exciting progress toward this goal. This month, the non-profit Alaska eHealth Network (AeHN) begins work with GCI to design the information infrastructure to interconnect electronic health records throughout Alaska. When complete, this Network will boost the safety, speed, and quality of our healthcare data while protecting privacy and reducing costs. Once in place, it will ***save Alaskans $250 million dollars annually,*** as much as 5% of our total healthcare costs!

What are electronic health records? Simply put, an electronic health record is a computerized record that replaces the paper record for patients like you and me. As any doctor will tell you, accurate patient information is the lifeblood of effective treatment.

When needed, electronic health records can access a health information exchange—the heart of the system--which connects them from your doctor's office to another office or hospital, making your vital records instantly available to cooperating healthcare providers you designate, wherever they are. Your lab results, allergies, medical history and other essential health data are at your healthcare providers' fingertips, with information about treatments, medications, and potential side effects, for quick, effective treatment.

This feature will especially benefit rural Alaskans, whose primary care may be in a village, but may require transfer to a larger healthcare facility in a larger community. In fact, any of us who travels and suffers illness or injury away from home will be much better off with an electronic health record system in place and available to us wherever we go.

A key advantage of the Network will be patient safety. Ask Ben Tisdale, a 71-year-old Alaskan who is now blind. While undergoing treatment for heart disease, Ben was mistakenly given a dangerous combination of medicines that destroyed his optic nerves.

Had interconnected electronic health records been in place, with their medicine alerts, Ben would still have his sight today.

Another advantage is less paperwork for everyone—no more filling out the same long forms each time you visit a health provider. Once it's done, it's done. Less paperwork means less cost and fewer delays for all of us.

To ensure privacy, your records will be stored in your medical provider's secure computer system. You can access your own files, but no one else can access them unless you give permission. If you do give approval, your records can be ***viewed by*** another healthcare provider. In addition, you can check at any time to see who has "viewed" your records.

Not interested in participating? No worries. Inclusion in the Network will be entirely voluntary. No one is required to participate.

Working with the partners represented by the Alaska eHealth Network, Alaska's Legislature and forward-thinking funders such as the Rasmuson Foundation deserve enormous thanks for the support they have provided to the strategic plan for interoperable electronic health records for all Alaskans.

But Alaska still needs $15 million dollars to finish this Network. The economic stimulus package will provide money to Alaska for this work, provided there is a qualifying state match of $1 dollar of State funds to $10 of federal funds. ***To receive federal funds, the State of Alaska must approve legislation that commits Alaska to building the infrastructure necessary for health information exchange.***

We strongly urge our legislators and Governor Palin to begin taking action today to ensure these health technology stimulus funds reach Alaska. For our health, and for our finances, it is the right thing to do, and the right time to do it. Let's get this shovel in the ground and get to work.

Doctors need to ditch the paper records and get on computers

Published: January 10, 2008 *Anchorage Daily News,* " Opinion"

It's shocking, when you think about it: While your bank, your employer and much of your life depend on computers to function, your doctor is most likely stuck in the dark ages of communication. "If we were the banking industry, we'd be dead in the water a long time ago," says Anchorage physician Tom Nighswander. "We are way, way behind."

The shelves and shelves of paper charts you see in many medical offices are evidence of that. Records that should be stored on a computer are taking up whole rooms and require staff to keep them sorted.

The lack of updated technology hurts the quality of care and contributes to high costs.

Say you get an EKG test at one Anchorage hospital, then a week later you show up at another hospital's emergency room with chest pains. The second hospital may not be able to get the results of the first EKG to see if there are changes to your heart, says Dr. Nighswander.

That's just unacceptable.

Two groups in Alaska are working to make electronic medical records the standard here.

The Alaska Native Tribal Health Consortium is managing, on behalf of the entire state, a $10.5 million, three-year grant. Funded by the Federal Communications Commission, the project will set up a high-speed, secure computer network for exchanging health information.

But there's a catch: The state must provide some matching money, and none of the FCC grant money can be used to manage the program.

Another group, the Alaska Electronic Health Record Alliance, is working to get individual doctors on electronic record systems, which could then connect to the medical information network. The technology would make doctors' offices work more efficiently and accurately.

The alliance is seeking grants to help health care providers switch over their record systems, says Dr. Jerome List, a doctor who has used electronic records for about 15 years.

It costs about $20,000 for small, two- to three-doctor offices to convert. That's too much for many small practices, Dr. List says, though electronic record-keeping is expected to reduce costs in the long run.

