2009 SENATE HUMAN SERVICES

SB 2332

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 01/27/2009

Recorder Job Number: 7844

Committee Clerk Signature Mary K Monson

Minutes:

Senator Erbele opened the hearing on SB 2332 relating to creation of a health information technology office and advisory committee.

Senator Lee District 13, introduced SB 23342. North Dakota is behind in the implementation of Health Information Technology but there is a task force that has been working on gathering information on how ND can proceed. This bill will help move forward the health information technology in ND.

Representative Kaldor District 20, Spoke in support of 2332.Health Information Technology (HIT) is a huge issue for rural hospitals and all hospitals. The interoperability of medical records is critical to proper health care. I would ask that the committee give this bill favorable consideration.

Kimber Wraalstad President/CEO of Presentation Medical Center in Rolla and member of ND HIT Steering Committee. Spoke in support of 2332. See attachment #1.

Craig Hewitt Senior Vice President and Chief Information Officer with Merit Care Health Systems and member of HIT Steering Committee. Spoke in support of 2332. In order to move this forward, we need to have a focus on it. A lot of work has been done over the last several years, especially by volunteers, but for us to really move forward we need to have better

planning and momentum. We really believe that this office residing in HS is vital to making this happen. We want to eliminate some of the competition and provide unified leadership. We feel it is important to have an officer representing all of our interests. We also believe it is important as we move into the digital age that we have a plan for sharing information. Whether we like it or not, technology is here. HIT is a pretty hot topic across the US. ND has had one bill relating to this which created the steering committee, but we need to move forward as other states have. It is also important relative to what is going on with the economic recovery act. With the ERA, there is some money available if we are able to show that we are moving forward to receive matching grants.

Senator Lee I have always thought the bigger the board the less that gets done. Maybe that isn't true here but we have a lot of representation on this committee. I certainly want all areas represented but do you see some cumbersome places?

Hewitt Other states have shown that it is beneficial to include everyone.

Discussion on how to structure advisory board

Hewitt Passed out a hand out on the proposed appropriation request and walked the committee through the information. See attachment #2.

Senator Marcellais I am all for technology, I was wondering if you collaborated with the federal organizations such as the Veterans Administration. I would recommend that they be on the steering committee so that we could be compatible.

Hewitt Absolutely, and that was part of the reason for having all these people at the table.

Senator Lee Especially with all the technology happening in the systems like the VA, it would be important.

Senator Marcellais The VA is looking into putting all the medical records onto their ID cards.

Brief discussion

Dan Ulmer Blue Cross Blue Shield. Spoke in support of 2332. Discussed the history of health care technology legislation. Also discussed quality, efficiency, and sustainability of health care. They see HIT as a huge step forward. In regards to the question about what congress is doing, I have an e-mail. Please see attachment #3.

Senator Dever Is there a way to put a structure in place that we can build on later if we do not have the funding right now?

Ulmer That is one of the problems in terms of timing. I would be surprised if Congress acted before you adjourned. I don't have the answer.

Senator Dever We have heard about a lot of good programs; it may just become a matter of prioritization.

Bruce Levi Representing the ND Medical Association. Spoke in support of 2332. See attachment #4.

June Herman Senior Director of Government Relations for the American Heart Association. Spoke in support of 2332. See attachment #5.

There was no opposition testimony given.

Michael Mullen Was not planning to testify but was asked by Senator Lee to stand for questions regarding privacy issues. Neutral. Commented on the fact that there is so much info to keep up with. One of the things holding up this process is concerns about liability. Keeping up with all the rules and compliance issues is overwhelming, we need the structure of a committee so that the information is disseminated. We need a central mechanism to keep people on the same playing field as other states.

Senator Lee Privacy is not perfect with paper charts either. What we have now is not the ideal either.

Michael Mullen Many people feel that with properly structured electronic records there will be better levels of privacy. Gave examples of how records can be structured.

Senator Lee Closed the hearing on SB 2332.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 02/04/2009

Recorder Job Number: 8698

Committee Clerk Signature Mary K Monson

Minutes:

Senator Lee Opened the discussion on SB 2332.

There was a discussion about whether or not to have an amendment to include VA and Indian Health Services. Decided against it as the bill already includes those organizations. Discussed the budget numbers. There were no language changes or amendments.

Senator Heckaman I move **Do Pass and Rerefer to Appropriations.**

Senator Marcellais Second.

The Clerk called the role on the motion to **Do Pass and Rerefer to Appropriations. Yes: 6, No: 0, Absent: 0.**

Senator Marcellais will carry.

Date: 2-4-09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2332

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Heckaman Seconded By Sen. Marcellais

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Marcellais

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2332: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2332 was rereferred to the **Appropriations Committee**.

2009 SENATE APPROPRIATIONS

SB 2332

This was never presented to the governor.

Senator Mathern I recommend we pass this, seconded by Senator Fischer

Senator Kilzer asked if we needed any amendments.

Senator Mathern said we should ask legislative council to draft an amendment for the FTE to come out of the Insurance Tax Distribution Fund.

Senator Kilzer said we will take this up with the full committee because they will want to be in on the discussion of where the money will come from.

4237 heard on 2-3-09 deals with the health care records industry. Secretary of State would like to do this with new software that is available now at the Secretary of State office. That could cost up to $100,000. 57.50 Subcommittee recommended we pass this. Mathern moved and Fischer seconded.

2302 relating to extended payments was a moved Do Not Pass.

2332 63.19 this bill is not done yet and scheduled for hearing on Friday.

2333 The Department of Health and the public health units worked out a deal to promote functions being done on a regional basis. Motion moved by Senator Mathern do pass and seconded by Senator Kilzer. Sub Committee approves of SB 2333.

Senator Mathern is that money that was anticipated there for immunizations in the budget.

Arvy we don't need funding in our budget because health insurance would pay.

Vote was taken do pass 3-0-0

2342 Sub committee recommends a Do pass on SB 2342 with amendment to be attached.

2356 this is a direct appropriation on the bill. Discussed bill.

Senator Mathern asked if there was a companion bill that would supply equipment.

Senator .... Said he thinks we have a bill loan payback.

Should the state be involved in this?

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 13, 2009

Recorder Job Number: 9453

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg: called the committee hearing to order on SB 2332 relating to the creation of a health information technology office and advisory committee.

Electronic Medical Records (EMR)

Kimber Wraalstad, President/CEO, Presentation Medical Center, Rolla, ND and member of ND Health Information Technology Steering Committee, testified in favor of SB 2332.

(Written attached testimony # 1)

Explained the benefits of health information technology, and Joint Data Center in Rugby. Costs $5.5 M for total package. Need health information exchange and if they don't have technology, they don't have exchange. Impact patient care, why not just buy it. Our average operating loss was a minus 3.4%. The grants are important and they need help getting matching dollars.

Senator Judy Lee: District 13, Fargo, testified in support of SB 2332. The policy committee strongly endorses this bill. We need technology that if we don't get up to speed in rural areas. We are going to lose those areas because they will go to the larger communities. There is a local match in all this.

Senator Christmann: Did someone try this bill last time and not enough vote?

Senator Judy Lee: We enabled them to go forward, but there was no money attached. There have been hundreds of hours put into this and it's time to step up to plate.

V. Chair Bowman: 10 communities on list. The other not on list, have they already implemented technology. We can communicate now. What do we have to do in our rural community to be a part of this if we are missing out?

Senator Judy Lee: Our goal is for those who don't have equipment to have it. There is steep curve on this and we want everybody to be a part. Our focus is very much on rural area's.

Darrell Vanyo: Chief Information Officer at BC/BS; Co-chair, Health Information Exchange (HIE), testified in favor of SB 2332. (Written attached testimony # 2)

Senator Warner: Could you speak about interface between your IT system and the state's system?

Darrell Vanyo: The communication backbone? In comparison with the state and BC/BS, I'd rather have BlueCross/BlueShield. When you tie into the state's system, I don't know what they tie into. Of a particular health care system, the last couple years, the exchange of information to other healthcare system, people did not want their information going out elsewhere. People are realizing the need.

V. Chair Bowman: You have stated that hospitals can't afford technology. If they can't the technology, how are they going to keep up after they get it? Is it going to be state-funded? Are you coming back in two years because you will need more? What is your vision for after implementation on how to sustain it?

Darrell Vanyo: What you are referring to is sustainability and what have other states done. As I stated earlier, incentives from payers such as Medicare and Medicaid are intended to be incentives for people to on-board with this. The sustainability has to come from people who

reimburse. To make this sustainable in the future, there would have to be continued dollars. This is really dollars for a kick start so we can insure we receive the federal dollars.

Senator Robinson: This is coming and is long overdue. The new physicians demand that this is a must before they will come to take job at your place. There is a price-tag for having it; however, there is also price tag for not having it.

V. Chair Grindberg: Does establishing 501 C 3 have any backing or interest as far as sustainability?

Lynette Dickson: Program Director, Center for Rural Health, UND, testified in favor of SB 2332. (Written attached testimony # 3)

Chairman Holmberg closed the hearing on SB 2332.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2332

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 02-17-09

Recorder Job Number: 9630

Committee Clerk Signature Alice Delzer

Minutes:

Chairman Holmberg opened the hearing on SB 2332 relating to the creation of a health information technology office and advisory committee. (Electronic Medical Records (EMR) (28.49)

Discussion followed regarding the funds in this bill.

Senator Krebsbach moved to pass the amendment to reduce the appropriation on SB 2332. And it was seconded by Senator Krauter. All in favor of the amendment say aye. It carried.

Senator Krebsbach moved Do Pass as Amended. Seconded by Senator Krauter.

Discussion followed. (30.56)

A ROLL CALL VOTE WAS TAKEIN ON A DO PASS AS AMENDED. 17 YEAS, 0 NAYS, 0 ABSENT. SENATOR KRAUTER WILL CARRY THE BILL.

Chairman Holmberg closed the hearing on SB 2332.

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Title. 0200

Prepared by the Legislative Council staff for
Senate Appropriations
February 17, 2009

PROPOSED AMENDMENTS TO SENATE BILL NO. 2332

Page 3, line 2, replace "$5,923,572" with "$500,000"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment reduces the appropriation from the general fund for the costs of the health information technology office in the State Department of Health from $5,923,572 ~~and~~ to $500,000.

Date: 2/17

Roll Call Vote # 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

Senate **Senate Appropriations** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number on Amendment

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Krebsbach Seconded By K Wardner

Senators	Yes	No	Senators	Yes	No
Sen. Ray Holmberg, Ch			Sen. Tim Mathern		
Sen. Tony S. Grindberg, VCh			Sen. Aaron Krauter		
Sen. Bill Bowman, VCh			Sen. Larry J. Robinson		
Sen. Randel Christmann			Sen. John Warner		
Sen. Rich Wardner			Sen. Elroy N. Lindaas		
Sen. Ralph L. Kilzer			Sen. Tom Seymour		
Sen. Tom Fischer					
Sen. Karen K. Krebsbach					

Total Yes yes all No

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2/17/09
Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

Senate _____ Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number new Amendment

Action Taken ☑ Do Pass ☐ Do Not Pass ☑ Amended

Motion Made By Krebs Seconded By Krauter

Representatives	Yes	No	Representatives	Yes	No
Senator Fischer	✓		Senator Warner	✓	
Senator Christmann	✓		Senator Robinson	✓	
Senator Krebsbach	✓		Senator Krauter	✓	
Senator Bowman	✓		Senator Lindaas	✓	
Senator Kilzer	✓		Senator Mathern	✓	
Senator Grindberg	✓		Senator Seymour	✓	
Senator Wardner	✓				
Chairman Holmberg	✓				

Total Yes 14 No 0

Absent 0

Floor Assignment ~~Holmberg~~ Krauter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2332: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2332 was placed on the Sixth order on the calendar.

Page 3, line 2, replace "$5,923,572" with "$500,000"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment reduces the appropriation from the general fund for the costs of the health information technology office in the State Department of Health from $5,923,572 to $500,000.

2009 HOUSE HUMAN SERVICES

SB 2332

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2332

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 16, 2009

Recorder Job Number: 10963

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz opened the hearing on SB 2332. Senator Lee is in three other committees right now testifying so had planned on to introduce the bill. She will try and get here whenever she can. Senator Robinson will carry the show this morning.

Sen. Larry Robinson from district 24: The bill before you addresses the health information technology which is one of the more important issues that we will deal with this session and subsequent sessions. This is a big and important issue and if you dig into it at all you will quickly find just how important it is. There is new language in the bill and there is also an appropriation. It is safe to assume at this point and time we feel it is important to keep this bill alive, we need the program, but we on our side and your side as well have been focusing in on the stimulus money and there is significant money there to fund this particular program. Health information technology is nothing totally new. We created a working group to monitor this effort a couple of years back. I attended one of their conferences a number of months ago and it is a very interesting and intriguing issue when you think about the ramification of having health information technology services and a program in place. At the conference last fall at the Raddison I listened to a physician who was recruited by one of the local medical facilities from Wisconsin. One of the reasons this individual elected to return to ND was the presence of this

effort in a medical facility here in Bismarck. When physicians would go to an outreach clinic, they would literally box up patient's files and carry them to the clinic. If the patient had been involved in an accident and transported here during the transport of their medical file to the outreach clinic, the file wouldn't be accessible. We have a large number of people who move south for the winter. If you are in Arizona and you walk into a clinic or you need a prescription refill, it would be wonderful if your medical records would be available on that screen. They aren't at the present time. There is a cost to health information technology, but there is a greater cost by not going down this road. Senator Conrad visited a lady in central ND that had 18-24 different prescriptions from multiple clinic and pharmacies and had no idea if they worked together or if they worked in opposition. We could prevent that from happening with health information technology. We need this bill and look at stimulus package to fund this bill.

Chairman Weisz: Being on the Appropriations you hear about stimulus money. There is a fair amount of money having to do with HIT in the stimulus package. From what you know of will some of the medical facilities that have invested a tremendous amount of money in this area be able to qualify for some of this money? Some concerns expressed to me because we are out front of the horse are we going to be penalized.

Sen. Robinson: That is a good question and I don't know. There are some people from the medical communities here who can speak to that. As I understand HIT, even those communities might be the large communities that have invested in this technology, they to stand to benefit to the extent that the entire region can become participants in the program.

Sen. Judy Lee from district 13 sponsored bill: ND is lagging a bit from other states on health information technology. We need to help rural area medical providers on electronic technology. My goal is my medical records are accessible in other states if I had an accident someplace other than ND. We need to make sure the big cities are linked with the small ones.

Dean Haas representing the ND Medical Association: See Testimony #1.

Rep. Conrad: Was this presented to the Governor and put into the budget?

Dean Haas: I know that it was, but I don't know what the amount was. (Someone answers from audience that it was not put into the budget.)

Rep. Potter: You talk about on page 2, that SB 2332 would re-establish the committee. Who are the committee members same as was with prior committee?

Dean Haas: I don't know the answer to that either, sorry.

Rep. Porter: On page 2, line 25 (reads from the bill). How does this mechanism work for the benefit of the health information technology office?

Dean Hass: I don't know the answer to your question either.

Rep. Potter: Section 2 repeals are particular law, Section 23-01-31. Do you have any idea of what it repeals?

Dean Haas: That section (inaudible) Health information technology committee. It re-establishes that committee.

Rep. Potter: The bill re-establishes it and the repeal undoes (inaudible).

Dean Haas: That's right.

Nancy Willis, works at St. Alexius Medical Center on HIT steering committee: See handout #2. Last legislative session the HIT steering committee was established, but only until this next session. We would like to change our name to advisory committee. We would like to see this bill go back to appropriations and have the appropriation go back to what we had originally requested which was $5.9 million I've passed out a handout about HIT and the steering committee and what we have been working on. (Explained some of the handout.) A concern we have is there is a certification that the government has talked about for electronic talk record and again even at this point and time across the country most

organizations either have already that certification or are in the process of getting that certification are large academic medical centers. The stimulus package, bulk of dollars are given to two federal agencies such as HERSA and HARQ and those dollars will then be available for competitive grants to organizations who are looking towards HIT. The concern we have with those competitive grants in ND is that when we look at some of the language on criteria for those grants, a lot of them are talking about either that the ones given priority are either certified or in the process of being certified. We are a long away from that. We are thinking ND won't be eligible for a lot of those grants and if so won't be a lot of dollars. The second portion of those dollars are being available directly to providers, but again there is significant criteria attached to those dollars. The way the language is written in the stimulus package is the dollars will be provided to these providers based on their quality performance. You can only apply up to a certain percentage based on the bench mark criteria and the business you are providing to those particular beneficiaries. The first group of funds and the purpose of requesting these grant dollars is that our hope would be with enough grant dollars you would be able to take some of the facilities that currently have nothing, some clinics still use appointment books, and we cannot communicate with them electronically if they have nothing in place. We looked at implementation grants which would allow those facilities to actually have some dollars to bring somebody in and access what their needs are for those who haven't even started this process. The second group of funds we asked for were dollars that would actually (coughing making inaudible) could move forward and implement some of those things. On the telemedicine side that primarily we were looking at for the transfer of radiology images or x-rays. Some facilities have what is called PAS (picture archival systems) where you can transmit images where a lot of them don't have the capability for that. We thought through all of these different portions of grants that were requested. In answer to your

question about the 501c3; the reason we ask for that is we know the state can currently accept grant dollars, but there was a thought that there might be individuals who would want to donate money towards HIT and we wanted a vehicle where that could happen as well.

Chairman Weisz: Could you state actually the 501c?

Nancy Willis: I don't know what kind of legal ramifications there is setting that up. The discussion was that it would be a private/public entity that could accept federal and private dollars donated to that organization. Some other states have that set up and can accept dollars.

Rep. Conrad: Did you say three facilities per grant?

Nancy Willis: Correct. In order to exchange information you need more than one entity. We wanted to apply as a group keeping in mind who they would be connecting to.

Rep. Conrad: Then the facilities could be involved in several projects.

Nancy Willis: Correct.

Rep. Conrad: Then twenty grants should have about sixty facilities?

Nancy Willis: Yes.

Rep. Frantsvog: Are the national standards in place as your medical facility goes through the kind of processing so at some point and time you can tie into this program nationally?

Nancy Willis: There are national standards that are recommended, but are not required. Most of the facilities follow the national standards to ensure that people can be connected. We would like to see if this office is established is that the HIT officer would create some standards for the state of ND.

Rep. Frantsvog: I'm assuming that when you are making reference to national standards that we aren't going to have competing standards so somebody here has a list on standards and

someone over here competes for somebody's business and all of a sudden one can't access the other. Are we going to be certain as we proceed with this that is not going to happen?

Nancy Willis: That is what we are hoping this office can do.

Rep. Holman: What is priority of what is most important of person's 50-60 year history?

Nancy Willis: Making sure x-rays and labs are available and whatever the last information on your file is.

Rep. Nathe: As far as physicians on your electronic portion of this, what has been there take on all this stuff?

Nancy Willis: It is a difficult challenge. It is not because they don't want to move into the electronic age, physicians want to take care of their patients and all of these things being required of them, sometimes they feel it gets in the way of taking care of their patients. We have started with those physicians who are more technologically adept. Physicians who are more technology oriented are early users of these systems. We are seeing younger physicians coming in our systems. All of the residency programs are now on it.

Rep. Nathe: When will all the physicians have to be up to speed?

Nancy Willis: By 2012.

Chairman Weisz: Under the present bill what will you do with the $500,000?

Nancy Willis: That amount just funds the HIT officer and leaves little money for any other activities from the grant standpoint.

Rep. Conrad: You don't sound hopeful about the stimulus package.

Nancy Willis: Not right away. Many other states a lot farther along than ND. Many of the dollars to the state they want it used for the MMIS system and to make sure claims are done timely so a lot of those dollars are looking at that. The other dollars are looking at meeting with the quality criteria. ND is far ahead of the nation in giving quality care so far us we probably

can apply for some of those dollars that are coming down through Medicaid and Medicare beneficiaries. A lot of those are being asked to be used claims processing and those types of things.

Rep. Potter: With the $500,000 and a do pass on the engrossed bill, then I look at your numbers for all these different things, it looks like $500,000 isn't going to go very far. Maybe they were thinking of stimulus dollars and that's why they took out money.

Nancy Willis: I think that is the case. The legislature is looking at a lot of these stimulus dollars in the stimulus package. The strings that are tied to those won't let us do some of the things we need to do.

Rep. Potter: If we consider bumping up the $500,000 from what the Senate did, but didn't get up to the nearly $6 million it started out at. Would you have any recommendation as to if you weren't going to do your $6 million, what we might want to consider?

Nancy Willis: I would be happy to come back to you with a number. I need to visit with the steering committee first.

Dan Ulmer from BC/BS: Need to take you back to 1996 on this bill. When congress passed it, it was the (inaudible) bill. Congress was just recovering from Clinton care and President Clinton thought it was a good idea if you were able to take your insurance from job to job you would make your insurance portable. That was the beginning of the Kennedy/Cassibond (?) bill and the back of the bill there was a discussion in a very small paragraph on two issues. One was confidentiality and at that time BC/BS was only doing business in 12 states and we thought it was good to have one confidentiality law rather than 50. At the same time there was a question asked as to how we measure quality? The answer was each of us had our own data dialects as insurers and we couldn't talk to each other. So, the move forward with something called HIPPA which basically said all of us needed to standardize codes and data

sets and that was in 1996. We are now in 2009, we are not done with HIPPA yet. The HIPPA is on a platform called 4010 which is far beyond me. We have now standardized codes and sets, but they have decided the platform it is on is not large enough so we have to move to platform 5010 and have a year left to do that, I think 2011 is when that has to happen. At the same time they want to move forward with from ICD-9 which has something like 8,000 potential codes for hospitals to ICD-10 which has over a 100,000 codes possible. The hospitals really want to do this because they can (inaudible) bill us better. The other detail is what was explained here, one of the problems if you look at the system from a larger level, 30% of the care in America is unnecessary and redundant. $7 billion dollars a year that we are not sure why we are doing it. One reason why it is wasted is because how we transfer records and move between doctors. You have a 50% chance of getting the right care and the right time. That is part of what is behind this kind of thinking in terms of moving forward with HIT. I'm sure that when this was heard in the Senate they thought a good chunk of the stimulus money was coming forward to do what this bill was proposing to do. Obviously there are a lot of strings attached to it.. We have been pushing on a national level is called Comparative Effectiveness Research. The question is what works and how do we find out what works? Unless we can get a hold of the data we don't really know. If you are going to move forward with reform you need to get your arms around what works. The problem with the healthcare system today is cost. Unless you lay the foundations for reform, it is not going to work. We support this bill strongly and hope you will restore the original appropriation. Know you have an uphill fight to do so. Nancy and the committee have done a really good job of telling you where the needs are and they did this for free.

Rep. Conrad: It sounds like we are behind and that is part of the reason we need $6 million.

Dan Ulmer: Yes. A friend of my son's as well as my manager in the district office who recently returned to ND to practice medicine. A surgeon who spent his residency in Kalamazoo, Michigan and he said he couldn't believe how far behind we are. He has it all on templates. When a does a particular surgery, he pops up the surgery and it comes out, be sure you do this, this, and this. He said, I can't possibly keep this in my head, I don't know how people do this on paper anymore.

Rep. Conrad: If we had done this two years ago, would we be ready for the stimulus dollars that we are not able to apply for?

Dan Ulmer: I think we would be in better shape than we are right now.

Chairman Weisz: Based on your testimony, there is a lot at stake here (inaudible) Blue Cross, etc. Why hasn't your organization put up dollars into this?

Dan Ulmer: We give out money for grants for the past 5-8 years. $350,000-500,000 a year for grants and we helped put together a program at UND where they used dummies to simulators and stuff.

Rep. Frantsvog: In information handed out to us this morning, it had who has electronic medical records, 6 urban hospitals etc. How were these funded other than probably grants that you were giving? Are any doing it on their own?

Dan Ulmer: Most of the bigger facilities have done it on their own based on whatever they can pull out of their operating accounts etc. Many of the rural areas relied on outside grants.

Mike Mullen, assistant attorney general: Testified in support One of the things that happens when private healthcare facilities or government agencies select a plan or exchanging records you get going and you are not very far down the line and I get a phone call, is that legal and can we do this? There is value in the exchanging of information.

Chairman Weisz: Can you explain the 501c from the standpoint if they've ever done this before and what are the legal ramifications?

Mike Mullen: There have been situations where a 501c3 corporation has been established to receive funds from a state agency to carry out programs that facilitate objectives of state agencies.

Chairman Weisz: Has the state established them or has other groups established 501c's to accept the funds? The state in this case is establishing the 501c.

Mike Mullen: Other situations I'm aware of regarding the public health and other matters like that some association has established a 501c3 and then the state agency has given a grant to them to carry out certain functions.

June Herman, Senior Director of Government Relations for the American Heart Association in ND: See Testimony #3.

NO OPPOSITION.

Chairman Weisz closed the hearing on SB 2332.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2332

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 16, 2009

Recorder Job Number: 11048

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's look at 2332. This is the HIT bill and I've had discussions with (inaudible). I'm going to make a recommendation. I think this is important to keep this alive. I think there was an assumption, particularly in the Senate that if we just passed the money for (inaudible) we'd get stimulus money to take care of it. As of today, it appears that to be the case. I believe we will have a tough time at this stage of the game with appropriation. This other issue is that this bill comes over with $500,000 and appropriations are going to ask what we are going to do with (inaudible) money. I think the bill is in danger of getting a do not pass out of appropriations. I would suggest we cut the $500,000 to $250,000. (Inaudible) some of that money to HIT. Keep it alive in appropriations and then it would be in conference committee. I'm on the bill and I want it still alive. I think it is a good thing. I haven't gotten any warm fuzzies putting $3-4 million back into the bill.

Rep. Conrad: When you talk to people about his, we are behind.

Chairman Weisz: About everybody still believes stimulus can cover that. By the testimony we heard this morning that will be a long shot at best. I think we need to find additional funding for the hospitals, but I wouldn't bet on it survive in Approp. The other option is to take the money

out here until we figure out what to do with it. If we can find other sources or we can send it out as it is.

Rep. Porter: Where are the FTEs in?

Chairman Weisz: Health Dept.

Rep. Porter: Is it in the budget?

Chairman Weisz: No it is not.

Rep. Porter: I don't see it mentioned here (interrupted).

Chairman Weisz: (Inaudible) the state medical officer. The $500,000 was for two FTEs to run the program. One I think, even if there is no money for grants, that is the worst case scenario, I think it is still important to have at least somebody (inaudible) and start working with the hospitals (inaudible) interoperable ability as was pointed out. If we don't get the money this session, maybe get it the next session, but you should at least have everybody on the same page. Some have been very progressive here in Bismarck with HIT. The worse that could happen down the road is $2 million dollars wasted because we didn't have that correlation we assume. I want at least one FTE funded because if all fall apart, at least we have all the criteria set forth and somebody that can coordinate, then we can work on getting it funded. If possible we can get funding at this session.

Rep. Porter: Motion to amend it on page 3, line 2, $250,000.

Rep. Pietsch: Second.

Rep. Porter: The policy side of what's in here is by far the most important part of it because it sets the framework up that the committee of HIT sets their standards. If we can get a grant that is even better. The 501c3 still bugs me. I'm sure I'll get over it.

Rep. Conklin: Aren't we better off leaving the $500,000 in there rather than cut it in half?

Chairman Weisz: From my perspective when I walk down to Appropriations to sell them, they are going to ask me what the $500,000 is for. I don't have any grant money to tell them these people are going to be working under. I think I can sell it, that position just with the coordination. Two positions is pretty hard to sell just for bringing the people together and the coordination.

Rep. Conrad: You did say you were going to fund the (inaudible) grant, the $150,000 to combine (inaudible).

Rep. Potter: I hate to see it cut back. I find the whole process discouraging. Here we have money that the state has that we don't have. Four sessions ago we really didn't have money and that's exactly what we had to do was nothing, nothing, and nothing.

Rep. Porter: Maybe we should send some of these guys down to SD where they really don't have any money and they would be so much happier then, they wouldn't have the challenge on how to spend money. Spending this money is good solid investment for the people. (Inaudible) but keep saying it until the people that understand it.

Rep. Porter: And good luck with that.

Chairman Weisz: We do have a motion in front of us.

Voice Vote: Motion Carried

Chairman Weisz: I have concerns on page 2, line 25.

Rep. Conrad: I make a motion to delete the 501c3.

Rep. Porter: Second.

Chairman Weisz: I know what the point was to accept non-profit (drops sentence). They can do that all the time, they can contract and to that (inaudible).

Rep. Pietsch: Couldn't they give the money to the foundation and designate it to this particular project? The hospital would be the 501c3. (Some talking at once.) They can get their money.

Chairman Weisz: I assume the Healthcare Association is a 501c3. I'm assuming they are.

Voice Vote: Motion Carried.

Rep. Frantsvog: Do Pass As Amended and re-referred to Appropriations.

Rep. Conklin: second.

Roll Call Vote: 12 yes, 0 no, 1 absent, Rep. Holman.

MOTION CARRIED DO PASS AS AMENDED AND RE-REFERRED TO APPROPRIATIONS.

BILL CARRIER: Rep. Weisz.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2332

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 25, 2009

Recorder Job Number: 11519

Committee Clerk Signature Vicky Steffes

Minutes:

Chairman Weisz called the meeting to order. SB 2332 was sent back from Appropriations to us. They had no idea what to do with it so they sat on it and now sent it back to us. If you look at the makeup of the committee, that language will be gone and revert back to most of the original language that is already in current law which says the committee will be the Governor or Governor's designee, the Health officer or designee and Human Service or their designee so that is 3 and an additional 9 members to be appointed by the Governor and the Health officer. Then it will be the Health Information Technology Office. The $250,000 we sent out would still stay in to fund that position and (inaudible) committee and the position to oversee the committee in the Health Dept. The duties of the committee as outlined in the bill stays, nothing has changed. Now we get to the real money part. There is a 10 to 1 match of federal HIT money that states can apply for. What the bill will do is authorize the state Health Dept. to accept the grant with a $2 million appropriation of state dollars to leverage $20 million dollars of HIT money from the feds. Now the rules are somewhat restrictive, but that 10 to 1 match only applies in the year 2010. Need to get this office up and going obviously in establishing he rules. The bill would state $2 million to leverage that would go to the Health Information Technology office for them to disburse. The appropriations would be there, but not the

authority to spend the money. The want the HIT office to decide on how the funds should be disbursed. They will have to go to the budget section for the authority to spend it. Has a checks and balances.

Rep. Conrad: (Something about people on the committee.)

Chairman Weisz: I'm aware of that, but this gives a sense of security to the legislature. There are no guidelines whatsoever in the bill on how the grant should be disbursed because that is the whole point of the HIT office. There are going to know and how to decide to disburse (drops sentence). This will end up in conference committee. We aren't setting guidelines on how to disburse money.

Rep. Pietsch: Do we want to put on the emergency clause then to speed things up?

Chairman Weisz: That is an option. They polled the hospitals and the best guess if we are to do everything we need to be completely compliant in HIT has about a $45 million price tag. The goal in this is to say, we do this now we get the 10 to 1 match. We are going to fund about half of what we think it is going to cost to get everybody compliant. Hospitals are going to start getting penalized on their Medicare rates if they are not compliant.

Rep. Conrad: It starts in 12?

Chairman Weisz: I think it starts in 12 and gets keeps jumping up (inaudible) up to 5% of your Medicaid reimbursement rate. Starts at 1% and (drops sentence). So that's an issue. The intent of the bill then, they have to report after this biennium (inaudible) $2 million they can match, but they have to come back and report to the assembly on how they used the money and what are the needs to finish this. How much is it going to take? By then they should know. Maybe it will only be $10 million more. It is 10 to1 in 2011 and goes to 7 to 1 in 2012. Then the legislation could look at it when they report back and decide if they want to finish it.

Rep. Potter: If we aren't interested in finishing it, we probably shouldn't even start it.

Chairman Weisz: Oh no. It's got to happen. Someone's got to finish it. Even if the legislature doesn't., they are going to have to. The feds say, you shall do this. Mr. Ulmer.

Dan Ulmer from BC/BS: One the things you have to understand is (inaudible) basically says that you bring your infrastructure up and make it interoperable, then you are also eligible for Medicare incentives. And additional payments to critical access hospitals. I think 20% in some cases, and if you are not (inaudible) then they start taking you down and start deductions from your Medicare payments. Payments only last so many years until everybody is interoperable. There is a window here that you have to start funding this. After time period is up, anyone not interoperable is penalized.

Rep. Kilichowski: This is strictly grant money and has nothing to do with the stimulus then?

Chairman Weisz: It is stimulus money that can be offered as a grant that has to have a 10 to 1 match. That's why it has cut off dates. In 2011 it is 10 to 1 in 2012 it is 7 to 1, 2013 it is a 3 to 1.

Rep. Kilichowski: If they are going to offer us 10 to 1 this time why wouldn't we put in even $3 million and get $30 million if they are figuring on a $45-47 million? Then put in 2 next time when it is 7 to 1, we would be money ahead.

Chairman Weisz: A couple of reasons. One, I'm not sure of the ability to even utilize (drops sentence) time wise to utilize that proper. We don't just want to spend money on the wrong thing. Two, I don't have a lot of skin left and there is only so much I can give to (everyone laughing and talking at once).

Rep. Conrad: I thought we were not ready to be competitive for the grants.

Chairman Weisz: This is a little different. These are matching grants now. The other area has to do with the position, payment, electronic health record (inaudible) up to $15,000. (Inaudible)

the first year would be at $15,000, year two $12,000, year three $8,000, in most cases we're not going to be able get any of that because we are not compliant.

Rep. Conrad: Right. I thought we were not to a point where we could not compete for the competitive grants.

Chairman Weisz: We can't compete in this area. This is for state that is behind, but the other area that has the (inaudible) in it (Rep. Conrad and Chairman Weisz talking at same time, inaudible). I don't know how much ND stands to get in that or qualify. Mr. Thomas, do you have an answer?

Arnold Thomas with ND Healthcare Association: First of all, ND's position (inaudible) on the provider's side. I'll give three examples. For the major institutions, the will not be able to take direct advantage of this bankroll. The reason is that they have already purchased and (inaudible, coughing) within their own structures accrued medical records programs and electronic (inaudible) so the budget would not incorporate those costs. Those institutions and eventually the additional two largest hospitals will be advantaged (inaudible) the statewide (inaudible) and a much greater cost of about $5 million to put that fabric infrastructure into place so as everyone else comes on line the systems and information will be able to go wherever the patient goes as long as the provider is hooked up to (inaudible). (Inaudible) eight facilities they haven't actually made it (inaudible) investment. So all of their institutions could come up over a period and this grant would relieve them of that investment which means those dollars could go into other kinds of support for those facilities. There are ten facilities up in the northeast that are trying to (inaudible). At first they are trying to get all of the infrastructure the same electronically. This grant would enable them to do that. That would cost about $5-6 million for those facilities. The committee is key in making sure that wherever the people are that over time it is all compatible relative to having everybody connected. Making sure the

dollars are spent in compliant with federal requirements. The final piece, all of the doctors that currently employed by the hospitals, are already included in the budget estimates that we shared with Rep. Weisz. However, not all doctors are hospital based. Many are independent practices or clinics. We have allocated dollars for that group of physicians so they too would be able to participate in this grant once it is made available to us. If you want to be the best in the nation, our best estimate would be in the neighborhood of $48 million.

Rep. Potter: I understand this is to be taken care of by 2010. Are we going to be able to (interrupted by others stating 2011.

Arnold Thomas: 2011, 2012, 2013. It is 10-1, 7-1, and then 3-1 in matches. We had no discussion at all on carryovers. We had more discussion in terms of, if you have a contract and it goes into another physical year, what happens. We had no discussion on terms of can you amend your initial document and then there are vehicles you have available relative to special emergency supervisions. There is a lot of flexibility in this framework that is contained (inaudible) amendments to 2332.

Rep. Conrad: Are they along the lines of what has been presented to us from the House?

Arnold Thomas: In terms of what Rep. Weisz suggested (inaudible) those proposed revisions? If I may, even though I wasn't asked if I could (inaudible) committee composition.

Chairman Weisz: Go ahead.

Arnold Thomas: In the current bill 2332, entities and interests identified or suggested are not mandatory in terms of (inaudible) committee. It has been my experience with agency constituted groups, one of the downsides is they get to be too big. There is nothing in the language of current law that would preclude an additional works, taskforce or subcommittees of the larger committee (inaudible) of the steering committee to be enabled. It does put a real

burden on the initial appointments so that the people who make it happen are at the table. So when the program is developed in advanced you have a workable (inaudible).

Chairman Weisz: Committee, I'll just read you quickly the program defined by CMS. "CMS may award timely implantation grants to state or state designated entities to expand or electronic exchange or use of helpful information. States must align with the national plan." That's part of the conversation Mr. Thomas mentioned. We don't know what that national plan is yet. "In order to qualify entities must be non-profit with broad stable representation. Must exist primarily to improve quality efficiency through HIT. Entities must consult with a broad use of stakeholders and make some recommendations. Beginning in FY'2011 it is 1 for 10, 2012 is 1 for 7 and 2013 is 1 for 3." The other thing that is also part of the amendment is that loan payment program may be established for states to purchase certified electronic health record technology to exchange health information. That requires a 20% match and that is also in the amendments that a provider could qualify for a loan if they have a 20% match. We don't know the terms or anything else, but it would allow this HIT office to get things (inaudible) from the feds to an entity to make up what they need to do. Committee we have two choices.

Rep. Kilichowski: Move the amendments.

Rep. Pietsch: Second.

Chairman Weisz: Would you like to tack an emergency clause on that?

(Consensus from committee was yes.)

Chairman Weisz: Is that your motion Rep. Kilichowski? And second from Rep. Pietsch. I need a motion to reconsider our actions.

Rep. Hofstad: So moved.

Rep: Damschen:

Voice Vote: Motion Carried.

Rep. Kilichowski: Move the amendments.

Rep. Pietsch: Second.

Rep. Uglem: The 2011 legislature could still access more money in the emergency clause.

Chairman Weisz: The fiscal year 2011 is October 2010 through October 2011 and then that ends. The federal fiscal year for 2011 starts October 1, 2010 and ends September 30, 2011 so we wouldn't be in, in time. Yes we would be. In theory they could (drops sentence) still appears 10-1 match available (inaudible). They should by the time we go into session in 11 and if it is apparent if we can get it in place in time we could actually address the 10-1 match.

Rep. Conrad: It has to go before the budget (inaudible)?

Chairman Weisz: I do.

Rep. Conrad: I'm really stumped at why that has to happen. I'm not going to vote against it no matter what the amendments say. I really think the appropriation committee should be reminded of their limit.

Chairman Weisz: I will have a lot of questions based on accountability and we don't even know (drops sentence). (Inaudible because of coughing) grants and I'll have to tell them I don't know.

Voice Vote: Motion Carried.

Rep. Kilichowski: Motion Do Pass as Amended and re-refer to Appropriations.

Rep. Uglem: Second.

Roll Call Vote: 11 yes, 0 no, 2 absent, Rep. Nathe and Porter.

MOTION CARRED DO PASS AS AMENDED RE-REFERRED TO APPROPRIATIONS.

BILL CARRIER: Rep. Weisz.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2332

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: April 1, 2009

Recorder Job Number: 11618

Committee Clerk Signature Vicky Steiner

Minutes:

Chairman Weisz: Call the committee to order. Everyone should have a copy of the amendments on 2332 that we did approve. Just want to make sure everybody agrees we are ready and we are meeting. You can look at them and see if they say what I told you would say.

Rep. Hofstad: It's exactly what it says.

Chairman Weisz: This is the third version to make this work. If anybody has a question on that speak now because I'm going to sign off on it.

Adopted by the Human Services Committee
March 16, 2009

VR
3/16/09

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

Page 2, line 22, after the underscored semicolon insert "and"

Page 2, line 24, replace "; and" with an underscored period

Page 2, remove lines 25 through 28

Page 3, line 2, replace "$500,000" with "$250,000"

Renumber accordingly

Date: 3-16-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. PORTER Seconded By Rep. Pietsch

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Total (Yes) 8 No 4

Absent 1 Holman

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

Do Pass Motion to Amendment

Date: 3-16-09

Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep Conrad Seconded By Rep Porter

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Voice Vote

Total (Yes) 12 No 0

Absent 1 Holman

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

Motion to Delete Sec C lines 25-28

Date: 3-16-09
Roll Call Vote #: 3

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Rep. FRANTSVOG Seconded By Rep. Conklin

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	√		REP. TOM CONKLIN	√	
VICE-CHAIR VONNIE PIETSCH	√		REP. KARI L CONRAD	√	
REP. CHUCK DAMSCHEN	√		REP. RICHARD HOLMAN	A	
REP. ROBERT FRANTSVOG	√		REP. ROBERT KILICHOWSKI	√	
REP. CURT HOFSTAD	√		REP. LOUISE POTTER	√	
REP. MICHAEL R. NATHE	√				
REP. TODD PORTER	√				
REP. GERRY UGLEM	√				

Total (Yes) 12 No 0

Absent 1 Holman

Bill Carrier Rep. Weisz

If the vote is on an amendment, briefly indicate intent:

Re-referred to Approp

REPORT OF STANDING COMMITTEE

SB 2332, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (12 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2332 was placed on the Sixth order on the calendar.

Page 2, line 22, after the underscored semicolon insert "and"

Page 2, line 24, replace "; and" with an underscored period

Page 2, remove lines 25 through 28

Page 3, line 2, replace "$500,000" with "$250,000"

Renumber accordingly

Adopted by the Human Services Committee
March 31, 2009

VR
4/1/09
18

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

In lieu of the amendments adopted by the House as printed on page 967 of the House Journal, Engrossed Senate Bill No. 2332 is amended as follows:

Page 1, line 3, replace "repeal" with "amend and reenact"

Page 1, line 4, remove "and" and after "appropriation" insert "; and to declare an emergency"

Page 1, line 10, remove "The health information technology office is established in the state department of"

Page 1, remove lines 11 through 24

Page 2, remove lines 1 through 11

Page 2, line 12, remove "represent a single interest."