One big incentive for getting medical offices online is eliminating prescription errors.

Wrong prescriptions and wrong doses are a big problem. Handwriting is often the culprit. If a doctor types the prescription and faxes it to the pharmacy, many potential errors are eliminated.

A patient's record, if online, might show whether that patient had been pharmacy-hopping, getting more drugs than he should have. And computer programs exist that will not let a doctor make a mistake in dosing.

The Veterans Administration is ahead of the rest of the country in creating electronic patient records that can be called up wherever the vet is, national experts say.

AARP Alaska supports the Alaska e-medicine efforts because the changeover will allow patients to be more engaged in managing their health care. They'll get message reminders, and can maintain diaries of symptoms and side effects, schedule medical appointments online and track their own test results.

There are caveats. Whatever system evolves, patients must be able to control who has access to it. For example, a person who tested HIV-positive might not want his employer or insurer to know that.

But the concerns can be resolved.

This effort now needs a big push from the state. State health officials should get behind it and encourage the Legislature to contribute the necessary funding.

BOTTOM LINE: Here's a proven way to cut medical costs and improve the quality of care.

Personal Health Records — Take Greater Control of Your Health!

An important element of the Alaska e-Health Network is that each Alaskan can access your own health and medical history via a secure, Personal Health Record (PHR). You control permissions for what is shared and with whom and you will know who else has seen your record. The PHR combines medical information from your various providers, and makes it available in a readable format for you to review and monitor. You can use tools to chart your own health, compare test results over time and take greater control over your own health.

What Alaskans Can Do To Help

Let your physicians, employers, legislative representatives, and insurers know that you want electronic access to your medical records and that you support the Alaska e-Health Network, providing exchange of health information to improve healthcare quality and reduce costs in Alaska. A show of support from the public will fuel these needed changes to our outdated healthcare system and result in positive benefits for all Alaskans. Call or write the AeHN office today to get involved.

More Information

www.ak-ehealth.com

Founding Members

AARP Alaska
Alaska EHR Alliance
Alaska Federal Health Care Partnership
Alaska Native Tribal Health Consortium
Alaska Primary Care Association
Alaska State Hospital and Nursing Home Association
Alaska Veterans Administration Health Care System
Premera Blue Cross/Blue Shield of Alaska
State of Alaska Division of Health and Social Services

PMB 1143, 2440 E. Tudor Rd. | Anchorage, AK 99507
Phone: (907) 729-3934 | www.ak-ehealth.com

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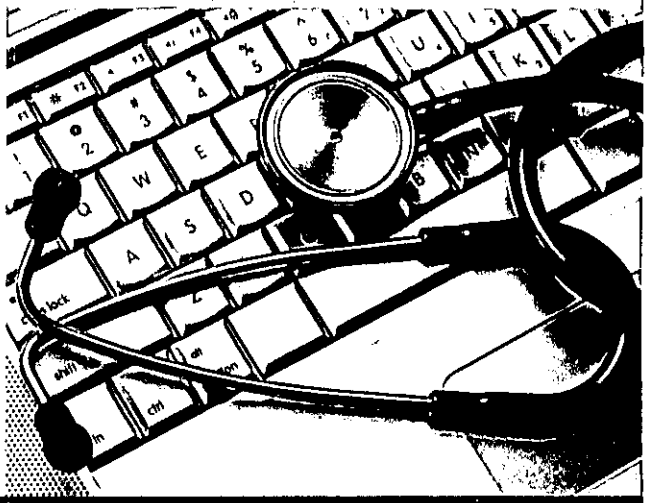
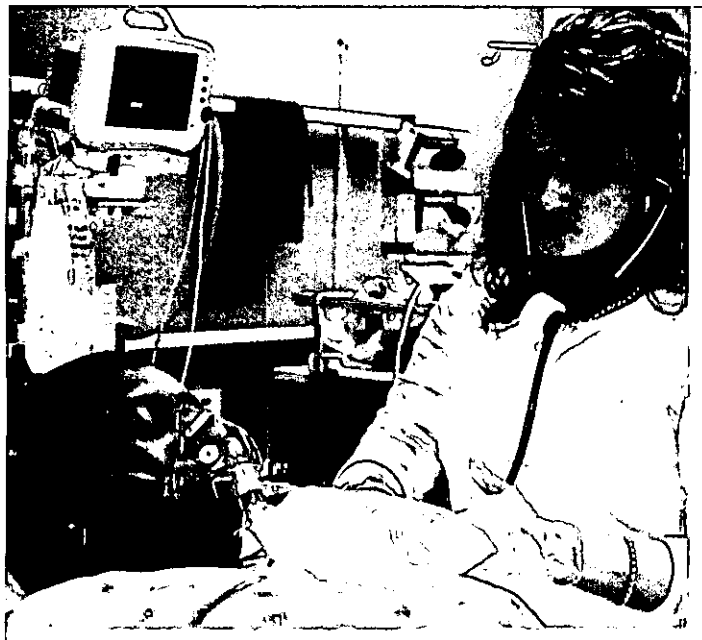
Online, that is!