Page 2, line 15, replace "4." with "2."

Page 2, line 22, after the underscored semicolon insert "and"

Page 2, line 24, replace "; and" with an underscored period

Page 2, replace lines 25 through 30 with:

"**SECTION 2. AMENDMENT.** Section 23-01-31 of the North Dakota Century Code is amended and reenacted as follows:

23-01-31. North Dakota health information technology steering committee. The North Dakota health information technology steering committee consists of the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and nine individuals appointed by the governor ~~to represent state government interests,~~ and ~~individuals appointed by~~ the state health officer to represent health information technology stakeholders.

SECTION 3. PLANNING AND IMPLEMENTATION GRANTS. The state department of health may accept planning and implementation grants under the federal American Recovery and Reinvestment Act of 2009 and disburse the funds to the health information technology office, which may distribute the funds to nonprofit providers with broad stakeholder group representation to improve quality and efficiency through the health information technology office. The state department of health may accept grants to establish loan programs for the purchase of certified electronic health record technology used to exchange health information and provide the funds to the health information technology office, to provide the funds to nonprofit providers with broad stakeholder group representation to improve quality and efficiency through the health technology information office. The grants require a twenty percent match of nonfederal funds by the nonprofit providers, beginning January 1, 2010. The granting authority of the health information technology office is limited to the biennium beginning July 1, 2009, and ending June 30, 2011. Before October 2010, the health information technology office shall report to the legislative council on the status of the current grant and potential funding needs for the 2011-13 biennium.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the state department of health for the purpose of defraying the costs of the health information technology office and advisory committee, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 5. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $2,000,000, or so much of the sum as may be necessary, and from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, the sum of $20,000,000, or so much of the sum as may be necessary, as planning and implementation grants to be accepted by the state department of health as provided in section 3 of this Act. The state department of health may spend funds under this section subject to budget section approval of the plan developed by the health information technology office. Any general fund moneys appropriated under this section are not part of the agency's 2011-13 base budget.

SECTION 6. EMERGENCY. This Act is declared to be an emergency measure."

Page 3, remove lines 1 through 5

Renumber accordingly

Date: 3-25-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Kilichowski Seconded By Rep. Pietsch

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					
	V	O	I C E		

Total (Yes) _____ No _____

Absent _____

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

Motion on Amendments
Motion carried

Date: 3-25-09
Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Total (Yes) _____ No _____

Absent _____

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

Motion Carried motion to add on emerg clause

Date: 3-25-09
Roll Call Vote #: 3

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Rep. Kilichowski Seconded By Rep. Uglem

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	✓		REP. TOM CONKLIN	✓	
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD	✓	
REP. CHUCK DAMSCHEN	✓		REP. RICHARD HOLMAN	✓	
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI	✓	
REP. CURT HOFSTAD	✓		REP. LOUISE POTTER	✓	
REP. MICHAEL R. NATHE	A				
REP. TODD PORTER	A				
REP. GERRY UGLEM	✓				

Total (Yes) 11 No 0

Absent 2

Bill Carrier Rep. Weisz

If the vote is on an amendment, briefly indicate intent:

Library

REPORT OF STANDING COMMITTEE (410)
April 2, 2009 2:05 p.m.

Module No: HR-56-6024
Carrier: Welsz
Insert LC: 90948.0204 Title: .0400

REPORT OF STANDING COMMITTEE

SB 2332, as engrossed: Human Services Committee (Rep. Welsz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). Engrossed SB 2332 was placed on the Sixth order on the calendar.

In lieu of the amendments adopted by the House as printed on page 967 of the House Journal, Engrossed Senate Bill No. 2332 is amended as follows:

Page 1, line 3, replace "repeal" with "amend and reenact"

Page 1, line 4, remove "and" and after "appropriation" insert "; and to declare an emergency"

Page 1, line 10, remove "The health information technology office is established in the state department of"

Page 1, remove lines 11 through 24

Page 2, remove lines 1 through 11

Page 2, line 12, remove "represent a single interest."

Page 2, line 15, replace "4." with "2."

Page 2, line 22, after the underscored semicolon insert "and"

Page 2, line 24, replace "; and" with an underscored period

Page 2, replace lines 25 through 30 with:

"**SECTION 2. AMENDMENT.** Section 23-01-31 of the North Dakota Century Code is amended and reenacted as follows:

23-01-31. North Dakota health information technology steering committee. The North Dakota health information technology steering committee consists of the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and nine individuals appointed by the governor ~~to represent state government interests,~~ and ~~individuals appointed by~~ the state health officer to represent health information technology stakeholders.

SECTION 3. PLANNING AND IMPLEMENTATION GRANTS. The state department of health may accept planning and implementation grants under the federal American Recovery and Reinvestment Act of 2009 and disburse the funds to the health information technology office, which may distribute the funds to nonprofit providers with broad stakeholder group representation to improve quality and efficiency through the health information technology office. The state department of health may accept grants to establish loan programs for the purchase of certified electronic health record technology used to exchange health information and provide the funds to the health information technology office, to provide the funds to nonprofit providers with broad stakeholder group representation to improve quality and efficiency through the health technology information office. The grants require a twenty percent match of nonfederal funds by the nonprofit providers, beginning January 1, 2010. The granting authority of the health information technology office is limited to the biennium beginning July 1, 2009, and ending June 30, 2011. Before October 2010, the health information technology office shall report to the legislative council on the status of the current grant and potential funding needs for the 2011-13 biennium.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the state department of health for the purpose of defraying the costs of the health information technology office and advisory committee, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 5. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $2,000,000, or so much of the sum as may be necessary, and from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, the sum of $20,000,000, or so much of the sum as may be necessary, as planning and implementation grants to be accepted by the state department of health as provided in section 3 of this Act. The state department of health may spend funds under this section subject to budget section approval of the plan developed by the health information technology office. Any general fund moneys appropriated under this section are not part of the agency's 2011-13 base budget.

SECTION 6. EMERGENCY. This Act is declared to be an emergency measure."

Page 3, remove lines 1 through 5

Renumber accordingly

2009 HOUSE APPROPRIATIONS

SB 2332

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 4/7/09

Recorder Job Number: 11770 @ 19:38

Committee Clerk Signature Jeanette Cook

Minutes:

Chr. Svedjan: This is SB 2332, which is the Health Information Technology Bill that we had earlier and sent back. The Human Services Committee did some more work based on federal matching.

Representative Weisz: What we did was take a look at the needs of HIT throughout the State of ND. The number presented to us was approximately $47 million to comply with the guidelines of HIT. The committee took a look at, because of the time-frame, we allocated $2 million to be matched 10 to 1. That would be $20 million federal. Approximately half of the money projected to be needed for the conversion would be handled in this bill. When we come back next session, we would have a much better handle on what the rest of the needs would be. There would still be time to actually use some of that 10 to 1 money, if the legislature would want to do that going into the 11-13 biennium. The money will flow through the State Health Department to the Health Information Technology office. The office isn't in place yet because they can't do anything until we allocate for it. They aren't able to spend the money until they go before the budget section to get approval. We did that because we have no way of knowing what the rules and what their criteria will be at this time because they don't exist. We added this language to ensure that they are doing it fairly and equitably across all the providers in North Dakota. One of the things we took a look at is under current federal provisions, if our

hospitals don't become technology compliant, they will now receive a Medicare penalty. It starts at 1% and goes to 5%. We many have smaller hospitals struggling already and a large portion of their patients are either Medicare or Medicaid. Now they are going to take 5% of that away from them because they aren't technology complaint. We looked at this as being extremely important. One of the best examples as to why this is important is the flood. We have moved tons of patients out of the Fargo area and sent them all across the state. They were literally sending garbage bags of patient files along with them. If all the hospitals are compliant, none of that would need to happen. All of the patient information would be accessible online no matter where the patient was. The feds are saying that we have to do this. The 10 to 1 match will be available until October of 2010. That is the reason for the emergency clause. We want to try to move this along, get the office established, and accept the funds through the Health Department. Most of these small hospitals do not have the funds available to do this now in addition to paying a penalty. Some hospitals have this internally, but do not have interoperability.

Chr. Svedjan: I have a question on the interoperability. There are certain facilities that are well positioned, but they have different systems. Can they communicate with each other? There has been some work done to begin to discern what will be necessary from a hardware and a software standpoint. You have given some significant ranges here on the dollars and worked from the mean of those ranges to arrive at a total figure. Would you speak to the numbers?

Representative Weisz: The numbers were arrived at by asking the Health Care Industry to provide us with numbers. They have already been taking a look at that. Some major consultants have arrived at many of these numbers. They took into account what hospitals have already done. Some of the major hospitals have invested a considerable amount. They

have taken that all into account. What will it take for the hospitals that are already there to become interoperable? Also for the solo practices, they have been looking at that. These numbers have been provided by them as a range in which a committee said they don't know for sure what it will cost totally. Their projection is $47 million. We know it is going to cost a lot, but we know how important that it is. We believe that there is time. If we fund it at $22 million total, we will be able to come back in two years and see where we are at. How much money will we need to finish this? Are they proceeding the way they should be? Is that HIT office doing the job it's supposed to? Then they have to come before the budget section, even before they get approval to spend any of this. We asked the Health Care Industry how much it would cost if they had to be compliant by next year. That is where the $47 million came from. We decided that you can't get that far in one year anyway. The feds are always dragging their feet. So, we decided to fund it to that point. We come back here and know where we are at. By then the feds have finalized whatever changes there might be. Then this body can decide if they want to fund any additional money to fund the implementation of HIT.

Chr. Svedjan: It's difficult to know how this is going to transpire. What I'm wondering is, probably with regard to the smaller units, how do you see this all coming together? I realize that the Health Information Technology Steering Committee is really going to be in charge. It would seem to me that you are going to need some boots on the ground, so to speak, all over the state to pull this all together.

Representative Weisz: That is important. Our committee changed the makeup of that original committee. We wanted to make sure that it's the stakeholders that have something in play. I would envision that when you have stakeholders like Minot and MedCenter that have already done a lot of work. They are going to be a major force in working with smaller hospitals and solo physicians. It is critical when you look at the make-up of the committee. There should be

people appointed that are involved in this that are going to know what they are doing to bring out the competing interest and also bring common interests together. They need to make a system that will work smoothly throughout the state and the nation. There are issues as far as different systems and how they operate. But, it's not that difficult to program to allow different internal systems to be interoperable with other systems. The major four facilities will get this done without an issue. But, we will have most of our small clinics and small physicians being hit by the Medicare decrease and they're already struggling. We already have trouble with clinics in many parts of the state. I can only imagine the benefits in time and management when the flood hit Fargo. They had to be so concerned about the files. I can't imagine how much money this would have saved. All they would have had to do was move the patients.

Chm. Svedjan: (35:14) I knew what it was like to move in the direction of adopting an electronic medical record internally. The amount of work that went into it, and the amount of training was huge. In this situation, I'm sure we are looking at variations in what the electronic medical records look like in the facilities that have them up now. Maybe there would be significant modification in which everyone will end up with an electronic record that looks the same. Is that true?

Rep. Weisz: In part that is correct. I think you can have some differences. The data will transfer no matter what the system. They may have a different way in what they are prescribing, but the data will be compatible across the system. So, the major four may not benefit as much, since they have already done so much work. They will benefit from the interoperability standpoint.

Rep. Kaldor: (37:55) In our community there are some models. We have several hospitals in the Northeastern region that are collaborating for this purpose. The issue they face is to select a system. They were caught between what Meritcare does, and what does Altru does. They

ultimately decided to do what was best for them and what was affordable. The key is to have the data that each hospital plugs in be basically seamless. I think this is valuable long term.

Rep. Glassheim: (39:00) Seeing that this will benefit hospitals and physicians in the future, is there any reason they shouldn't be assessed some kind of fee? Should the private sector be putting something in or not?

Rep. Weisz: We did discuss that in Committee, and that was an issue. They are all putting substantial amounts of money in now to get where they are. Especially the smaller hospitals are having a hard time getting the resources. They all understand that it is important. You could just give the Health Department authorization to give grants, but it doesn't do any good if the facilities can't cash in on them. There is a provision for interest free loans through the stimulus package, so that they could also qualify for them. This is in no way paying for all the costs that are involved in this.

Chm. Svedjan: (40:49) Explain the timeline again.

Representative Weisz: The stimulus package says that the 10:1 match is only good until October 2010. Then it goes to a 7:1 match for one year (2011). Then it goes to a 3:1 match until October 2012. After that, it goes away.

Chm. Svedjan: With October 2010 falling in the next North Dakota biennium, will we have the opportunity to enhance this level of funding with a 10 to 1 match?

Rep. Weisz: That's why we put the emergency clause in. If we are at the point where we know where we are at, we will have the ability to seek and receive some of that money yet.

Chm. Svedjan: Then the Budget Section would give the blessing.

Rep. Kreidt: (42:16) Has there been any discussion in regards to Long Term Care facilities? A lot of them are already going to electronic medical records and there a lot of transfers from

hospitals to nursing homes. How will they interface with the LTC facilities? They are spending a lot of money to get their records up to date.

Rep. Weisz: There was some discussion about that. That is where this Health Information Technology office is to come into play. They will have to look at the whole picture. Every player that has to deal with this needs to be part of the solution. The language is somewhat unclear on the federal stimulus act.

Rep. Kreidt: The LTC facilities do deal with the Medicare and Medicaid side of it. There could be some ramifications with those two entities.

Rep. Weisz: I'm not sure if the penalties apply to LTC facilities. It might, but I don't think so.

Chr. Svedjan: We have the bill with the amendments as recommended by the Human Service Committee. What are the wishes of the committee?

Rep. Kerzman moved a **Do Pass** on Engrossed Senate Bill 2332.

Rep. Onstad seconded the motion.

Rep. Skarphol: Is this the maximum amount of money that the state could be eligible to receive?

Rep. Weisz: I don't believe so. There wasn't a dollar amount put on to these grants. You have to apply.

Rep. Skarphol: We're not going to meet again until this deadline passes. We would be in session after the 7:1 match. Does this give us an opportunity to get additional dollars at the 10 to 1 match?

Rep. Weisz: When it said the year 2010, it starts in October 2010 and goes to October 2011. When we meet again, we would have time to still qualify for some of the 10:1 match.

Chr. Svedjan: A roll call vote will be taken on the motion for a Do Pass on SB 2332.

Aye 20 Nay 3 Absent 2

The motion carried.

Representative Weisz will carry SB 2332.

Date: 4/7/09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2332

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number ———

Action Taken Do Pass

Motion Made By Kempenich Seconded By Onstad

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Rep. Skarphol	✓		Rep. Kroeber	✓	
Rep. Wald	✓		Rep. Onstad	✓	
Rep. Hawken	✓		Rep. Williams	✓	
Rep. Klein	✓				
Rep. Martinson	✓				
Rep. Delzer	—	—	Rep. Glassheim	✓	
Rep. Thoreson		✓	Rep. Kaldor	✓	
Rep. Berg	✓		Rep. Meyer	✓	
Rep. Dosch		✓			
Rep. Pollert	—	—	Rep. Ekstrom	✓	
Rep. Bellew		✓	Rep. Kerzman	✓	
Rep. Kreidt	✓		Rep. Metcalf	✓	
Rep. Nelson	✓				
Rep. Wieland	✓				

Total (Yes) 20 No 3

Absent 2

Floor Assignment Rep. Klein

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2332, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **DO PASS** (20 YEAS, 3 NAYS, 2 ABSENT AND NOT VOTING). Engrossed SB 2332 was placed on the Fourteenth order on the calendar.

2009 SENATE HUMAN SERVICES

CONFERENCE COMMITTEE

SB 2332

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Human Services Committee

☒ Check here for Conference Committee

Hearing Date: 04.23.09

Recorder Job Number: 12153

Committee Clerk Signature Mary K Monson

Minutes:

Chairman Dever Opened the conference committee on SB 2332. I understand that we have house amendments but that some of the discussion goes beyond that. Maybe we should start with what the house looked at.

Representative Weisz The bill as it came to the house had $500,000 and established a working group to develop health information technology (HIT). Initially HS sent it out with $250,000 just to keep the bill alive while we took a look at some of these issues. Once the committee received info on the federal stimulus package we realized there isn't any direct money in the stimulus plan that is coming back for HIT. There was money available for HER, etc. There is a possibility for grants on a 10-1 match and loans as part of the stimulus plan. What the committee did is kept the $250,000 in to establish a HIT steering committee which is funded by the governor and appointed by him and the state health officer. Then what we did is put in 2.2M which can be leveraged for a total of 22M in federal stimulus grants. The department of health would apply for the grant and then pass the grant of through the steering committee who would then upon approval of the budget section, develop a criterion for who gets the grants and how they will be disbursed. The language allows the health department to accept loans from the federal government even through the HIT program and then through

approval, offer the loans. We put an emergency clause so that we can the committee started and apply for the grant and get the process started. That way when the grants come, the committee will be ready for it. We picked 2M based of the best estimates that we received. They need about 48M and we wanted to provide roughly half of that. There is no way in this biennium that we are able to give everyone 100%. We looked at starting out with 22M and they will come back next session. We wanted to strike a balance as we don't know what all the requirements will be at this point. There are also 7-1 grants available. We saw the danger of handing a large check and all of it being used and then some. This provides a process. Spoke about hospitals being unable to step up and pay for this particular program, the state has to step up.

Chairman Dever The senate hasn't dealt with the stimulus dollars, have there been any further updates with stimulus plan that may have affected your plans?

Representative Weisz I haven't seen anything as far as even what the terms of the grant and all that. I don't believe any of that has been established yet.

Chairman Dever What I have read is that there is money in the stimulus package for HIT. The stimulus has to be spent.

Representative Weisz I think there is one clarification, when I first had the bill in our committee we knew there was money available. We were not aware at that time that there were match grants available—that is the reason we sent it out with just the $250,000 at that time. Talked about the committee's actions after they realized that there was more information available

Senator J. Lee Thanked the house for their hard work. Introduced Lynette Dickson

Lynette Dickson Center for Rural Health and HIT steering committee member. See chart attachment #1. Explained the chart.

Chairman Dever Are all the dollars you refer to here general fund dollars?

Dickson These three columns are.

Representative Skarphol In column two you talked about long term care. For this system to be really functional, all aspects/parts of health care need to be involved. How do we get those folks in the private clinics, etc. into the picture? Are we incorporating them into any aspects? Are we able to?

Dickson This bill is a health system bill so any of these opportunities would be open as long as the federal dollars can be used for those particular facilities. Extrapolated on the chart

Representative Skarphol I am assuming that the initial impetus of this is to get the rural hospitals involved. Is that a correct assumption?

Dickson Yes, for the most part.

Representative Skarphol So the majority of the loans in column one and two are primarily for rural/small hospitals?

Dickson Primarily, yes. Keep in mind that rural hospitals have long term care facilities and clinics. When they are connecting their facilities it might be more than just a hospital involved.

Chairman Dever Are pharmacies included in this?

Dickson We would include them yes. Spoke about the evolving process

Senator J. Lee I doubt this is an epiphany for anyone else but me but as I was thinking about 2333 and the difficulties local health units are having with administration of immunizations, this is something they could be connected in with as well. This is something that might help them set up those optional networks a little easier, everybody has to be in or this doesn't work.

Representative Weisz Does the program require a state match or can it be a hospital match.

Dickson With the language we've got, it's a state required match because you are writing a grant not for individual facilities.

Representative Skarphol I don't think there is much of a question in any of our minds abou t the importance of this. It is all in how to get it to work and how to get it to work right. I am here to deal with the financing mechanism. We want to make this money available but not just give it away. If the grants don't come through, we don't have to have made an appropriation that is just going to be sitting there either. I think the discussion is going to be about the mechanics of this and who is going to manage this. I will certainly work on the financial aspect of this trying to ensure that we have a mechanism that might be workable. Talked about some of the questions he had about the program funding

Discussion about funding

Chairman Dever Suspended the discussion.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Human Services Committee

☒ Check here for Conference Committee

Hearing Date: 4/27/09

Recorder Job Number: 12314

Committee Clerk Signature Mary K Monson

Minutes:

Senator Dever called the conference committee on SB 2332 to order. All members were present: Senator Dever, Senator J. Lee, Senator Robinson, Rep. Weisz, Rep. Skarphol, and Rep. Homan.

Senator Dever said that at the last meeting they had talked about establishing a roadmap of where they wanted to go. The committee members all seemed to be headed in the same direction.

Rep. Skarphol provided a proposed amendment .0206 for discussion. (Attachment #2)

Page 1 subsection 4 – "The health information technology office may approve....." .If there is going to be a director should that director have some participation in that decision. It might need to be reworded a little differently in that there would be a joint decision of the committee and the director.

The committee agreed with that thought.

Senator J. Lee asked if he was thinking that maybe the director would make a recommendation to the committee or executive committee.

Rep. Skarphol said just a joint decision. He would say the director would be the final person because he would need to sign the paperwork.

He went on to explain that the idea of this amendment would be to create a fund somewhere to the ITD fund that was in place at one time. That would be the mechanism. He suggested that Rep. Weisz would like to speak to that.