How an Electronic Health Records Exchange Network will improve your health and Alaska's healthcare system.

SPEED • QUALITY • PRIVACY • SECURITY
SAFETY • EFFICIENCY



Imagine You're Sick

It's a weekend. You end up at the local emergency room. Because your medical records are electronic, your ER doctor accesses them quickly via a new, statewide, electronic health record exchange network.

When this scenario becomes real, and the Alaska eHealth Network provides an exchange for health information, here are just some of the benefits you can expect:

Improved Speed & Quality of Care: With an Electronic Health Record (EHR) that is securely connected to other EHRs, doctors are allowed immediate access to your essential medical information to treat you quickly. Drugs, lab results, allergies, medical history — all are included. Potential drug interactions are identified.

Improved Safety: Since critical information is available in real time at the point of care, the risk of a medical error is greatly decreased. And, since past test results are included, expensive duplicate testing is avoided.

Increased Efficiencies: Decreased paperwork and immediate access to records, labs and other test results increase the efficiencies for delivering health care services while lowering medical costs for all involved, including you, the patient. *National studies demonstrate a 5% reduction in health care expenses when electronic records exchange is available.*

Greater Convenience: No more need to repeat your medical and personal history, contact data, or insurance and billing information! You give it once; it's in your electronic record.

Privacy and Security Safeguards: Safeguards are required and provided to ensure your privacy and the secure exchange of your medical information. Your records are identified and confirmed through a careful criteria-matching process. Contrast that with the unwieldy paper records still in use in many facilities, with outdated and error-prone faxed exchange of information.

Electronic Health Record Exchange: Alaska's Plan

What's at Stake

"I am a victim of not having electronic health records. I am legally blind because they put me on medication for my heart and four months later, the medicine killed the optic nerve in my eye. They made a mistake by giving me a medication that interacted with one of my existing medications. Had EHRs, with their medicine alerts, been available, I would have my sight today. I hope Alaska will adopt interoperable electronic health records soon, so this won't happen to anyone else."

– Alaskan Ben Tisdale, 71 years old

Ben's wish will become real in the near future! The electronic exchange of health information is becoming reality in many parts of the U.S., Alaska included. Many Alaska hospitals, labs and some clinics are utilizing their own Electronic Health Records, while many other systems are under development. Alaska has a plan to exchange health information electronically to increase quality and decrease costs.

The Alaska eHealth Network (AeHN) has received partial funding to develop a statewide, electronic health network to safely and securely exchange health information between authorized healthcare providers and patients. Collaborative efforts are also underway to help providers adopt EHRs. If network development funding becomes available as planned, electronic health information exchange will be available to all Alaskans by 2011.

AeHN Alaska eHealth Network℠
Secure Access to Your Health Record

FACT SHEET

Overview

The Alaska eHealth Network (AeHN) is a carefully planned solution to our national health care problem of high spending and low returns on healthcare. AeHN was established as a 501(c)(3) in 2008 to create a statewide, standards- based electronic health network which 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.