Rep. Weisz said the original was to look at direct loan from the Bank of ND. The bank had some real concerns with that from the standpoint that they are just going to be told to make a loan which creates issues such as creditworthiness. That's when the discussion moved to setting up a fund so that the monies are put into the fund and then it is allocated according to the way it is set up – the technology office and steering committee. That way it's off the books – it takes away from its capital assets because they are transferring it – it's not a loan. The bank would administer it and would want some sort of a processing fee but it's not going to show up as a loan on their books.

Rep. Robinson asked if there was a need in section 5 to provide for more structure in terms of positioning the bank to approving applications and the criteria.

Rep. Skarphol referred to section 4 and said it would be the health information technology office and the director that would make the decision qualifying the loan.

They then moved to page 2 of the amendment (meter 06:00)

He addressed section 2 subsection 1. There is some concern about having a specific number of individuals – the nine reference. There may be a time where there is a need for a larger group or a smaller group.

Senator J. Lee referred to the member list of the ND Health Information Technology Steering Committee. (Attachment #3) She requested that they consider enlarging the number. The people on this group represent a very diverse group. They have all worked hard on the task force. If there is some way of enabling those people currently working in there to be considered for membership, she would like to see them consider opening it up for them.

Rep. Weisz didn't think he would have a problem with just saying" these 3 specific and individuals appointed by the Governor". Ultimately he's going to be responsible for the success or the failure of this group.

(Meter 08:30) Discussion continued on the number of members that could be needed and leaving it up to the Governor.

Rep. Skarphol said another suggestion in subsection 2 was that they work collaboratively with the HIT director to apply for federal grants. The director, again, should be the one signing the application as opposed to the committee.

Rep. Holman, following up on the membership discussion, said one of the e-mails they got added the words "not to exceed eighteen". Leaving it open and trusting the Governor to do it would not make it unworkable.

Rep. Weisz had a concern. He thought the federal stimulus says it has to be a state entity. The person applying for the federal fund has to be like the Department of Health, Dept. of Human Services, or ITD. He didn't think the committee could apply for the fund. The intent that came out of the House was that, and it didn't have to be, but it was the Department of Health who applied for the funds and then handed them over to the committee.

Rep. Skarphol suggested they move to section 3 and look at the language (meter 11:25).

Senator Dever said another question was whether they were a state agency – the committee. There are references that read state agencies, boards, and commissions.

(Meter 12:30) Discussion followed that it needs to be appropriated to a state agency – ITD is a state agency. They could appropriate to ITD who would then pass it on to the committee. ITD would be responsible for monitoring everything. They would apply for the federal funds.

Rep. Skarphol said there had been suggested language that should be added somewhere "to facility the adoption and implementation of health information technology."

Lynnette Dickson, Center for Rural Health, speaking on behalf of the HIT Steering Committee, explained that language was just suggested as a better use of terms.

(Meter 14:35) Infrastructure was discussed. Lisa Feldner, ITD, was asked to take the podium and tell the committee about the Health Alert Network.

Ms. Feldner explained that the Health Alert Network is connecting all the health care institutions and is partly used by the health department. They are separate from the state network.

Senator Robinson asked who governs that board and if there is any structure to it or if it is a cooperative relationship where they come together because of common concerns & issues.

Jenny Witham, Dept. of Human Services, said the granting for it came from bioterrorism. It was for a public health alert. The health network when they were first putting it in place was about notification to people who were going to be able to be in areas where they were safe from potential outbreaks. It is a broad based group and the main focus is more about alerting and reacting to a potential public health risk.

Rep. Skarphol asked if, in her mind, that network has the capability to handle the kind of capacity that this is going to need.

Ms. Witham didn't think it would be a good match. She felt the backbone that is needed for a health information exchange is going to be more focused on identifying the individual, resolving whether or not this is the individual, focused on consent rights, and passing of information on standardized transactions.

Rep. Skarphol said his point was that somehow this information is going to have to be exchanged and it is going to have to be exchanged on somebody's network. In the past, the legislature has had issues whether or not they want that to be on the state network. That's why this network was developed. He said they need to know who it is that the health

information technology committee is going to have to deal with in order to ensure the network they are going to do this on has the capacity to deliver. It won't do any good to invest $40 million in a system developing facilities to be able to exchange information if there isn't a system that it can be exchanged on. He said Ms. Feldner was correct – this system is on DCN and it might have the capability but he wasn't sure this group wanted to be responsible for that network. When he talks about infrastructure, he is talking about that network.

Rep. Weisz asked if he was talking physical network.

Rep. Skarphol – yes.

Ms. Dickson said that with regard to developing where it is housed and the capacity that would be some of the discussion of the advisory committee. There are already five work groups that would come up with a plan with the CIO in the state and the ITD and the appropriate folks to figure out what they have and what they don't and how that would fit into a potential plan to apply for some of those dollars for the health information exchange. It will be assessing what they have and what they can use.

Sen. Robinson said that Rep.Skarphol was right and that was a highly contentious issue. They need to be sensitive to that so they get off to a good start. There will be those for which this will be an immediate red flag. He said if they can keep that in mind and look at other options they would be well served from the get go.

Rep. Skarphol said they would have to follow up with that. That is his concern about the word "infrastructure" on page 2 subsection e. He didn't think this group wanted to get into infrastructure; they want merely to be the entity that plans and implements this. Let someone else worry about transmitting.

Page 3 is the grant fund that would be created if grant monies were received.

Section 5 discussion took place (meter 22:30). Conversations with the Bank of North Dakota have taken place.

Section 6 - Rep. Skarphol said there had been some discussion that whether the 250 is enough. Some would like to see it at 350, hire a director and make it an unclassified position. Senator Robinson asked if the various parties had a chance to review the set of amendments. There was discussion that some of the various parties involved had a chance to review the amendments and there was some broad acceptance providing some revisions talked about were made.

Rep. Weisz was inclined to put more money into the loans. Because of information he had received he thinks there will be more need for the money on the loan end than on the HIE end.

Rep. Skarphol said they had talked about a $6.5million loan program up front that they can access today and start moving forward. He thought Rep. Weisz was saying it was more appropriate to put a higher level of funding into the 5 to 1 loan grant and make them wait to see if they got that before they move forward. If they don't get that, committing $6.5 or $8million to loans up front does commit you to completion of the project. It's a case of how much risk they want to assume and when. (Meter 27:00)

Rep. Weisz said if they delay on the dollar part he didn't think they delay the moving forward. It's very important this committee gets up and running immediately. They can start looking at the parameters of the requirements and the proposals. (Meter 27:45)

Rep. Skarphol asked for feedback from those parties in the room as to what the right position is to take. (Meter 29:00).

The discussion on SB 2332 was adjourned for the day.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Human Services Committee

☒ Check here for Conference Committee

Hearing Date: 4-29-09

Recorder Job Number: 12389

Committee Clerk Signature Mary K Monson

Minutes:

Senator Dever called the conference committee on SB 2332 to order. All members were present.

Rep. Skarphol explained that they would be doing a combination of amendments .0209 (attachment #4) and .0210 (attachment #5). Jennifer Clark, LC, had been working on both of these and he said they tried to clean up and give consistency throughout the amendments with regard to the reference to the health information technology advisory committee. Previously it has been a steering committee. In this bill it needs to be an advisory committee.

Version .0210 moves this entity from the health department to the Information Technology Dept. He asked Jennifer Clark, LC, to walk through the amendments for the committee.

(Meter 03:40) Ms. Clark worked from the .0210 version which dealt with the substance versus the fiscal components of .0209.

Section 1 creates a loan fund in the Bank of North Dakota. There is a continuing appropriation so once the money is in they can start implementing it. Although the BND is administering this they have to play by the rules established by the committee and the office.

Senator Robinson wanted clarification of subsection 2 in section 1. He wanted to know if the 10 years to repay a loan was too long a period.

(Meter 06:00) Rep. Weisz replied that probably within four years they would get the reimbursement under the depreciation that would cost the vast majority of this which is going to pay it back.

Ms. Clark said the rationale for putting that in there was in information LC had initially reviewed. There was a note that this program needed a 10 year payback. There could be a federal provision.

Discussion followed that maybe it could say "not more than ten years" or "not to exceed ten years".

Section 2 – Currently under section 23-01-31there is a ND HIT steering committee. Under 23 it made it appropriate to call it a state dept. of health committee. This version differs in that it repeals that existing steering committee in 23 and replaced it with this language in section 2. This is being put in ITD so now it is more appropriate to have ITD provide the administrative services for that committee. She went on to explain that the appointment process is still very similar to what it was under title 23.

Rep. Skarphol said the language is similar to that used for CJIS.

(Meter 12:10) Section 3 – This creates a new office in ITD to help information technology office. The office is charged with the duty to apply for federal funds under "a", establishing a loan program under "b" and the grant program under "c".

Senator Robinson wanted to know what the intent is if the criteria is in "d".

Ms. Clark's understanding was that the rationale was when talking about the loan program under sect. 1 of the amendments the framework is laid out there. However, this office will be applying for federal funds and some of the requirements for that application are not known yet. Part of that is going to be the application and criteria.

(Meter 15:20) Section 4 – The grant program. The Health Information Technology office shall administer this fund and shall distribute monies in the fund accordingly.

Attachment #6 was information distributed by Senator J. Lee with points connecting with what the national criteria are. This might be the spot to see whether or not there is a need to plug in any language that reflects these points (meter 16:50).

Section 5 is the repeal for the existing steering committee.

(Meter 17:50) A comparison of the .0209 and .0210 versions of the section on report took place. Rep. Skarphol thought they would prefer the report go to the budget section. He wasn't sure there would be a budget section on human services but if there is that would be a good place to report as well. A suggestion to report to both was made by Senator J. Lee. She felt two copies of the report being provided could be helpful. Rep. Skarphol said the report could go to LC and then direct LC to distribute to those appropriate entities.

(Meter 20:10) Discussion moved to the .0209 version to talk about the appropriation clauses. Rep. Weisz explained section 8 would set up a fund very much like they did with ITD dollars. BND will set up a fund which will transfer a total of $8 million from the profits out of the BND into this fund. $6 million of the fund will be used for the match for the federal revolving loan fund. $2 million will go to the 10 to 1 match for HIE (section 10).

(Meter 22:15) Section 9 is $350,000 which will go for the director and the expenses of the advisory committee. This was bumped up from $250,000. The language still says steering committee and will need to be changed to say advisory committee.

Rep. Skarphol stated that the change in .0209 was because of some level of discomfort at the bank with the initial $6 and a half million loan funds and unwillingness of leadership to just fund that. He thinks the intent is to increase the amount of money available for this loan fund so if they get the grant they will have $36 million to loan to whatever number of entities. It will delay

the implementation to some extent but it will ensure they will have more adequate dollars available if and when they get the grant.

Rep. Weisz pointed out that the committee is critical and the time between now when they start and, say, Jan. 1 when the grant applications are supposed to be done is going to be needed and necessary to make sure that they have a state plan in effect.

Senator J. Lee pointed out that hospitals aren't the only ones who are going to make use of these funds. She had a concern with not having the funds available earlier.

(Meter 29:30) Rep. Skarphol spoke about the current scenario, the 5 to 1 money dollars that would become available for the loans is not eligible to be utilized to repay an earlier loan. What if that changes? He asked if it was conceivable to put language in that would allow the BND to loan that money if the rules change. It might give some flexibility.

(Meter 31:00) Discussion about this continued that the bank should be consulted.

Sen. Robinson said they had come a long way with the amendments and was pretty impressed with them but there are some issues and thought maybe one more meeting could resolve those issues.

(Meter 34:00) Section 10 – Appropriations Rep. Weisz asked if the committee was at least comfortable with that portion.

Senator J. Lee said she was not comfortable making a commitment on anything until what the stakeholders might have to say about what their review of the amendments might be. They are the persons who will be working with it.

Senator Dever suggested they hear from anybody that could not be at the next meeting.

Craig Hewitt, Meritcare Health System, was recognized by Senator Dever. He said the federal standards in the stimulus act are moving targets. One thing is clear – there is a certain set of money that the national coordinator is responsible for allocating to the states. The qualification

to that is that any of the funds need to comply to the strategic plan as set forth by the national coordinator who has ninety days to put that together from the signing of the bill. He suggested that this should be a requirement that it ties to the strategic plan as set forth by the national coordinator. That way anything done here is protected.

He was also concerned about the amount of funds we assume we will get through grants.

Rep. Skarphol asked what he thought a realistic number would be for our expectations for the 5 to 1 and the 10 to 1 match.

Mr. Hewitt said there is nothing wrong with the amount put in but cautioned them not to assume they would get the automatic match. He also said that continuing on with the suggested timelines as quickly as possible is the right way to go (meter 40:00).

Rep. Skarphol asked if there is a potential for the match to change.

Mr. Hewitt replied that it is "up to". There is no guarantee that says "just because you are approved...."

He said the grant portion looked somewhat arbitrary.

(Meter 40:20) Mr. Hewitt talked about the phases of the electronic health record adoption - the final phase being the transfer of patient information to another facility.

Rep. Skarphol asked him what he would suggest they should do with regard to this if this was a perfect world.

Mr. Hewitt replied that he suggest having a multi pronged approach with having a loan program available as just an option in case the grants or loans don't come through from the feds. Continue on with what you've put together regarding the loans around the HR and health information exchange. He was less concerned about the big systems; the rurals is where the issues are. Those are the ones he thinks are going to get hurt with the requirement to do the electronic health record and do information exchange. They won't be able to afford it.

(Meter 44:00) Senator J. Lee put a face on this with examples of evacuating flood victims and sending records with them.

Nancy Willis, St. Alexis Medical Center (meter 46:10) echoed comments by Mr. Hewitt but did have one thing to clarify. St. Alexis Medical Center actually created their own electronic health record. It is not CCHIT certified and they don't know how long it will take to get certified but they don't feel they will be certified in time to take advantage of the Medicare incentives. She asked if, on version .0209, they didn't' receive the grants if the dollars would still be available to the providers to be accessible for loan fund or if this is to be used only for matching funds (meter 47:50).

Rep. Weisz said that as the language is currently it would not be available. It's only to be used to match the federal.

Ms. Willis said that would be a concern. They would still be required to be certified or they would start getting penalized.

Rep. Skarphol said that, based on what they had heard today, they might need additional discussions about the whole financing package. The language put together by Jennifer with regard to the policy and configuration was pretty well worked through.

Ms. Clark commented on the discussion on the state as well as federal requirements. Technically it is a little challenging to make a requirement in state law based upon something that doesn't exist yet. She hesitated recommending putting it in statute. That's why appropriations bills have legislative intent language (meter 50:05).

Both sides agreed to talk to their leadership about financial commitment and then meet again.

The committee was adjourned for the day.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Human Services Committee

☒ Check here for Conference Committee

Hearing Date: 4-30-09

Recorder Job Number: 12411

Committee Clerk Signature Mary K Monson

Minutes:

Senator Dever brought the conference committee on SB 2332 to order with all members present.

The version .0211 amendments (attachment #7) was a combination of versions .0209 and .0210.

The committee was pretty much in agreement in terms of timelines and basic layout. The money seemed to be the issue – how to allocate the loans/grants and when and how much.

Rep. Skarphol thought the policy issues were pretty well resolved.

Rep. Weisz had a question for Jennifer Clark from LC dealing with adding language that had to do with the national standards. He wondered where it was.

Jennifer Clark, LC, explained that language is on page 3 sub d.

She went on to explain that two things had come to her attention when she reviewed this version: On page 1 under the loan fund – the purposes were expanded a little but it isn't as broad as it sounds (meter 03:15). As long as the language is in the section that is just broad enough for the HIT office to direct the bank to do it they are ok. They don't mind issuing a loan that may be to pay for some services already received as long as they are within the scope of

what they are supposed to be for. To be consistent, they probably should make a similar change in the language for the HIT office on page 3 sub c.

She said if they want to allow the office to provide these services directly, section 4 should probably be clarified for consistency sake.

Rep. Skarphol said there is another change he would like to discuss dealing with the money. (Meter 06:15) He said they had limited the capabilities of the utilization of dollars for a particular aspect of the ratios of sharing. He thought it would be appropriate to give them the flexibility to utilize what portion they think they need in which category by a mere report to the budget section as to their intentions.

Discussion then followed on section 7 of the bill, combining the grants and loans to make an $8 million appropriation for the purpose of the grants and the loans and then let the HIT office apply for the federal funds (meter 09:00). Rep. Skarphol said he would probably try to state it based on current federal rules because the rules are probably going to be changing. His side agreed with the philosophy that they are given that flexibility.

Ms. Clark - as long as they aren't talking about the report to the budget section being approval for them to go forward. They have their periodic reports so as those decisions are made that information will come forward.

Removal of section 9 would almost be necessary. It says that the $2 million is designed for the 10-1 match. That change would have to be made all the way through if that is what they decided to do.

Sen. Robinson said for this purpose a report to the budget section would suffice. Seeking approval slows the process down.

Senator J. Lee felt it was important to do that flexibility and the report is the right idea.

(Meter 10:50) She wanted to address some questions brought up when she asked Lynnette Dickson to review it. Rep. Weisz explained why the upfront was taken out.

Senator J. Lee felt it was a big mistake to not permit some movement forward. She didn't understand why a low interest loan wouldn't be something that would be an important thing. She didn't think it would take 6-8 months to move forward and felt there has to be some state safety net for this program.

Rep. Skarphol agreed that it wouldn't take a long time for the committee to get active. Until the rules get firmed up there's not a lot they can officially do other than ask the players to begin to think through the process. (Meter 15:40)

Senator J. Lee provided the committee with information that she had requested from Ms. Dickson (attachment #8). She wanted to know where they were standing compared to where they thought they were a couple of meetings back.

(Meter 19:40) Rep. Skarphol thought the first four listed were most critical and the total needed was $44,500,000. If you took the entire $8 million at a 5 to 1 match you would have 48 million dollars. Senator J. Lee submitted that the local public health units are also very important and would make it the top five. It is the understanding that they would qualify in the same way as a health care provider would and they have an equal need.

(Meter 21:00) Senator J. Lee gave more examples of how all these bills are not independent of one another.

Senator Robinson made a point that Mr. Hewitt's comment was valid in that the large systems will find a way to make at least some progress. There is a real question whether the rural hospitals will make much if any progress – not only financial resources but also the human resources.

Rep. Skarphol again went back to the numbers and the 5-1 match.

Rep. Weisz – you're not putting any into HIE.

Rep. Skarphol – by the time we come back in 2011, if they've invested $48 million, he would maintain they've made substantial movement forward to achieving "meaningful user status" and would be much more ready to make more immediate progress with an investment in 2011.

Senator J. Lee – what happens if we don't get any of that money? Is this the best format in which we can lay this out so that people can start doing what they have to do? Are we going to be able to make an adequate step forward during the next biennium with what we've done here?

Rep. Skarphol – explained that with the experience he's had with information technology his instinct would be that maybe 5% of the hospitals are ready to do this and have the knowledge to move forward. There's a lot of work that needs to be done to get them to the point where it would even be wise for them to think about borrowing money. What doesn't need to happen are failures but we do need to ensure that everyone is successful.

Senator Robinson asked if there is a set of conditions that they could put forth that, if met, would allow some comfort in a trigger sometime down the road to buy some time for us and also position our facilities to move. (Meter 27:00)

Rep. Skarphol had thought about that. An end of the year trigger – if we had 50million in excess revenue projections fine but, at the end of the year, they should have some sense whether or not they are going to be successful here. If they are successful, what do we need to do because they have $48 million if they get the 5-1 match and utilize the full 8. If they utilize the full 8 he thinks it would be extremely difficult for them to invest that wisely between the end of this year and the next legislative session. He was trying to be realistic and wanted everyone to be successful.

Senator Dever asked if he understood correctly that the amounts and the way they are structured in the bill now, as far as appropriations, is what Rep. Skarphol feels comfortable with.

Rep. Skarphol replied that with the amendments he suggested giving them the flexibility to use any of the dollars for whichever purpose they want, they would have, in essence, 48 million dollars if they get the 5-1 grant to fully funded. If the feds do not deliver he did not believe they can start to penalize. He felt everything could come together and work if they were just patient. (Meter 30:50)

Rep. Weisz said his comments when he talked about the timeline weren't meant to imply that the committee wouldn't necessarily be up to speed right away. The technical requirements and all the other issues that are going to make for that RFP are going to be extremely difficult to resolve. That takes time. For this to be successful it's the preplanning that's going to make the difference.

They are looking at a broad spectrum of players that have to come on board to make this fit. From a timeline he feels starting in January is plenty soon.

Senator J. Lee said she needed some consultation time on this. She also suggested asking one of the stakeholders if they have a response to what the proposal is to get their perspective on how this might work – to answer concerns about the time and the discussion about the early loans.

Nancy Willis, St. Alexis Medical Center, said there is confusion between terms HIE and HIT. In the language in the stimulus package the loan fund is for providers to move toward an EHR, an electronic health record (meter 35:46). She talked about the "meaningful use" of the EHR and explained how a facility who currently has nothing now, if there is money now in a loan pool,

could borrow money, buy a product and start using it in a meaningful way before they are completely electronic.