Mission

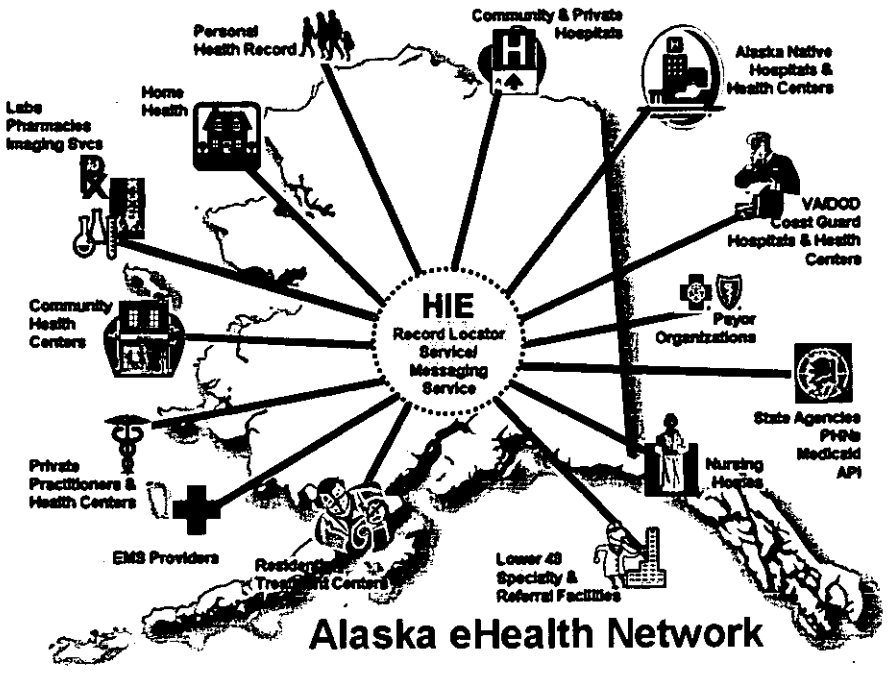
To improve the safety, cost effectiveness, and quality of healthcare in Alaska through the promotion and facilitation of widespread implementation and use of secure and confidential electronic clinical information systems, including electronic health records and clinical data exchange capabilities.

Partners

The Alaska e-Health Network to date has been a collaborative partnership effort of the Alaska Federal Health Care Partnership (including the Veterans Administration, the Department of Defense, the Indian Health Service, and the U.S. Coast Guard), the Alaska Primary Care Association, the Alaska Native Tribal Health Consortium, the Alaska State Hospital and Nursing Homes Association, the Alaska Mental Health Trust Authority, Premera Blue Cross/Blue Shield, the University of Alaska, AARP Alaska, the State Department of Health and Social Services, and the Alaska EHR Alliance (private physicians).

Services

When complete, the Alaska e-Health Network 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.



Sustainability

AeHN partners are determined to ensure the long-term viability and success of the network when completed. Several models have been considered, including provider/user fees and payor contributions. Networks with the highest degree of success have secured long-term support from their state governments (e.g. Arizona, California, New York, Delaware). The annual operating cost of the Alaska e-Health Network, when fully deployed and used by the majority of state residents, is estimated at $6 million, or approximately $10 per year per resident.

Alaska's Need for Coordinated Health Information Exchange

Alaska health providers are going electronic: Many Alaskan health care agencies and providers have begun the expensive and gradual transformation of their medical record systems from paper to electronic (commonly referred to as Electronic Health Records or EHRs). Alaska medical providers are expected to invest well over $100 million in these systems over the next five years. But EHRs alone do not solve the health care problem. It takes all the EHRs sharing data through a statewide network to create change in health care.

Alaska health providers need a private, secure 'network of networks": The parallel development of a private statewide Alaska e-Health Network will unify and secure these separate electronic health record networks, connecting health providers and consumers to critical medical information for timely and quality patient care. Such Health Information Exchange (HIE) networks are being developed in many lower 48 states and regions with support from the U.S. Department of Health and Human Services and the Federal Communications Commission.

Where they have been developed successfully, the benefits of HIE networks include;

- improved patient access to medical care,
- reduction in duplicate and unnecessary testing and procedures,
- improved patient safety,
- reduced health agency administrative costs,
- greater patient and provider satisfaction, and
- enhanced rapid response to public health emergencies.

National studies demonstrate annual cost savings from the use of Electronic Health Records and HIE networks at approximately 5% of health care expenditures; this equates to an annual savings of $250 million based on Alaska's $5 billion health care expenditures, or an annual savings of $10-14 million based on the State of Alaska's $250 million Medicaid program.

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AeHN Alaska eHealth Network™

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EXCHANGE

— NEWS OF ELECTRONIC HEALTH TECHNOLOGY FROM ALASKA AND BEYOND —

Alaska eHealth Network

Welcome to the Exchange.

This is our first newsletter dedicated to health information exchange and the advancement of electronic health records in Alaska. We are excited to be bringing you information on the Alaska eHealth Network and other eHealth projects throughout Alaska. The Alaska eHealth Network (AeHN) is a non-profit membership organization formed to advance solutions for health information exchange across disparate health systems throughout the State. Our mission is to improve the safety, cost effectiveness, and quality of healthcare in Alaska through the promotion and facilitation of widespread implementation and use of secure and confidential electronic clinical information systems.