She also felt if there is the ability to access dollars ahead of time they could work together with other facilities (meter 37:50).

The other concern they had is that 2011 is actually the federal fiscal year which starts Oct. 1, 2010. It is their understanding that facilities or providers could already start applying for incentives in January 2010. She didn't feel they had the time they think they do to wait for the federal stimulus dollars.

(Meter 39:09) Discussion followed on the federal fiscal year 2011. Rep. Skarphol submitted that they could have money on the table in a very short time if they come back to session in 2011 and there is an immediate need.

A chart from the American Hospital Association was referenced by Rep. Weisz. He said it didn't show any reduction to 2013 on the incentives (meter 40:10).

Rep. Skarphol asked a question relating to getting software and becoming a user of it immediately. He wanted to know if anybody was aware of or had any exposure to the products and if it is user friendly or if it takes some degree of implementation. He pointed out the difficulty higher education had implementing a software program.

Lynette Dickson, Center for Rural Health, said they just finished an eighteen month project which she was the co-director of – putting in electronic health records in Park River, Cavalier, and Northwood. It is absolutely a challenge but it is realistic to get it done in these facilities if they want it to be done and if they have some funding. (Meter 45:11) She talked about the challenges but felt they shouldn't wait. Some facilities have done the work and are more than willing to step up and help.

(Meter 48:00) Rep. Weisz asked for clarification on the Medicare incentive. Discussion followed that it applies to critical access hospitals.

Chip Thomas said that if you talk about reimbursement you talk about two different kinds of hospitals – critical access which is paid on cost and PPS hospitals which are paid on a fixed fee. (Meter 49:15) He went on to explain them in more detail. Then he talked about the incentive for the critical access hospital being twofold – when they start relative to when they can get their cost recovered. The sooner they are in line and able to make the program work for them beginning Oct. 1, 2010 they get an additional enhancement on their depreciation payment. If they start before that they get the depreciation but without the enhancement. The PPS is different. They get an incentive based on a percentage of their discharges that are associated with Medicare. It's an add on. The PPS have the biggest incentive to be compliant and all six will be in the five year period (meter 51:20).

Senator J. Lee asked if he saw a benefit to the hospitals if, in the flexibility, they included the potential for earlier loans.

Mr. Thomas said if they would have made a commitment to be compliant the answer would be yes. The problem is, the lenders would not loan to the group of facilities that would be eligible for the loan for the reimbursement based on depreciation.

The conference committee meeting was adjourned for the day.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2332

Senate Human Services Committee

☒ Check here for Conference Committee

Hearing Date: 5-01-09

Recorder Job Number: 12432

Committee Clerk Signature Mary K Monson

Minutes:

Senator Dever opened the conference committee meeting on SB 2332. All members were present.

The committee is now looking at version .0213 (attachment #10).

Rep. Skarphol reported that after the last meeting and all of the conversations about needing some potential loan money they made a decision to make some potential early loan money available. He emphasized it was potential because there are some caveats that need to be met in order for it to happen. Those changes show on pages 4-5 of the amendment.

Section 9 is the major portion where it talks about the contingent appropriation. The office of management and budget has to indicate there is a demonstrated need for these loan dollars and a specific amount needs to be requested.

Page 4 subsection e talks about some of the things that need to happen. It is designed to try to make sure whatever entity is getting a loan has at least done some preparatory work.

Rep. Skarphol moved that the house recede from its amendments and adopt amendment .0213. The motion was seconded by Rep. Weisz.

Rep. Skarphol reported that the concerns from Jennifer Clark, LC, had been addressed in these amendments.

Senator Dever asked if the dollars in section 11 are the same dollars that are in section 8.

Rep. Skarphol said there will be 13 million dollars available. The first 5 would be the loan dollars, the contingent Bank of ND transfer. If there is a demonstrated need for all of that there could be 5 million dollars available at the end of the first quarter.

The second change in the money is that 8 million dollars was provided - as opposed to the previous draft of 6 and 2 – and gives total flexibility as to how the 8 will be utilized (meter 05:20).

Senator Dever asked for clarification that the 8 million dollars in section 8 is the same as in section 11.

Rep. Skarphol – said that was correct.

Senator J. Lee – Section 2 is new and lays out how the loan fund would work and she didn't have a concern with it. She was interested in seeing what the dollars might be in section 9 and if they might see some potential to moving it up three months and opening it up for discussion.

Rep. Skarphol said the 22 and a half million was selected after consultation with the Office of Management and Budget. That is not a number that is intended to try to make it impossible to achieve but rather a realistic goal. The real issue is that you are transferring money from the Bank of ND that they may or may not have available. They may not have earned 5 million dollars in that three months. It comes out of Bank of ND earnings.

Senator J. Lee said that if we see we will have a significant ending fund balance there we should just appropriate it from the general fund instead of pulling it out of the Bank of ND.

Rep. Skarphol said there wasn't a willingness on the House side to do that.

Senator J. Lee said this is a terribly important program and she recognized they have some challenges to meet. She said she had a hard time understanding why they wouldn't consider the possibility of ending June 30, for example, and appropriating from the general fund. She

didn't think they should have to rely on whether or not they can pull any more dollars out of the BND when the money is there. She asked to hear from someone who had information on whether it is likely the money will be there and what the situation is likely to be June 30 and Sept. 30 recognizing the projections.

Allen Knudson, LC, said there is no way of knowing if they will be over or under at this point.

Senator J. Lee asked what is going on now as far as compared to projections and what is really there. Not just for the BND but for what there is now for potential general funds.

Mr. Knudson (meter 10:30) replied that they haven't received the latest budget collections report from OMB. Through Feb. collections were coming in above forecast.

Senator J. Lee said she would like to have a discussion on whether or not a portion of that could be appropriated from general fund with the balance coming from the BND after that if the bank isn't likely to earn that money before that time.

Rep. Skarphol asked Mr. Knudson to tell the committee what is going on with the spending in this session with regard to ongoing spending versus what is anticipated to be ongoing revenue.

Mr. Knudson answered that we are in the negative (meter 11:55).

Rep. Skarphol said that is one of the problems on the House side. The other problem is that they need to ensure the people who want to borrow the money to do this are ready to do what needs to be done. He pointed out that they aren't ready to go back to the days when they had a lot of IT project failures and a lot of money spent that wasn't appropriate at the time.

Rep. Weisz didn't think they would be ready prior to Sept. 30, 2009. Timing wise he would feel more comfortable if he knew they were ready to go (meter 13:40).

Senator Dever - This says "based on legislative estimates made at the close of the 2009 legislative session". Are legislative estimates the same as OMB estimates?

Mr. Knudson said what it's going to be is the legislative forecast that was adopted by the appropriations committees in February and then adjusted by all of the legislation approved during the session that affects those revenue numbers. OMB would take those numbers and do their projections for the biennium.

Rep. Skarphol said it's a number that's agreed on by both of the appropriations committees and leadership and is endorsed in committee.

Senator Dever asked if that would be conservative.

Rep. Skarphol – in this case it was reduced from what OMB's number was.

Senator J. Lee pointed out that this is a onetime investment, because of the stimulus money, in trying to get these systems up and running. This isn't ongoing spending.

The roll call vote was taken on the motion of the house recede from the house amendments and adopts amendments .0213. The motion passed 6-0-0.

Senate Carrier – Senator J. Lee

House Carrier – Rep. Weisz

Date: 4-23-09

Roll Call Vote #: _____

2009 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2332 as (re) engrossed

Senate Human Services Committee

☒ Check here for **Conference Committee**

Action Taken
- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House Amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ pages(s) _____--_____

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

Motion Made By _____ Seconded By _____

Senators				Yes	No		Representatives				Yes	No
Senator Dever	P						**Rep. Weisz**	P				
Senator J. Lee	P						**Rep. Skarphol**	P				
Senator Robinson	P						**Rep. Holman**	P				

Vote Count _____ Yes _____ No _____ Absent

Senate Carrier _____ **House Carrier** _____

LC NO._____._____ of amendment

LC NO._____._____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

Date: 4-27-09

Roll Call Vote #: _____

2009 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2332 as (re) engrossed

Senate Human Services Committee

☒ Check here for **Conference Committee**

Action Taken
- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House Amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ pages(s) _____--_____

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

Motion Made By _____ Seconded By _____

Senators				Yes	No		Representatives				Yes	No
Senator Dever	P						**Rep. Weisz**	P				
Senator J. Lee	P						**Rep. Skarphol**	P				
Senator Robinson	P						**Rep. Holman**	P				

Vote Count _____ Yes _____ No _____ Absent

Senate Carrier _____ **House Carrier** _____

LC NO._____._____ of amendment

LC NO._____._____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

Date: 4-29-09

Roll Call Vote #: _____

2009 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2332 as (re) engrossed

Senate Human Services Committee

☒ Check here for **Conference Committee**

Action Taken
- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House Amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ pages(s) _____--_____

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

Motion Made By _____ Seconded By _____

Senators				Yes	No		Representatives				Yes	No
Senator Dever	P						**Rep. Weisz**	P				
Senator J. Lee	P						**Rep. Skarphol**	P				
Senator Robinson	P						**Rep. Holman**	P				

Vote Count _____ Yes _____ No _____ Absent

Senate Carrier _____ **House Carrier** _____

LC NO._____._____ of amendment

LC NO._____._____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

Date: 4-30-09

Roll Call Vote #: _____

2009 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2332 as (re) engrossed

Senate Human Services Committee

☒ Check here for **Conference Committee**

Action Taken
- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House Amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ pages(s) _____--_____

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

Motion Made By _____ Seconded By _____

Senators				Yes	No		Representatives				Yes	No
Senator Dever	P						**Rep. Weisz**	P				
Senator J. Lee	P						**Rep. Skarphol**	P				
Senator Robinson	P						**Rep. Holman**	P				

Vote Count _____ Yes _____ No _____ Absent

Senate Carrier _____ **House Carrier** _____

LC NO._____._____ of amendment

LC NO._____._____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

Adopted by the Conference Committee
April 30, 2009

5-1-9
1 of 5

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

That the House recede from its amendments as printed on pages 1258-1260 of the Senate Journal and pages 1126 and 1127 of the House Journal and that Engrossed Senate Bill No. 2332 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact two new sections to chapter 6-09 and three new sections to chapter 54-59 of the North Dakota Century Code, relating to Bank of North Dakota loan funds for health information technology, the creation of a health information technology advisory committee and a health information technology office, and to health information exchange grants; to repeal section 23-01-31 of the North Dakota Century Code, relating to the North Dakota health information technology steering committee; to provide an appropriation; to provide for transfers; to provide for a report to the budget section and the legislative council; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology loan fund - Appropriation.

1. The health information technology loan fund is established in the Bank for the purpose of providing loans to health care providers to purchase and upgrade electronic health record technology, train personnel in its use, improve security of information exchange, and for other purposes as established by the health information technology office, in collaboration with the health information technology advisory committee. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care providers as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology office director under section 4 of this Act. A loan made under this fund must be repayable over a period that may not exceed ten years.

3. The Bank shall administer the health information technology loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may take a subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 2. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology planning loan fund - Appropriation.

1. The health information technology planning loan fund is established in the Bank for the purpose of providing low-interest loans to health care entities to assist those entities in improving health information technology infrastructure. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care entities as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology director under section 4 of this Act.

3. The Bank shall administer the health information technology planning loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may make a loan subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 3. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology advisory committee - Duties.

1. The health information technology advisory committee consists of the state chief information officer or the chief information officer's designee, the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and individuals appointed by the governor and the state health officer to represent a broad range of public and private health information technology stakeholders.

2. The health information technology advisory committee shall collaborate with and make recommendations to the health information technology office, as provided under sections 1, 2, 4, and 5 of this Act.

3. As requested by the health information technology advisory committee, the department shall provide or arrange for administrative services to assist the health information technology advisory committee.

4. The health information technology advisory committee may employ an executive director who serves at the pleasure of and under the direct supervision of the health information technology advisory committee. The executive director may employ personnel as necessary for the administration of this section.

SECTION 4. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health Information technology office - Duties - Loan and grant programs.

1. The health information technology office is created in the department. The health information technology advisory committee shall make recommendations to the health information technology office for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards; promote the adoption and use of electronic health records and other health information technologies; and promote interoperability of health information systems for the purpose of improving health care quality, patient safety, and the overall efficiency of health care and public health services.

2. The health information technology office director, in collaboration with the health information technology advisory committee, shall:

   a. Apply for federal funds that may be available to assist the state and health care providers in implementing and improving health information technology.

   b. Establish a health information technology loan program to provide loans to health care providers for the purpose of purchasing and upgrading certified electronic health record technology, training personnel in the use of such technology, and improving the secure electronic exchange of health information, and for any other purpose under section 1 of this Act.

   c. Establish a health information technology planning loan program to provide low-interest loans to health care entities to assist those entities in improving their health information technology infrastructure under section 2 of this Act.

   d. Facilitate and expand electronic health information exchange in the state, directly or by awarding grants.

e. Establish an application process and eligibility criteria for and accept and process applications for loans and grants under subdivisions b, c, and d. The eligibility criteria must be consistent with federal requirements associated with federal funds received under subdivision a. The eligibility criteria for loans under subdivision c must include a requirement that the recipient's approved health information technology be strategically aligned with the state's health information technology plan and the associated federal standards and that the recipient has passed an onsite electronic medical record readiness assessment conducted by an assessment team determined by the health information technology advisory committee and the health information technology office director.

SECTION 5. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Electronic health information exchange fund.

1. There is created an electronic health information exchange fund. The fund consists of moneys deposited in the fund from federal or other sources or moneys transferred into the fund as directed by the legislative assembly. The health information technology office shall administer this fund and shall distribute moneys in the fund accordingly. The moneys in the fund must be used to facilitate and expand electronic health information exchange. Moneys in the fund may be used, subject to legislative appropriations, to provide services directly, for grants as provided under this section, and for the costs of administration of the fund.

2. A grant applicant shall submit an application to the health information technology office, which shall determine the applicant's eligibility based upon criteria established by the health information technology office director in collaboration with the health information technology advisory committee.

3. This section does not create an entitlement to any funds available for grants under this section. The health information technology office may award these grants to the extent funds are available and, within the office's discretion, to the extent such applications are approved.

SECTION 6. REPEAL. Section 23-01-31 of the North Dakota Century Code is repealed.

SECTION 7. HEALTH INFORMATION TECHNOLOGY OFFICE AND HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE - REPORT TO LEGISLATIVE COUNCIL AND BUDGET SECTION. During the 2009-10 interim, the health information technology office and health information technology advisory committee shall provide periodic reports to the legislative council and the budget section on the status of health information technology activities.

SECTION 8. BANK OF NORTH DAKOTA TRANSFERS. The industrial commission shall transfer, during the period beginning with the effective date of this Act and ending June 30, 2011, as requested by the health information technology office director, up to $8,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology loan fund to meet any required match for federal funds or to the electronic health information exchange fund to meet any required match for federal funds or as directed, a portion to both funds to meet any required match for federal funds. The health information technology office director shall request fund transfers from the Bank only as necessary to comply with federal requirements and to meet cash flow needs of the funds.

SECTION 9. CONTINGENT BANK OF NORTH DAKOTA TRANSFER. If actual general fund revenues for the period July 1, 2009, through September 30, 2009, exceed estimated general fund revenues for that period by at least $22,500,000, as determined by the office of management and budget, based on the legislative estimates made at the close of the 2009 legislative session and upon certification by the health information technology office director to the director of the office of management and budget of a demonstrated need for health information technology planning loans, the industrial commission shall transfer, as requested by the health information technology office director, up to $5,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology planning loan fund, for the biennium beginning July 1, 2009, and ending June 30, 2011. The health information technology office director shall request transfers from the Bank only as necessary to meet cash flow needs of the fund.

SECTION 10. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $350,000, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the costs of the health information technology advisory committee and the health information technology office, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 11. APPROPRIATION. There is appropriated out of any moneys in the electronic health information exchange fund, not otherwise appropriated, the sum of $88,000,000, or so much of the sum as may be necessary, including up to $80,000,000 of federal funds deposited in the fund from the federal American Recovery and Reinvestment Act of 2009 to the information technology department for the purposes established under section 5 of this Act, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 12. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: 5-1-09

Roll Call Vote #: _____

2009 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2332 as (re)engrossed

Senate Human Services Committee

☒ Check here for **Conference Committee**

Action Taken
- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House Amendments
- ☒ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ pages(s) 1258 -- 1260

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) 2332 was placed on the Seventh order of business on the calendar.

Motion Made By Rep. Skarphol Seconded By Rep. Weisz

Senators				Yes	No		Representatives				Yes	No
Senator Dever	P			✓			**Rep. Weisz**	P			✓	
Senator J. Lee	P			✓			**Rep. Skarphol**	P			✓	
Senator Robinson	P			✓			**Rep. Holman**	P			✓	

Vote Count 6 Yes 0 No 0 Absent

Senate Carrier Senator J. Lee **House Carrier** Rep. Weisz

LC NO. 90948 . 0214 of amendment

LC NO. _____ . _____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

REPORT OF CONFERENCE COMMITTEE

SB 2332, as engrossed: Your conference committee (Sens. Dever, J. Lee, Robinson and Reps. Weisz, Skarphol, Holman) recommends that the **HOUSE RECEDE** from the House amendments on SJ pages 1258-1260, adopt amendments as follows, and place SB 2332 on the Seventh order:

That the House recede from its amendments as printed on pages 1258-1260 of the Senate Journal and pages 1126 and 1127 of the House Journal and that Engrossed Senate Bill No. 2332 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact two new sections to chapter 6-09 and three new sections to chapter 54-59 of the North Dakota Century Code, relating to Bank of North Dakota loan funds for health information technology, the creation of a health information technology advisory committee and a health information technology office, and to health information exchange grants; to repeal section 23-01-31 of the North Dakota Century Code, relating to the North Dakota health information technology steering committee; to provide an appropriation; to provide for transfers; to provide for a report to the budget section and the legislative council; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology loan fund - Appropriation.

1. The health information technology loan fund is established in the Bank for the purpose of providing loans to health care providers to purchase and upgrade electronic health record technology, train personnel in its use, improve security of information exchange, and for other purposes as established by the health information technology office, in collaboration with the health information technology advisory committee. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care providers as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology office director under section 4 of this Act. A loan made under this fund must be repayable over a period that may not exceed ten years.

3. The Bank shall administer the health information technology loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank,

the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may take a subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 2. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology planning loan fund - Appropriation.

1. The health information technology planning loan fund is established in the Bank for the purpose of providing low-interest loans to health care entities to assist those entities in improving health information technology infrastructure. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care entities as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology director under section 4 of this Act.

3. The Bank shall administer the health information technology planning loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may make a loan subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 3. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology advisory committee - Duties.

1. The health information technology advisory committee consists of the state chief information officer or the chief information officer's designee, the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and individuals appointed by the governor and the state health officer to represent a broad range of public and private health information technology stakeholders.

2. The health information technology advisory committee shall collaborate with and make recommendations to the health information technology office, as provided under sections 1, 2, 4, and 5 of this Act.

3. As requested by the health information technology advisory committee, the department shall provide or arrange for administrative services to assist the health information technology advisory committee.

4. The health information technology advisory committee may employ an executive director who serves at the pleasure of and under the direct supervision of the health information technology advisory committee. The executive director may employ personnel as necessary for the administration of this section.

SECTION 4. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Duties - Loan and grant programs.

1. The health information technology office is created in the department. The health information technology advisory committee shall make recommendations to the health information technology office for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards; promote the adoption and use of electronic health records and other health information technologies; and promote interoperability of health information systems for the purpose of improving health care quality, patient safety, and the overall efficiency of health care and public health services.

2. The health information technology office director, in collaboration with the health information technology advisory committee, shall:

   a. Apply for federal funds that may be available to assist the state and health care providers in implementing and improving health information technology.

   b. Establish a health information technology loan program to provide loans to health care providers for the purpose of purchasing and upgrading certified electronic health record technology, training personnel in the use of such technology, and improving the secure electronic exchange of health information, and for any other purpose under section 1 of this Act.

c. Establish a health information technology planning loan program to provide low-interest loans to health care entities to assist those entities in improving their health information technology infrastructure under section 2 of this Act.

d. Facilitate and expand electronic health information exchange in the state, directly or by awarding grants.

e. Establish an application process and eligibility criteria for and accept and process applications for loans and grants under subdivisions b, c, and d. The eligibility criteria must be consistent with federal requirements associated with federal funds received under subdivision a. The eligibility criteria for loans under subdivision c must include a requirement that the recipient's approved health information technology be strategically aligned with the state's health information technology plan and the associated federal standards and that the recipient has passed an onsite electronic medical record readiness assessment conducted by an assessment team determined by the health information technology advisory committee and the health information technology office director.

SECTION 5. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Electronic health information exchange fund.

1. There is created an electronic health information exchange fund. The fund consists of moneys deposited in the fund from federal or other sources or moneys transferred into the fund as directed by the legislative assembly. The health information technology office shall administer this fund and shall distribute moneys in the fund accordingly. The moneys in the fund must be used to facilitate and expand electronic health information exchange. Moneys in the fund may be used, subject to legislative appropriations, to provide services directly, for grants as provided under this section, and for the costs of administration of the fund.

2. A grant applicant shall submit an application to the health information technology office, which shall determine the applicant's eligibility based upon criteria established by the health information technology office director in collaboration with the health information technology advisory committee.

3. This section does not create an entitlement to any funds available for grants under this section. The health information technology office may award these grants to the extent funds are available and, within the office's discretion, to the extent such applications are approved.

SECTION 6. REPEAL. Section 23-01-31 of the North Dakota Century Code is repealed.

SECTION 7. HEALTH INFORMATION TECHNOLOGY OFFICE AND HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE - REPORT TO LEGISLATIVE COUNCIL AND BUDGET SECTION. During the 2009-10 interim, the health information technology office and health information technology advisory committee shall provide periodic reports to the legislative council and the budget section on the status of health information technology activities.

SECTION 8. BANK OF NORTH DAKOTA TRANSFERS. The industrial commission shall transfer, during the period beginning with the effective date of this Act and ending June 30, 2011, as requested by the health information technology office director, up to $8,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology loan fund to meet any required match for federal funds or to the electronic health information exchange fund to meet any required match for federal funds or as directed, a portion to both funds to meet any required match for federal funds. The health information technology office director shall request fund transfers from the Bank only as necessary to comply with federal requirements and to meet cash flow needs of the funds.

SECTION 9. CONTINGENT BANK OF NORTH DAKOTA TRANSFER. If actual general fund revenues for the period July 1, 2009, through September 30, 2009, exceed estimated general fund revenues for that period by at least $22,500,000, as determined by the office of management and budget, based on the legislative estimates made at the close of the 2009 legislative session and upon certification by the health information technology office director to the director of the office of management and budget of a demonstrated need for health information technology planning loans, the industrial commission shall transfer, as requested by the health information technology office director, up to $5,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology planning loan fund, for the biennium beginning July 1, 2009, and ending June 30, 2011. The health information technology office director shall request transfers from the Bank only as necessary to meet cash flow needs of the fund.

SECTION 10. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $350,000, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the costs of the health information technology advisory committee and the health information technology office, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 11. APPROPRIATION. There is appropriated out of any moneys in the electronic health information exchange fund, not otherwise appropriated, the sum of $88,000,000, or so much of the sum as may be necessary, including up to $80,000,000 of federal funds deposited in the fund from the federal American Recovery and Reinvestment Act of 2009 to the information technology department for the purposes established under section 5 of this Act, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 12. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Engrossed SB 2332 was placed on the Seventh order of business on the calendar.

2009 TESTIMONY

SB 2332

#1

Human Services Committee

January 27, 2009

Senator Lee and Committee Members:

Thank you for the opportunity to speak with you today regarding health information technology and SB2332. I am Kimber Wraalstad, President/CEO of Presentation Medical Center in Rolla and a member of the North Dakota Health Information Technology Steering Committee.

I would like to speak to four issues:

1. Impact of Health Information Technology to Patient Care

2. Cost of Health Information Technology

3. Bottineau/Rolla/Stanley and Northwest Alliance for Information Technology Projects

4. The Rationale for the Proposed Grant

Thank you for your consideration and I will be happy to address any questions.

Modules
Dairyland Healthcare Solutions
Northwest Alliance for Information Technology

		Rolla	Bottineau	Stanley	Tioga	Watford City	Crosby	Kenmare	Harvey	Rugby	Cando
# of Hospital Beds		25	25	11	25	24	25	25	25	38	20
Applications	**Retail Price**										
Base System Software	$172,400	Owns	Owns	Owns	Owns	$172,400	$172,400	$172,400	Owns	Owns	Owns
Archiver	$7,750	Owns	Owns	Owns	Owns	$7,750	$7,750	$7,750	Owns	Owns	Owns
Admit Labels and Wristbands	$2,500	Owns	Owns	$2,500	Owns	$2,500	$2,500	$2,500	Owns	Owns	Owns
Chart Locator / Deficiency	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	Owns	$12,000
Executive Reporting	$8,500	Owns	Owns	$8,500	$8,500	$8,500	$8,500	$8,500	Owns	Owns	$8,500
Materials Management	$21,000	$21,000	Owns	Owns	Owns	$21,000	$21,000	$21,000	Owns	Owns	Owns
Personnel	$10,500	Owns	Owns	$10,500	Owns	$10,500	$10,500	$10,500	Owns	Owns	Owns
Release of Information	$9,355	$9,355	$9,355	Owns	$9,355	$9,355	$9,355	$9,355	$9,355	Owns	$9,355
ERA's 3 Payors	$19,295	$19,295	$19,295	$19,295	$19,295	$19,295	$19,295	$19,295	$19,295	Owns	Owns
Forms Express	$20,900	Owns	$20,900	Owns	Owns	$20,900	$20,900	$20,900	Owns	Owns	Owns
Physician Practice Management	$58,500	$58,500	Owns	$58,500	Owns	$58,500	$58,500	$58,500	Owns	$58,500	Owns
Scheduler	$28,250	$28,250	$28,250	$28,250	$28,250	$28,250	$28,250	$28,250	$28,250	Owns	Owns
Financial Scanning	$27,000	Owns	Owns	$27,000	Owns	$27,000	$27,000	$27,000	$27,000	Owns	$27,000
Encoder Interface	$4,500	$4,500	$4,500	$4,500	$4,500	$4,500	$4,500	$4,500	$4,500	Owns	$4,500
Long Term Care	$31,800	$31,800	$31,800	$31,800	Owns Training	$31,800	$31,800	$31,800	Owns Training	Owns	Owns Training
Clinical Applications											
Clin Doc	$68,200	$68,200	$68,200	$68,200	$68,200	$68,200	$68,200	$68,200	$68,200	Owns	$68,200
Laboratory	$63,800	Owns	Owns	$63,800	$63,800	$63,800	$63,800	$63,800	$63,800	Owns	$63,800
Order Communication	$63,800	Owns	Owns	$63,800	$63,800	$63,800	$63,800	$63,800	$63,800	Owns	$63,800
Pharmacy	$38,505	Owns	Owns	$38,505	$38,505	$38,505	$38,505	$38,505	$38,505	Owns	$35,505
On Line MAR	$16,200	Owns	Owns	$16,200	$16,200	$16,200	$16,200	$16,200	$16,200	Owns	$16,200
Physician Access	$26,100	$26,100	$26,100	$26,100	$26,100	$26,100	$26,100	$26,100	$26,100	Owns	$26,100
Radiology	$23,200	$23,200	$23,200	$23,200	$23,200	$23,200	$23,200	$23,200	$23,200	Owns	$23,200
Transcription	$11,600	Owns	Owns	$11,600	$11,600	$11,600	$11,600	$11,600	$11,600	Owns	$11,600
Long Term Care Documentation	$21,200	$21,200	$21,200	$21,200	$21,200	$21,200	$21,200	$21,200	$21,200	Owns	$21,200
Physician Practice Documentation	$67,400	$67,400	$67,400	$67,400	$67,400	$67,400	$67,400	$67,400	$67,400	$67,400	$67,400
Patient Care Instructions	$5,200	$5,200	$5,200	$5,200	$5,200	$5,200	$5,200	$5,200	$5,200	Owns	$5,200
Clinical Scanning	$17,000	Owns	Owns	$17,000	$17,000	$17,000	$17,000	$17,000	$17,000	$17,000	$17,000
	$856,455	$396,000	$337,400	$625,050	$504,105	$856,455	$856,455	$856,455	$522,605	$142,900	$480,560
Annual Maintenance	$94,210	$43,560	$37,114	$68,756	$55,452	$94,210	$94,210	$94,210	$57,487	$15,719	$52,862

Total Software Price $5,577,985

Total Annual Maintenance $613,578

Pricing Effective 01-2009

Same handout given to Senate Approp.

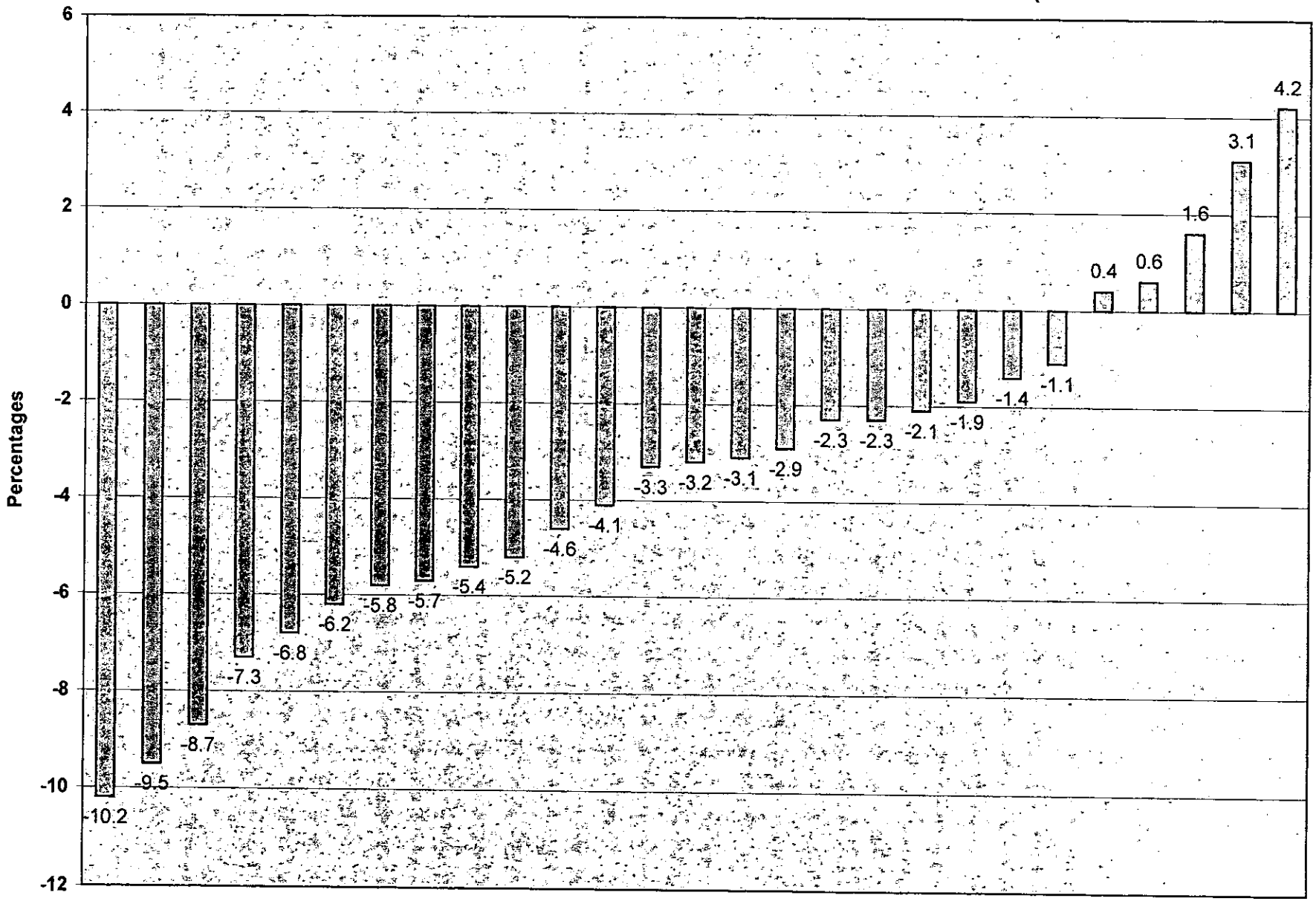
Same given to Senate Approp.

North Dakota Critical Access Hospitals

- Provide Services in Rural Areas
- Often the Hub of Local Healthcare Services Provided
- Contribute to the Economic Vitality of the Community
- 27 CAH Facilities Participated in a Financial Analysis
  - 22 of 27 CAH's Reported an Operating Loss in 2007
  - Median Operating Loss was -3.4% or -$263,000
  - No Funds are Available for Infrastructure/Equipment
  - Status of the Rural Healthcare Network is Fragile

North Dakota Critical Access Hospitals
2007 Operating Margins

Same handout given to Senate Approp.



Health Information exchange (HIE)

Definition: The mobilization of health information electronically across organizations *within a region or community*. HIE provides the capability to electronically *move clinical information between disparate health care information systems* while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable and patient-centered care.

Electronic Medical Records (EMRs) from different facilities may not be able to share data without a work and planning from both the technical side and the operational side. Some issues are listed below.

Technical considerations

- The EMRs must have some minimal predefined functionality and have the capability to send and receive data using established standards
- If there is no unique person identifier, it may be difficult to identify a patient across different organizations' EMRs
- Unless the data (i.e. drugs, tests, allergies, etc.) is standardized, much of the information contained in one facility's EMR would be meaningless to another facility's EMR even if both facilities have a system from the same vendor

Other considerations

- A structure or organization will be required to:
  - Administer access to the records
  - Follow up if an unauthorized access complaint is received
  - Oversee day to day activities
- Procedures may need to be defined to support the patient's ability to opt in or opt out (from participation in the HIE) or restrict access to parts of their medical record
- There may be substantial startup costs

Prepared by Alan Okerson, Director of Information Technology, Trinity Health, Minot ND on behalf of the North Dakota Health Information Technology Committee

Electronic Medical Records (EMR)

Definition(s): A computer-accessible resource of medical and administrative information available on an individual collected from and accessible by providers involved in the individual's care *within a single care setting.*

National Alliance for Health Information Technology

An application environment composed of the clinical data repository, clinical decision support, controlled medical vocabulary, order entry, computerized provider order entry, pharmacy, and clinical documentation applications. This environment supports the patient's electronic medical record across inpatient and outpatient environments, and is used by healthcare practitioners to document, monitor, and manage health care delivery within a care delivery organization (CDO). The data in the EMR is the legal record of what happened to the patient during their encounter at the CDO and is owned by the CDO.

HIMSS Analytics Database

Features of an EMR

- The patient's information is in one place
- Based on role and need, access to information is secured
- Information available to multiple care givers at one time wherever they may be
- Information may be entered in real time so the record is kept up to date
- Availability of patient history
    - Previous visits
    - Drugs
    - Allergies
    - Test results
    - Radiology images
    - Etc.
- Treatment guidelines can be provided to assist providers
- Orders entered electronically and appropriate care givers notified
- Drug to drug and drug to allergy interaction alerts
- Immediate notification of appropriate staff of orders placed
- Test results immediately available
- Because all information is available from multiple visits to multiple providers, duplicate tests are reduced or eliminated
- May contain discrete data that can be used for trending and reporting

Not all EMR systems are created equal and may have only some of the above capabilities.

Connecting North Dakota for a Healthier Future

2009

North Dakota
Health Information Technology

About HIT

What is health information technology (HIT)?

HIT is a method of managing health information electronically, rather than traditional paper records and charts. HIT gathers health information in one place so providers can thoroughly understand and easily access it. HIT is often used interchangeably with:

- electronic medical records (EMR)
- electronic health records (EHR)
- health information exchange (HIE)

How can HIT be used?

HIT can improve the efficiency, safety and quality of care that patients receive by making patient information easily accessible across providers.

HIT in North Dakota

- Rural hospitals and clinics lag behind urban facilities in adopting HIT, creating an urban/rural divide across North Dakota health care system.
- Health professions students strongly prefer practicing in clinical environments supported by HIT.
- Telemedicine (the provision of clinical services via telephone, the Internet, or other networks) adoption across ND is limited.

What is the North Dakota HIT Steering Committee?

- Legislatively created in 2007, the committee works to facilitate the adoption and use of health information technology and exchange to improve health care quality, patient safety and overall efficiency of health care and public health services in North Dakota.

Recommendations for improving HIT in North Dakota:

- Create a state-funded grant or loan program to support rural and public health entities in the implementation of health information technology-driven quality improvement programs.
- Develop a North Dakota Strategic Plan for implementing and sustaining a statewide electronic health information exchange.
- Develop health information technology training programs to build human resource capacity.
- Implement a peer-to-peer HIT support program for rural health care provider organizations.
- Sponsor rotating rural HIT technical support team to assist organizations that do not have the necessary staff to implement HIT projects.
- Create a formal organization within the state charged with coordinating HIT efforts and potentially governing a health information exchange initiative.

Lynette Dickson, MS, LRD, Chair, ND Health Information Technology Steering Committee
Center for Rural Health • University of North Dakota School of Medicine & Health Sciences
701-777-6049 • ldickson@medicine.nodak.edu
website: http://ruralhealth.und.edu/projects/sorh/hit.php

Who is involved with the Steering Committee?

The HIT Steering Committee is a statewide collaborative involving 22 public and private members committed to strengthening statewide HIT initiatives. There are five work groups, with 48 members representing 44 organizations, which report to the Steering Committee. Members include providers, academic institutions, state representatives, and public and private organizations.

What does the Steering Committee do?

- Assess the overall HIT environment in North Dakota.
- Engage with leadership from other state HIT and HIE initiatives.
- Assess current state laws and standards for exchanging health information.
- Identify and disseminate new funding sources and track information planning and implementation projects in the state.

How are the activities of the Steering Committee funded?

The Steering Committee was authorized but not funded by state government. Statewide activities have been supported financially through Blue Cross Blue Shield of North Dakota and in-kind contributions from committee members. Additionally, the majority of support is provided by federally funded grants through HRSA's Office of Rural Health Policy, administered by the UND Center for Rural Health through the following:

- State Office of Rural Health Grant Program
- Small Hospital Improvement Program
- Medicare Rural Hospital Flexibility Grant Program

ND HIT Report
Connecting North Dakota for a Healthier Future, Dec. 2008.
ruralhealth.und.edu/projects/sorh/ndhitreport.pdf

FACTS ABOUT HEALTH INFORMATION TECHNOLOGY IN NORTH DAKOTA

Who has Electronic Medical Records (EMR) in North Dakota?

- **Urban Hospitals** – 6 (100%)
- **Rural Hospitals** – 14 (38%)
- **Primary Care Clinics** – 44 (47%)
- **Local Public Health Units** – 4 (16%)
- **Long Term Care Facilities** – 10 (23%)

Students in medicine, clinical laboratory science, and radiology technology indicate that technology is extremely or very important when selecting a place of employment.

Top two uses of **telemedicine** in hospitals: videoconferencing (e.g. meetings) and teleradiology.

Most ND health care facilities indicate:

- The most significant barrier to implementing EMRs is lack of funding and current reimbursement.
- The most significant reasons to implement HIT are to improve quality of health care and patient safety.

Connecting North Dakota for a Healthier Future

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Center *for* Rural Health

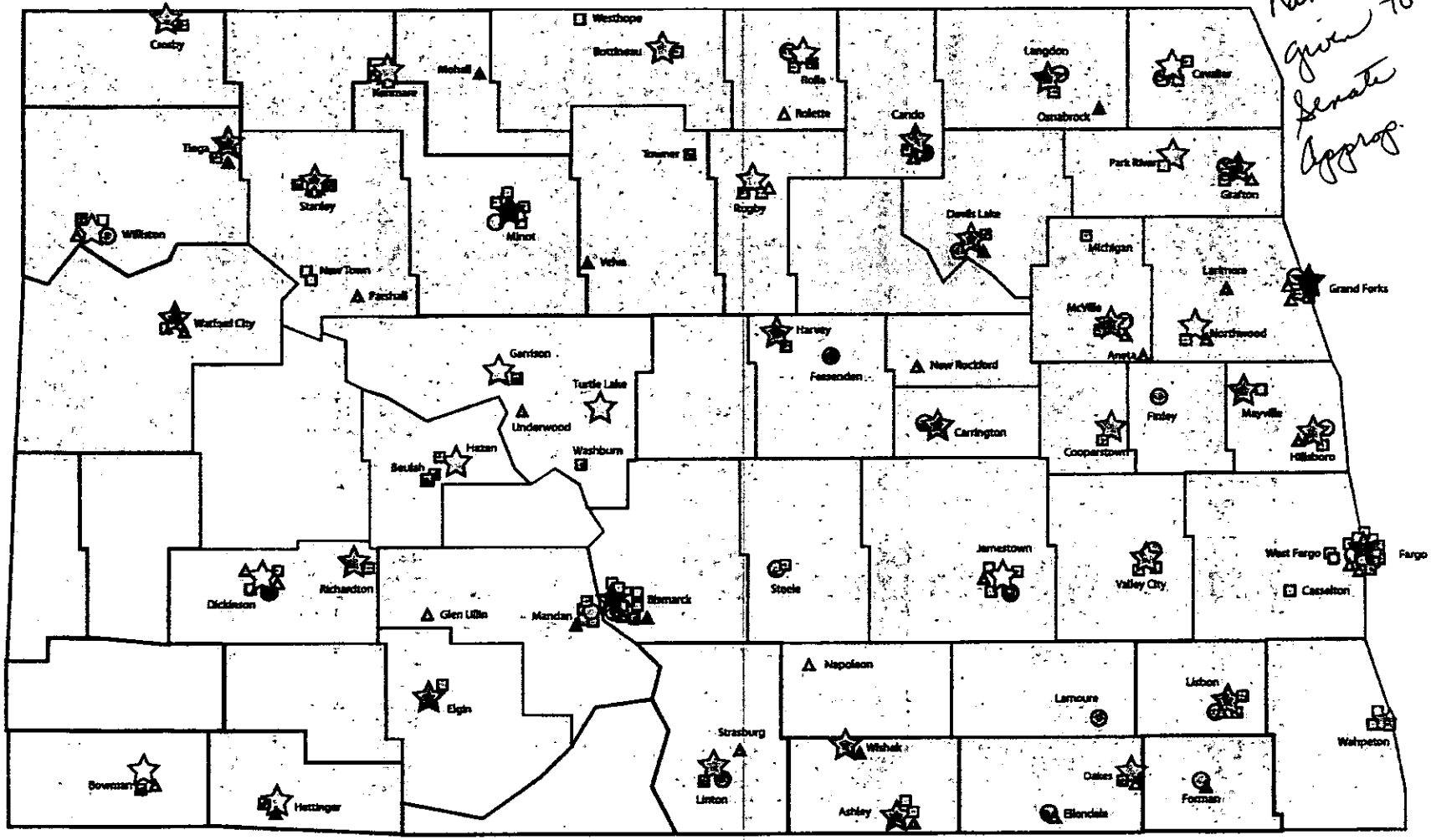
University of North Dakota
School of Medicine and Health Sciences

Electronic Medical Records (EMR) in North Dakota

August 2008

Connecting North Dakota for a Healthier Future (December 2008)
http://ruralhealth.und.edu/projects/sorh/pdf/state_hit_report.pdf

Same handout given to Senate Approp.