The Board of Directors for AeHN understands that the true value of EHRs comes from connecting them together to share health care data among all providers. The Board's vision is to promote widespread access to a statewide health information exchange system that improves quality, safety, outcomes and efficiency in healthcare by making vital data available to patients, providers and payers when and where they need it.

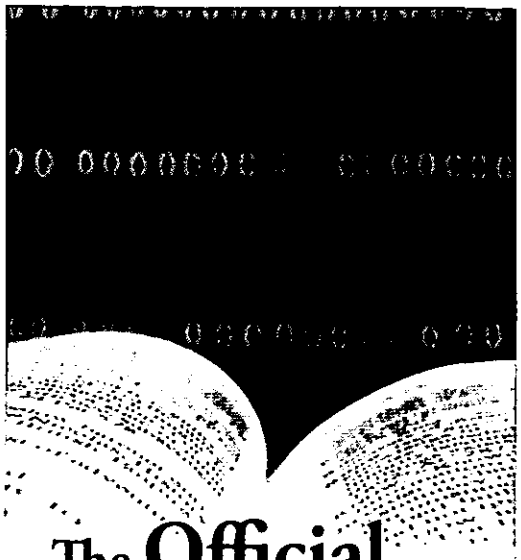
Sustainability is key to the success of this project. The Board is currently developing a sustainability plan to support health information exchange (HIE) well into the next century. It is crucial that the State of Alaska take an active role in HIE. Efforts are underway to engage legislators, consumers and providers in discussions to ensure that adequate funds are made available.

We plan to send out this newsletter quarterly. One of the regular features will include stories about eHealth projects around our State. We encourage you to share your success stories and look forward to hearing from you so that our newsletter, the Exchange, lives up to its name.

Sincerely,

Paul Sherry

Paul Sherry, Interim President,
Board of Directors



The Official Definition of EHR, HIE & PHR! Really!

The National Alliance for Health Information Technology has issued the final word(s) on what these letters really mean!

HIE: The electronic movement of health-related information among organizations according to nationally recognized standards.

EHR: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

PHR: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

So, now you know!

Alaska eHealth Projects

Health Information Security and Privacy Collaboration (HISPC)

Alaska has received $300,000 to participate in the development of model language for inter-organization and participation agreements for use when exchanging health information across multiple agencies and providers. Over 200 providers and consumers from around Alaska participated in discussions to identify security and privacy issues related to data sharing. Input from the statewide meetings has been instrumental in informing nationwide policy efforts.

To receive copies of these agreements and sample policies contact Rebecca Madison at (907) 729-3924 or rebeccam@akrivertracks.com.

New EHR Survey of Alaska Providers planned for December

A new, statewide survey of Alaska's healthcare providers will seek to determine current usage of EHRs, and interest by non-users in their adoption," announced Jerome List, M.D., President of the Board of Directors for the non-profit Alaska EHR Alliance. Formed in 2005, to assist Alaska's non-public sector providers in the adoption of EHRs, the Alliance is made up of physicians, medical organizations, insurers and consumers. "The information gathered from the survey is critical to our plan to select and recommend 1-3 EHR vendors for Alaska's providers," Dr. List said. Information from the survey will be used to help guide the EHR selection process, and to identify interested providers to invite to participate in its oversight and in a future pilot program.

In addition to selecting the recommended EHRs, they plan to seek funding to help lower the initial costs of adoption and help with the necessary employee training and office redesign. The Alliance supports the development of a statewide network by AeHN to assure EHRs can be exchanged and accessed quickly and safely by authorized providers. For more information, contact Linda Boochever at (907) 337-6218, or lbooch@gci.net.

U.S. eHealth News

President-Elect Obama Strongly Supports Health IT

When President-Elect Obama takes office in January, he will have three major priorities: the economy, the war, and healthcare reform. In campaign speeches, Obama has stressed the importance of a federal investment in "electronic health information technologies" to reduce errors and "save lives and money." His plan calls for $50 billion over five years to promote adoption of secure, interoperable electronic health records. Obama's plan or a similar version is likely to move forward in Congress in 2009 due to broad bipartisan support.

2009 ePrescribing CMS Incentive Program

In January 2009, CMS is implementing an e-prescribing incentive program for physicians, which will increase Medicare payment by 2% for those who use e-prescribing technology. CMS envisions that this initiative will encourage providers to invest in technology.