- Rural Hospitals with an EMR
- Urban Hospitals with an EMR
- Rural Hospitals without an EMR
- Primary Care Clinics with an EMR
- Primary Care Clinics without an EMR
- Long Term Care Facilities with an EMR
- Long Term Care Facilities without an EMR
- Public Health Units with CMS (electronic Client Management System)
- Public Health Units without CMS

- Bismarck referral area
- Fargo referral area
- Grand Forks referral area
- Minot referral area

Bism[redacted] Referral Area

Urban Hospitals with an EMR
Bismarck, MedCenter One
Bismarck, St. Alexius Medical Center
Rural Hospitals with an EMR
Bowman, Southwest Healthcare Services
Dickinson, St. Joseph's Hospital
Garrison, Garrison Memorial
Hazen, Sakakawea Medical Center
Hettinger, West River Regional Medical Center
Turtle Lake, Turtle Lake Community Hospital
Rural Hospital without an EMR
Ashley, Ashley Medical Center
Carrington, Carrington Health Center
Elgin, Jacobson Memorial Hospital Care Center
Harvey, St. Aloisus Medical Center
Linton, Linton Hospital
Richardton, Memorial Hospital and Health Center
Wishek, Wishek Hospital Clinic Association
Clinics with an EMR
Bismarck, Bismarck Family Clinic South
Bismarck, Bismarck Health Center
Bismarck, Medcenter One Family Medical Center North
Bismarck, Mid Dakota Clinic
Bismarck, Mid Dakota Clinic Gateway
Bismarck, Mid Dakota Clinic Kirkwood
Bismarck, St. Alexius Medical Center
Dickinson, Great Plains Clinic
Mandan, Q & R Clinic Mandan East
Mandan, Q & R Clinic Mandan North
Mandan, St. Alexius Center for Family Medicine
Clinics without an EMR
Ashley, Ashley Clinic
Ashley, Ashley Medical Center
Beulah, Coal Country Community Health Center
Beulah, Sakakawea Beulah Clinic
Bismarck, Center for Family Med-Bismarck
Bismarck, Center for Family Medicine-Bismarck
Bismarck, Jay R Huber DO PC
Bowman, Southwest Medical Clinic
Carrington, Foster County Medical Center
Dickinson, Adult Medicine of Dickinson
Elgin, Elgin Community Clinic
Garrison, Garrison Family Clinic
Harvey, Central Dakota Clinic
Hazen, Sakakawea Hazen Clinic
Hettinger, West River Health Clinics
Linton, Linton Medical Center
Mandan, Regional Medical Center
Richardton, Richardton Health Center Clinic
Steele, Kidder County Community Health Clinic
Washburn, Washburn Family Clinic
Public Health Units with a CMS
Mandan, Custer Health
Public Health Units without a CMS
Bismarck, Bismarck Burleigh Public Health
Carrington, Foster County District Health
Dickinson, Southwestern District Health Unit
Fessenden, Wells County District Health Unit
Linton, Emmons County Public Health
Steele, Kidder County District Health Unit
Long Term Care Facilities with an EMR
Bowman, Southwest Healthcare Services
Dickinson, St. Benedict's Health Center
Glen Ullin, Mariam Manor Healthcare Center
Long Term Care Facilities without an EMR
Ashley, Ashley Medical Center
Bismarck, Missouri Slope Lutheran Care Center, Inc
Dickinson, St. Luke's Home
Hettinger, Western Horizons Living Center
Mandan, Dakota Alpha
Napoleon, Napoleon Care Center
Strasburg, Strasburg Care Center
Underwood, Medcenter One Prairieview
Wishek, Wishek Home for the Aged

Fargo Referral Area

Urban Hospitals with an EMR
Fargo, Innovis Health
Fargo, MeritCare Health System
Rural Hospitals with an EMR
Jamestown, Jamestown Hospital
Rural Hospitals without an EMR
Cooperstown, Cooperstown Medical Center
Hillsboro, Hillsboro Medical Center
Lisbon, Lisbon Area Health Services
Mayville, Union Hospital
Oakes, Oakes Community Hospital
Valley City, Mercy Medical Center
Clinics with an EMR
Casselton, Dakota Clinic Ltd. Casselton
Fargo, Dakota Clinic Ltd.
Fargo, Dakota Clinic Ltd. Northport
Fargo, Dakota Clinic West Acres
Fargo, Meritcare Clinic North Fargo
Fargo, Meritcare Hospital
Fargo, MeritCare Internal Medicine Resident Clinic
Fargo, Meritcare Island Park
Fargo, MeritCare Southpointe
Hillsboro, Meritcare Clinic Hillsboro
Jamestown, Dakota Clinic Ltd. Jamestown
Jamestown, Medcenter One Jamestown
Jamestown, Meritcare Clinic Jamestown
Lisbon, Dakota Clinic Ltd. Lisbon
Mayville, Meritcare Clinic Mayville
Valley City, Dakota Clinic Ltd. Valley City
Valley City, Meritcare Clinic Valley City
Wahpeton, Dakota Clinic Ltd. Wahpeton
Wahpeton, Meritcare Clinic Wahpeton
West Fargo, Dakota Clinic West Fargo
West Fargo, Meritcare Clinic West Fargo
Clinics without an EMR
Cooperstown, Cooperstown Medical Center Clinic
Fargo, Family Healthcare Center
Fargo, Internal Medicine Assoc Ltd.
Lisbon, Family Medical Clinic
Oakes, Southeast Medical Center
Wahpeton, Medical Arts Clinic
Public Health Units with a CMS
Fargo, Fargo Cass Public Health
Jamestown, Central Valley Health District
Public Health Units without a CMS
Ashley, McIntosh District Health Unit
Ellendale, Dickey County Health District
Finley, Steele County Public Health Department
Forman, Sargent County District Health Department
Hillsboro, Trail District Health Unit
LaMoure, LaMoure County Public Health Deparment
Lisbon, Ransom County Public Health Department
Valley City, City-County Health Department
Wahpeton, Richland County Health Department
Long Term Care Facilities with an EMR
Ellendale, Prince of Peace Care Center
Fargo, Elim – A Caring Community
Lisbon, ND Veterans Home
Wahpeton, St. Catherine's Living Center
Long Term Care Facilities without an EMR
Hillsboro, Hillsboro Medical Center
Fargo, American Lutheran Homes
Forman, Four Seasons Healthcare
Jamestown, Hi-Acres Manor
Oakes, Good Samaritan Society Oakes

Grand Forks Referral Area

Urban Hospitals with an EMR
Grand Forks, Altru Health System
Rural Hospitals with an EMR
Cavalier, Pembina County Memorial Hospital
Northwood, Northwood Deaconess Health Center
Park River, First Care Health Center
Rural Hospital without an EMR
Devils Lake, Mercy Hospital
Grafton, Unity Medical Center
Langdon, Cavalier County Memorial Hospital
McVille, Nelson County Health System
Clinics with an EMR
Cavalier, CliniCare
Park River, First Care Health Center
Clinics without an EMR
Cavalier, Altru Clinic-Cavalier
Devils Lake, Altru Clinic- Lake Region
Grafton, Grafton Family Clinic
Grand Forks, Altru Clinic Family Medicine Center
Grand Forks, Family Medicine Associates
Grand Forks, Grand Forks Family Med-Residency
Langdon, Cavalier County Memorial Hospital Clinic
McVille, Nelson County Health System Clinic
Michigan, Michigan Medical Community Clinic
Northwood, Valley Community Health Centers
Public Health Units without a CMS
Cavalier, Pembina County Health Department
Devils Lake, Lake Region District Health Unit
Grafton, Walsh County Health District
Grand Forks, County Public Health Department
Langdon, Cavalier County Health District
McVille, Nelson/Griggs District Health Unit
Long Term Care Facilities without an EMR
Aneta, Aneta Parkview Health Center
Devils Lake, Heartland Care Center
Grafton, Lutheran Sunset Home
Grand Forks, Valley Memorial Homes
Grand Forks, Woodside Village
Larimore, Good Samaritan Society Larimore
McVille, Nelson County Health System
New Rockford, Lutheran Home of the Good Shepherd
Northwood, Northwood Deaconess Health Center

Minot Referral Area

Urban Hospitals with an EMR
Minot, Trinity Health
Rural Hospitals with an EMR
Bottineau, St. Andrew's Health Center
Kenmare, Trinity Kenmare Community Hospital
Rolla, Presentation Medical Center
Rugby, Heart of America Medical Center
Williston, Mercy Medical Center
Rural Hospitals without an EMR
Cando, Towner County Medical Center
Crosby, St. Luke's Hospital
Stanley, Mountrail County Medical Center
Tioga, Tioga Medical Cener
Watford City, McKenzie County Healthcare System
Clinics with an EMR
Kenmare, Kenmare Health Center
Minot, St. Alexius Medical Clinic
Minot, Trinity Health Center- Medical Arts
Minot, Trinity Health Center-Town & Country
New Town, New Town Health Center
New Town, Trinity Community Clinic
Watford City, McKenzie County Clinic
Westhope, Trinity Community Clinic
Williston, Trinity Community Clinic
Clinics without an EMR
Bottineau, St. Andrew's Clinic
Cando, Towner County Medical Center Clinic
Crosby, Crosby Clinic
Minot, Center for Family Med- Minot
Minot, Center for Family Medicine-Minot
Rolla, Presentation Medical Center
Rolla, Rolla Clinic PC
Rugby, Heart of America Medical Center
Rugby, Johnson Clinic PC
Tioga, Tioga Medical Center Clinic
Towner, Johnson Clinic PC
Stanley, Mountrail County Medical Center Clinic
Stanley, Patels Medical Clinic
Williston, Craven Hagan Clinic Ltd.
Public Health Units with a CMS
Minot, First District Health Unit
Public Health Units without a CMS
Cando, Towner County Public Health District
Rolla, Rolette County Public Health District
Williston, Upper Missouri District Health Unity
Long Term Care Facilities with an EMR
Rugby, Heart of America Medical Center
Long Term Care Facilities without an EMR
Cando, Towner County Medical Center
Kenmare, Trinity Kenmare Community Hospital
Mohall, Good Samaritan Society-Mohall
Parshall, Good Samaritan Society, Rock View at Parshall
Rolette, Rolette Community Care Center
Stanley, Mountrail Bethel Home
Tioga, Tioga Medical Center
Velva, Souris Valley Care Center
Watford City, McKenzie County Healthcare Systems, Inc
Williston, Bethel Lutheran Home

More information: Lynette Dickson, Chair NDHIT Steering Committee, 701-777-6049 or ldickson@medicine.nodak.edu

#2

January 25, 2009

North Dakota
Health Information Technology

Connecting North Dakota for a healthier future

PROPOSED REQUEST for APPROPRIATION – 2009 Legislative Session

1) Establish the ND Health Information Technology (HIT) Office to be located within the ND Department of Health.

This DOH-HIT Office will exist to:

- Serve and maintain relationships with ND HIT Steering Committee (Advisory Committee) and other public and private partners for the purpose of insuring coordination of information systems planning, development, implementation and electronic exchange of information.
- Identify improvements in the management and use of public health and health care data to assess and improve the health status of North Dakota, through collaborative efforts.
- Serve as liaison between state agencies (e.g. DOH, DHS and ITD) and the HIT Steering Committee (Advisory Committee) and other
- Bridge gaps and link public health professional staff and clinical staff to the technology staff. The position assures linking internal and external partners around public health data and informatics issues to support better use of data to guide public health and health care practice.
- Provide oversight for administration of the grant program.

2) Create two positions to staff the ND HIT Office:

HIT Officer

This position reports to the State Medical Officer, Department of Health.

Knowledge, Skills and Ability:

This position is supervisory staff in the DOH- Health Information Technology Office and oversees the performance of the project assistant and support staff. This position will be leading a wide range of planning, assessment, policy development, and other activities related to informatics, the incumbent will be required to possess strong core planning skills, and informatics skills, including a working knowledge of the various planning methodologies for defining the needs for information system applications and the data standards necessary for HIT interoperability.

The incumbent is also required to be skilled in group facilitation, consensus-building, communications strategies, and translating complex HIT terms and concepts for non-IT staff.

This position must also have: strong interpersonal communication skills, with an ability to generate consensus among a variety of different perspectives; project management skills necessary to plan, organize and manage projects; and a high level of skill in the use of computers for data processing, presentations, and report writing. A sound understanding of public health, health care systems, health data, and health data standards is required. The incumbent must be able to work closely on teams and lead or participate in respectful joint decision-making.

Project Assistant

This position reports to the HIT Officer/Director

Knowledge, Skills and Ability:

- Knowledge and experience with grant program development, RFP and contracting processes.
- Excellent ability to organize and develop and accomplish short and long range goals and objectives.
- Excellent written and verbal communication skills in providing technical assistance.
- Ability to prepare and review reports and papers on the results of grant projects and other activities.

Direct operation of the DOH-HIT Office and administer grant program:
(Cost based on 24 months)
Personnel – Salary/Fringe (Based on 24 months): $247,322
HIT Officer/Director (100% FTE) and Project Assistant (50% FTE)
Operating (phone, travel, rent, printing, etc.): $26,250

Total DOH Administrative Cost: $273,726

3) Amend the existing statute to change the ND HIT Steering Committee (same members) to the ND HIT Advisory Group which will provide direction to the DOH-HIT Office and Grant Program.

4) Establish a Grant Program

Grant Program Title:
Improving Access, Quality and Patient Safety through Health Information Technology (HIT)
The overarching goal for this grant program is to improve access, quality and patient safety, through the effective adoption and implementation of electronic exchange of health information within and among health care facilities in a given region (e.g. electronic health records, regional health information exchange, telehealth, etc.).

Eligible health care entities: All rural health clinics and community health centers; hospitals; licensed nursing facilities; local public health units and nonprofit entities(with the purpose of providing health information exchange coordination governed by a representative and other providers of health or health care services) approved by the ND HIT Steering Committee.

All proposed grant projects will *require collaboration between three (at minimum) or more eligible health care entities which are not owned by any one entity.* The intent of the grant program is to facilitate the formation of collaborative efforts between distinct corporate entities.

Matching Funds: Grant funds shall be awarded on a 25% match basis for the total grant amount awarded. Applicants shall be required to provide 10% in the form of cash match and 15% in-kind match, such as staff or services.

Proposed Funding Period: July 1, 2009-June 30, 2011

Eligible Technology Solutions: All grantees will be required to purchase or upgrade new health IT products, that apply Healthcare Information Technology Standards Panel(HITSP) interoperability specifications and have Certification Commission for Health Information Technology (CCHIT) certification.

I. Readiness Assessment and Planning Grants:
Purpose: To support the structured planning activities that will prepare for successful adoption/implementation of technology solutions. Activities may include: initial stages of collaboration with partners, readiness assessment, development of education/training programs for healthcare professionals and staff, workflow analysis within individual health care facilities as well as between community/regional facilities, business planning, determining specific network HIT functions.
Total Number of Grants to be Funded: 20 *(Minimum of three facilities per grant)*
Amount of Each Grant: $45,000

Total Planning Grants Funded: $900,000

II. Implementation Grants
A. Electronic Medical Records (or related technology) **Implementation Projects**

Purpose: To support communities/networks who can clearly demonstrate they have completed a structured planning process and are in the position, at the time of submitting an application, to begin implementation of electronic health record, e-prescribing or other related technology.

Total Number of Grants to be Funded: 4 *(Minimum of three facilities per grant)*

Amount of Each Grant: $900,000

Total EMR Grants Funded: $3,600,000

B. Telehealth Implementation Pilot Projects

Purpose: To support communities/regions who can clearly demonstrate the completion of the planning and readiness phase and are in the position to begin implementation of a new or expanded telehealth program (e.g. teledialysis, telestroke, telemental health, etc.)

Total Number of Grants to be Funded: 3 *(Minimum of three facilities per grant)*

Amount of each Grant: $50,000

Total Telehealth Grants Funded:$150,000

III. Health Information Exchange(HIE) Collaborative Grants

Purpose: To support existing or newly established collaborative who can clearly demonstrate the completion of the planning and readiness phase and are in the position to begin to connect and facilitate the exchange of health information between eligible health care entities in a selected geographical region.

Total Number of Grants to be Funded: 2 *(Minimum of three facilities per grant)*

Amount of each Grant: $500,000

Total HIE Grants Funded: $1,000,000

Total Amount of Grants: $5,650,000

TOTAL APPROPRIATION $5,923,726

Definitions

Health Information Technology: The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing and use of healthcare information, data, and knowledge for communication and decision making.

Electronic medical record: An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Electronic health record: 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.

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

#3 Dan Ulmer #3 SB2332

JOB-CREATING INVESTMENTS IN HEALTH CARE

Health Information Technology Proposals in the Finance Committee. ***In addition to the provisions included in the Chairman's Mark, the Appropriations Committee Mark will include tandem policies addressing privacy of health information and additional funding through discretionary programs.*** The Finance proposals would:

1) Require the Health and Human Services (HHS) Secretary to implement an ongoing process for the development and adoption of health IT standards (for interoperability and minimum functionality), including the certification of systems as meeting those standards
2) Invest in the adoption and use of health IT systems by health care providers who serve Medicare and Medicaid patients
3) Beginning in 2011, providers participating in the Medicare program would be eligible for temporary bonus payments if they exhibit to the Secretary that they are meaningfully using a certified HIT system; those who do not eventually meaningfully use certified HIT would not receive full Medicare payments. Hardship exceptions would be available to providers who face significant barriers to adoption, such as limited access to the internet
4) Beginning in 2011, high-volume Medicaid providers would be eligible for a temporary payment to subsidize the adoption of a certified HIT system. Also beginning in 2011, high-volume Medicaid providers who meaningfully use certified HIT would be eligible for a temporary payment to offset the ongoing costs of supporting, maintaining, or upgrading certified HIT systems

5) The Secretary of HHS would adopt measures for determining the meaningful use of a certified HIT system. At minimum, measures would include the use of electronic prescribing technology, the exchange of health information with other providers to help coordinate care, and the reporting of clinical quality measures

These proposals are estimated to cost $17.9 billion.

The Finance Committee has also contributed to the finalization of a spending proposal on Comparative Effectiveness Research Funding. *It will be marked up in the Appropriations Committee, and not as part of the Chairman's Mark in Finance. This proposal would invest $700 million to fund immediate studies on the comparative effectiveness of various medical tests and treatments through the Agency for Healthcare Research and Quality and the National Institutes of Health. The proposal would also provide $400 million to the Secretary of Health and Human Services to fund additional new studies. This proposal is estimated to cost $1.1 billion.*

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Testimony in Support of SB No. 2332
Senate Human Services Committee
January 27, 2009

Madam Chair Lee and Committee Members, I'm Bruce Levi and I represent the North Dakota Medical Association.

The North Dakota Medical Association supports SB No. 2332. Health information technology is fast becoming a key component of state efforts to improve health care and is a means for facilitating quality improvement and cost control. Appropriate, well-coordinated health information technology strategies can bring together vital pieces of patient data essential for providing quality care.

Despite documented advantages and federal support for HIT initiatives, physician adoption of HIT nationally has been slow. Research on HIT adoption rates indicates that concerns about HIT adoption's high cost, uncertainty of return on investment after adoption, and worry over the usability and obsolescence of new technologies rank highest among reasons surveyed physicians have not yet adopted HIT. Doubts about the privacy and security of patient data, practice compliance with HIPAA legislation, and the potential for inappropriate disclosure of patient information to third parties rank just behind financial concerns. Initiatives such as that provided in SB No. 2332 provide incentives and the means to overcome these barriers.