Featured eHealth Solution

EMR Metamorphosis in Juneau Clinic

By Richard Welling, MD

Ever wonder what a caterpillar might feel like if it went through all the effort to wrap itself in a cocoon and after waiting the prescribed period as indicated by the manufacturer — spread its wings, only to find it was a moth? Sure, it can fly, and the view is all right, but the problem is in the expectation. The transition to an electronic medical record (EMR) can be a little like that... here's my brief take on our clinic's recent "metamorphosis."

In 2005, our 7-partner family practice clinic decided that it was time to make the quantum leap to an EMR. We spent the next several months reading articles, calling practitioners who had made the change, and eventually hired a consultant to guide us through the process. But in the end, no matter how much homework you do, the good, the bad, and the ugly of an EMR is hard to appreciate until you spread your wings and buy — or rather, fly.

The Good. Much of what an EMR vendor says will be true. Your laptop computer is lighter than your heaviest chart, and with it, you can open everyone else's chart. When a patient needs a referral, you can print out a summary and fax it to the waiting specialist. Hardware is getting better. Your transcription bill will fall substantially, prescriptions are sent to the pharmacy without being printed out and are always legible. Allergy alerts will make you feel smart. Your computer isn't prone to under billing and can improve revenue with better coding, supported by your documentation. If your system interfaces with labs or hospitals out of town, electronic faxes can limit your paper costs by placing results directly in your EMR "in box." Lab results and patient vitals can be easily graphed over time for educational purposes. When you don't know the answer, your favorite Internet reference site is only a few clicks away. Clearly being a moth has some advantages over a caterpillar.

The Bad. Time. Our experience has been that with an EMR we are spending twice the time making half the note. Retrieving labs and x-rays generally take longer than turning a tab in a paper chart. Some of this can improve by using computers with faster processors, like desktops instead of laptops. Without an interface, lab work and hospital paper work will not necessarily arrive electronically, requiring conversion from fax to paper, and then scanning back to digital.

The Ugly. Money. Let's be honest, being a caterpillar had its moments. Pen and paper is relatively cheap in comparison to a tablet PC. And then there are proprietary software costs that vary wildly without obvious justification. In the first year with an EMR, our clinic's net revenue decreased substantially. In addition, our practice had to hire a full time technical staff member to manage our routine problems, and still flies in the occasional specialist when things get really, well, ugly. Expect at least two years to pass before breaking even on your system.

In the end, we are flying. And going back to crawling as a caterpillar isn't really an option; but, it would have been nice not to have been expecting a butterfly.

Consumer Point of View

For This Alaskan, Adopting EHRs is Personal

Alaskan retired businessman, Ben Tisdale, has a personal interest in EHRs. He is legally blind due to a medication error that could have been avoided had his physicians used electronic health records. EHRs have a medication alert system built into the software that will notify physicians of contraindications of medications when they prescribe them. "An error was made giving me a medication that interacted with one of my existing medications. Had EHRs, with their medicine alerts, been available, I would have my sight today. I hope Alaska will adopt electronic health records soon, so this won't happen to anyone else," Ben said. Ben feels so strongly about the importance of EHRs that he serves as a board member for the Alaska EHR Alliance.

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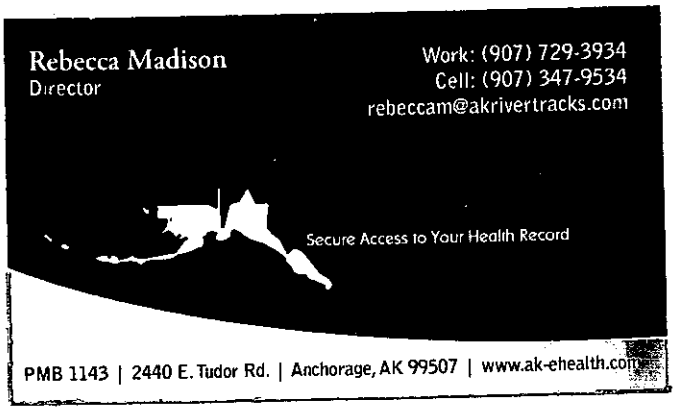
This is your space.

Please let us know about your health IT efforts, advice, opinions, or what you'd like to see in the newsletter. We hope it will become a forum for the exchange of ideas and news, thus the name- the Exchange! To participate, just go to the AeHN website: **www.ak-ehealth.com.**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