The North Dakota Medical Association was a member of the ND Health Information Technology Steering Committee created to facilitate the adoption and use of health information technology and exchange to improve health care quality, patient safety and overall efficiency of health care and public health services in North Dakota. As such, we support SB No. 2332 as a logical step forward and urge a "Do Pass" on the bill.

#5

American Heart Association. | American Stroke Association.
Learn and Live.

Senate Bill 2332

Senate Human Services Committee

Chairman Lee and members of the Senate Human Services Committee. I am June Herman, Senior Director of Government Relations for the American Heart Association in North Dakota. I am here today asking for your favorable consideration of SB 2332.

This session the American Heart Association has already focused on two key pieces of legislation:

- establishing Primary Stroke Center certification and EMS response systems for acute stroke events (House Human Services) HB 1339
- inclusion of a stroke registry appropriation into SB 2004, the Department of Health's budget.

SB 2332 represents another important building block for improved stroke care, as within it is the potential to fund special telemedicine projects, projects such as tele-stroke services to provide acute stroke care.

To put the need in perspective:
North Dakotans ages 65 and older are more likely to die from heart disease and stroke than any other age group. In fact, 95 percent of stroke deaths and 87 percent of heart disease deaths in 2005 were people 65 and older. Sixty-eight percent of North Dakotans with a history of stroke are 65 and older, with stroke the leading admission cause for Long Term Health Care. In 2003, North Dakota Medicare (ages 65 and older) payments for heart disease and stroke hospital discharges exceeded $61 million dollars.

The most pronounced change in the state's population will be a dramatic increase in the elderly population. In 2000, 14.7 percent of the state's residents were 65 and older. By 2010 the proportion of elderly will jump to 17 percent, and will move to 23 percent by 2020. It is important for North Dakota to address Health Technology needs as an important access to care issue for our future.

I've provided with my testimony some examples highlighting the need and potential for improved stroke systems of care.

- Map showing incident of stroke deaths by county, with comprehensive hospitals marked with red dots
- Article explaining tele-stroke opportunities and the relationships possible between hub and spoke hospitals
- Example of web-based guideline tools addressed through our stroke registry recommendations.

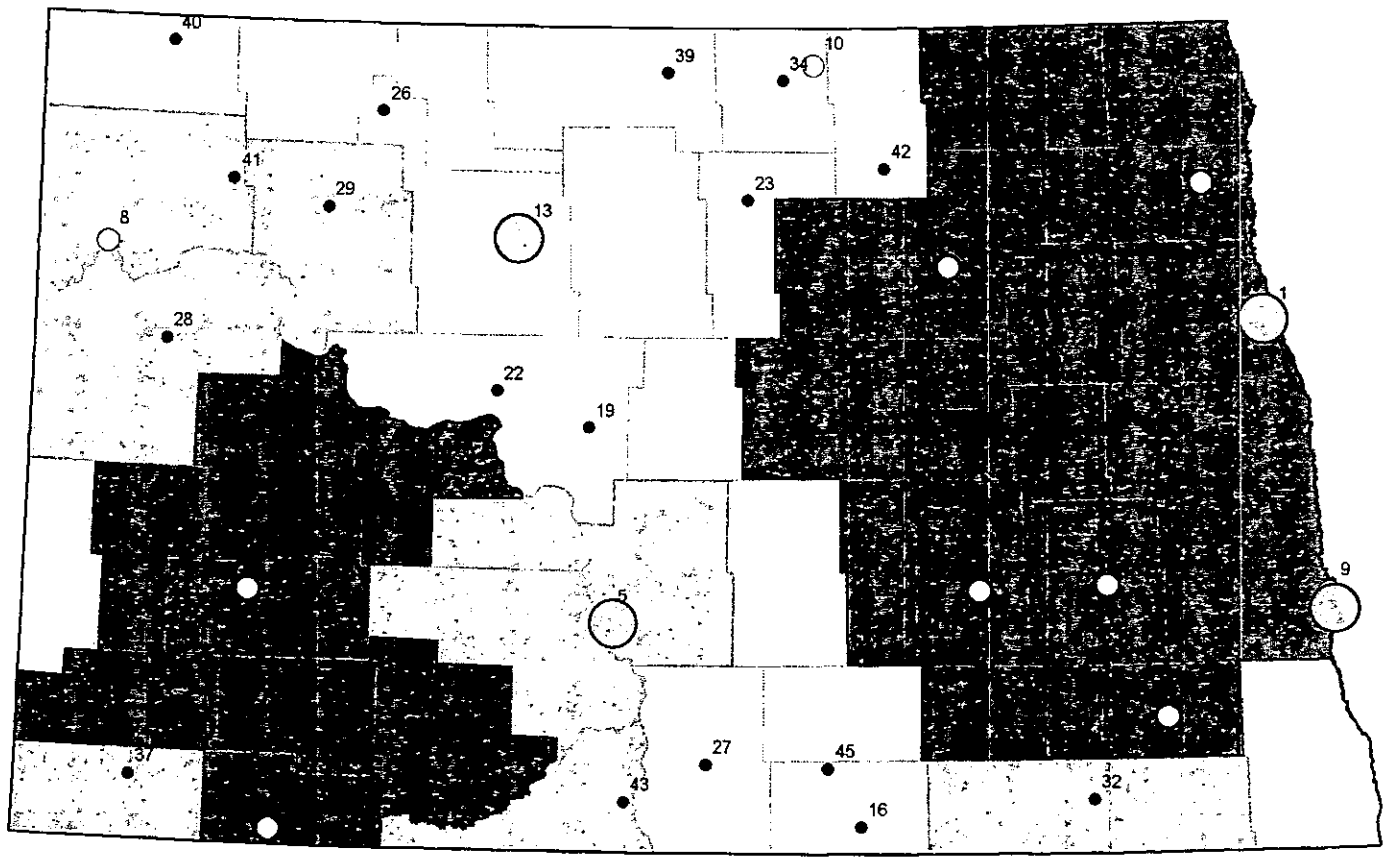
With a stroke, time lost is brain lost. We feel SB 2332 will enable North Dakota to build critical health technology potential that can help us reduce stroke's toll.

In conclusion, I ask for your "Do Pass" recommendation on SB 2332. I would be happy to answer any questions you may have at this time.

State Stroke Systems Hospital Mapping Initiative

North Dakota: Age 35+ Stroke Death Rate per 100,000 by County

American Heart Association. American Stroke Association.
Learn and Live.



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REVIEW

Stroke Telemedicine

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Stroke telemedicine is a consultative modality that facilitates care of patients with acute stroke at underserviced hospitals by specialists at stroke centers. The design and implementation of a hub-and-spoke telestroke network are complex. This review describes the technology that makes stroke telemedicine possible, the members that should be included in a telestroke team, the hub-and-spoke characteristics of a telestroke network, and the format of a typical consultation. Common obstacles to the practice of telestroke medicine are explored, such as medicolegal, economic, and market issues. An example of a state-based telestroke network is thoroughly described, and established international telestroke networks are presented and compared. The opportunities for future advances in telestroke practice, research, and education are considered.

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ADHS = Arizona Department of Health Services; AV = audiovisual; CT = computed tomography; IRB = institutional review board; MeSH = medical subject heading; NIH = National Institutes of Health; PSC = primary stroke center; STARR = Stroke Telemedicine for Arizona Rural Residents; STRokE DOC = Stroke Team Remote Evaluation Using a Digital Observation Camera; TIME = The Initial Mayo Clinic Experience; tPA = tissue plasminogen activator

Studies have described variability in the depth of stroke care provided at hospitals in the United States and abroad.[1,2] Although primary stroke centers (PSCs) are equipped with the resources and personnel to provide patients with acute stroke with a timely, adequate assessment and emergency stroke treatments, they represent only a minority of all hospitals. Unfortunately, this level of expertise may be unavailable at some urban and most rural centers that do not specialize in stroke. This gap in availability of emergency stroke care can be attributed to a low number of certified PSCs, insufficient availability of stroke specialists, and long distances between remotely located patients and centrally located stroke specialists.[3,4] Accordingly, therapies for acute stroke, such as tissue plasminogen activator (tPA), are underused by hospitals that cannot provide patients with timely access to stroke expertise. To overcome this gap in availability of and access to stroke specialists and to address the underuse of therapies for acute stroke, telemedicine techniques that can be adapted to the emergency evaluation of acute stroke can be used.[5] According to the American Telemedicine Association, *telemedicine* is the exchange of medical information from one site to another using electronic communication, such as telephone, Internet, or videoconference.[6] Telemedicine practices allow for a specialist consultation, direct patient consultation, patient monitoring, and medical education. The application of telemedicine for care of acute strokes, often called *telestroke*, was a natural progression from general telemedicine because of a shortage of stroke neurologists and recent advances in technology.[2]

For editorial comment, see page 3

Telecommunications, which started with the telephone and advanced to audiovisual (AV) communication, has changed the face of medicine not only in remote areas but also in urban areas with a shortage of subspecialists. A surge in the use of telestroke across the United States, Canada, and Europe occurred in the late 1990s and early 2000s, resulting in the development of 20 new telestroke networks. In this review, *telestroke* refers to live, AV telecommunication applied to care of acute stroke. The implementation of telemedicine for stroke is a vital piece to the puzzle of creating universal access to emergency care for all patients with stroke, regardless of geographic location or hospital resources.[7]

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This study was funded by an Arizona Department of Health Services research grant (HI754123), a Mayo Clinic research grant (90256993), the STRokE DOC Arizona—The Initial Mayo Experience (TIME) trial (clinicaltrials.gov identifier: NCT00623350), and the Stroke Telemedicine for Arizona Rural Residents (STARR) Registry.

Individual reprints of this article are not available. Address correspondence to Bart M. Demaerschalk, MD, MSc, FRCP(C), Department of Neurology, Mayo Clinic Hospital, 5777 E Mayo Blvd, Phoenix, AZ 85054 (demaerschalk.bart@mayo.edu).

TABLE 1. **Comparison of Telemedicine Systems**

Factor	BF Technologies[a] (San Diego, CA)	Polycom[b] (Pleasanton, CA)	Tandberg[c] (New York, NY)	InTouch Health[d] (Santa Barbara, CA)	Remote Evaluation of Acute Ischemic Stroke Call (REACH)[e] (Augusta, GA)	Specialists On Call[f] (Westlake Village, CA)
Product offering	AccessVideo Telemedicine	VSX/HDX Practitioner Cart System	Tandberg Intern MXP	RP-7 Remote Presence System (integrates robotic platform audiovisual)	Web-based tools that integrate audiovisual communication into clinical practice	Third-party provision of physicians on call 24 h/d, 7 d/wk via video-conference software
Hardware provided	Yes	Yes	Yes	Yes	No	No
Software	Yes	Yes	Yes	Yes	No	No
Web-based	No	No	No	No	Yes	Yes
Annual cost (US $)	~24,000	~25,000	~25,000	Varies	On the basis of monthly stroke volume	On the basis of monthly stroke volume
Maintenance fee	Yes	Yes	Yes	Yes	No	No
Technology support 24 h/d, 7 d/wk	Telephone	Telephone and online	Telephone and online	Continuously monitored	Telephone and online	Telephone and online request
Radiology transmission	Yes	Yes	Yes	Yes	No	No

[a] Web site: http://www.bf-technologies.com/.
[b] Web site: http://www.polycom.com/usa/en/solutions/industry_solutions/healthcare/tele_medicine.html/.
[c] Web site: http://www.tandberg.com/ind_focus/healthcare/hc/_solutions.jsp.
[d] Web site: http://www.intouchhealth.com/products_rp7robot.html.
[e] Web site: http://www.reachcall.com/company.html.
[f] Web site: http://.brainsavingtech.com.

METHODS

A team of clinicians (B.M.D., M.L.M.) and a medical librarian (K.E.W.) independently developed search strategies, reviewed the medical literature, screened titles and abstracts, identified potentially useful articles, extracted relevant information, and assembled the review. The literature search was conducted in the following Ovid databases: MEDLINE (1950 to 2008), EMBASE (1988 to 2008), Healthstar (1966 to 2008), and CINAHL (Cumulative Index to Nursing and Allied Health Literature, 1982 to 2008). In July 2008, the search was repeated in MEDLINE to identify any additional published articles. The same combination of medical subject heading (MeSH) terms, textwords, and keywords was used in all databases. The MeSH terms *cerebrovascular accident, cerebral infarction, brain ischemia, ischemic attack, transient, cerebrovascular disorders,* and *tissue plasminogen activator* were all exploded and combined using the Boolean operator "OR." Textwords *tPA* and *stroke* were added to create one set. Another set was created using the exploded MeSH terms *telemedicine, telecommunications,* and *remote consultation* and the textwords *telemedicine* or *telemedical*. A collection of journals in the area of telemedicine was also included in the last set with the "OR" operator. The 2 sets (set of stroke results and set of telemedicine results) were combined using the Boolean operator "AND" and limited to the English language. Review articles on telemedicine in general were also consulted. The bibliographic database search was supplemented by hand searching for published abstracts, consultations with investigators and practitioners in the field, and review of conference proceedings. Duplicate publications were removed.

TELESTROKE TECHNOLOGY AND SERVICES

One early step in designing a telestroke network is selecting an operating system. Information technology support is essential because the chosen system should be applicable within any new or existing telestroke network. A growing interest in telestroke has led to the development of numerous equipment options for the stroke telemedicine team. Popular equipment for telestroke includes a hardware and software package, such as the systems provided by Polycom (Pleasanton, CA), Tandberg (New York, NY), BF Technologies (San Diego, CA), and InTouch Health (Santa Barbara, CA). Alternatively, REACH Call (Augusta, GA) and Specialists On Call (Westlake Village, CA) are Web-based online services for videoconferencing between a patient and a stroke specialist.

Table 1 presents a comparison of these telemedicine systems. In the current era of technology, an ideal telestroke system should involve a 2-way AV connection for assessment and diagnosis of patients with stroke. Telemedicine systems enable online, real-time communication using a digital camera and software that are controlled by the stroke specialist. The interrater reliability of a neurological examination and a National Institutes of Health (NIH) Stroke Scale score obtained by AV teleconferencing equipment was found to be excellent. Multiple studies concluded that remote examinations of patients with acute stroke with these systems are feasible and reliable.[8-10] Most equipment choices feature a high-resolution digital camera,

phone, speakers, server for scan storage, and a monitor e patient to view the telestroke practitioner. Maintenance needs are typically minor.

Computed tomography (CT) transmission via a picture archiving and communication system is relatively easy to learn and implement into telestroke practice. Privacy and security of the system can be maintained by secure socket layer conditional access, data encryption, intruder alerts, and access logging and reporting. These security features ensure Health Information Portability and Accountability Act adherence for virtual telestroke consultations. Most operating systems incorporate a remote pan-tilt-zoom interface to give a remote user full control over the transmitted image. An added feature of recording capability allows the consultant to record and store the AV consultation.

HUB-AND-SPOKE MODEL CHARACTERISTICS

Fisher[11] proposed a hub-and-spoke model of telemedicine-delivered stroke care designed to enhance the administration of acute stroke therapies. Evidence-based care[5] from the hub, which should ideally be a Joint Commission–certified PSC,[12] is transmitted to the spokes. Hubs are generally located in urban areas, and spokes are usually located in rural regions or urban hospitals that are not stroke centers. The optimal t oke spoke hospital has a sufficient volume of patients te stroke but does not have available neurologists on ca for emergencies. In addition, the emergency department staff should be receptive to collaborating on a telestroke program, should have access to CT 24 hours per day 7 days per week, and should be supported by hospital administration. Collaboration between hub and spoke hospitals with these characteristics lays the foundation for maturation of stroke practice skills and credentials.

Ideally, spoke hospitals should track the same stroke performance measures as hub PSCs track. An experienced spoke hospital could attain PSC certification via established telestroke practice. The spoke center should use stroke quality measures from patient admission to discharge. The spoke center would not be required to admit all patients with stroke to attain PSC status; rather, transfer agreements with other institutions could be established for stroke patients with advanced care needs. As the guidelines for comprehensive stroke centers[13] are further refined for implementation and practice, the spoke hospital's acquisition of PSC status and the hub hospital's acquisition of comprehensive stroke center status would be inherent in the hub-spoke relationship.

TELESTROKE TEAM MEMBERSHIP

T elestroke team should consist of a broad range of c administrative, and research members at both the hub and spoke[14] to fulfill all aspects of the telestroke dynamic. Table 2 lists the proposed members of a telestroke team. Neurologists, emergency physicians, nurses, and radiologists should collaborate on the provision of remote care for patients with acute stroke. In general, telestroke practitioners are board-certified vascular neurologists; however, no formal requirements for the practice of telestroke currently exist. In reality, any trained practitioner in the field of stroke could learn the requisite skills of telestroke assessment because these skills are not difficult to acquire.[15] Stroke neurologists, often aided by a remote bedside nurse, can quickly and reliably obtain valid NIH Stroke Scale scores by a high-speed AV telemedicine link.[8-10] Potentially efficient models of telestroke systems might use vascular neurology fellowship–trained nurse practitioners, physician assistants, or neurology residents and fellows to perform preliminary triage, screening, and neurologic assessments. This preliminary work could then be followed by a reassessment or review by a supervising vascular neurologist, depending on pertinent state laws. Having emergency medicine physician stroke leaders participate at hub-and-spoke centers is a model that appears to be associated with program success.[16]

TABLE 2. **Team Members of a Stroke Telemedicine Network**

Hub hospital	Spoke hospital
Director (vascular neurologist)	Director (emergency physician)
Codirector (emergency physician)	Site coordinator
Program coordinator/project manager	Emergency physician
Neurologist	Information technologist
Information technologist	Radiology technologist
Nurse practitioner or physician assistant	Credentialing and privileging assistant
Lawyer	Lawyer
Administrative assistant	Radiologist
Financial analyst	Emergency nurse
Operations administrator	
Research coordinator	

To gain the endorsement of spoke hospitals, a successful collaboration between neurology and emergency medicine practitioners is essential. Collaboration between emergency medicine and neurology practitioners is probably the most important element of a successful telestroke program. By definition, spoke hospitals are underserviced or undersupported by neurologists, which creates the need for telestroke. For several reasons, many emergency physicians are hesitant to accept the sole responsibility for administering intravenous thrombolysis for acute ischemic stroke. As a result, these emergency physicians are not using the available acute stroke treatments, such as tPA.[17,18] In contrast, nearly 90% of rural emergency departments would be receptive to joining a telestroke network and

TABLE 3. Suggested Target Intervals (From Emergency Department Arrival to Activity) for a Telestroke Consultation[a]

Activity	Time (min)
Emergency department arrival	0
Triage nurse assessment	5
Emergency physician assessment	10
Laboratory tests and CT of head ordered	15
Laboratory tests and CT of head conducted	25
Telestroke hotline activated by spoke hospital	30
Preliminary telephone communication between hub and spoke hospitals	35
2-Way audiovisual telestroke consultation commences	40
Teleradiology review of head CT	45
Diagnosis of stroke established and eligibility for short-term treatment determined	55
Treatments recommended and administered	60
Admission or transfer arranged, marking end of telestroke consultation	65
Consultation note dictated by hub hospital neurologist	75
Consultation note transcribed and transmitted to spoke hospital	120

[a] CT = computed tomography.

treating patients with acute stroke with thrombolysis if a vascular neurologist could provide a telemedicine consultation.[19]

Telestroke networks could benefit from a full-time program manager to bridge the clinical and administrative aspects of a network. Spoke radiology technologists serve the critical role of ensuring that neuroimaging is transferred successfully to allow hub teleradiologic interpretation. Information technologists are invaluable to the initial development, maintenance, and expansion of the network's telecommunication requirements. Education specialists may help to apply continuing medical education credits to stroke tele-education opportunities. Research coordinators are involved in any research effort ranging from the maintenance of a simple prospective registry to a sophisticated randomized controlled trial of telemedicine-delivered experimental therapy. Institutional review board (IRB) specialists may be necessary at institutions less familiar with the unique aspects of conducting teleresearch. Finance specialists may help explore all of the currently available reimbursement opportunities for the hub provider and spoke recipient of the teleconsultations. Business and administration leaders, guided by legal counsel that is familiar with telemedicine law, assist with the development of regulatory documents and contracts between the respective institutions. Credentialing, privileging, and licensing experts assist the hub teleconsultants in establishing the appropriate authorization to perform remote stroke teleconsultations. Depending on the setting of the telestroke practice, a telestroke hotline service should be implemented with the requisite support personnel. Risk management and quality should be involved at both the hub and spoke. Teamwork between personnel at hubs and spokes is essential to a successful telestroke practice.

THE MODEL TELESTROKE CONSULTATION

Acute stroke is a time-sensitive condition that requires multidisciplinary coordination; therefore, the American Stroke Association created the stroke chain of survival to improve clinical outcomes.[5] Although this sequence of events progresses smoothly for patients who have direct access to expert stroke care, this model becomes interrupted for patients who are remotely located and lack this immediate access. When the chain of survival breaks, patients who may have benefited from specific short-term therapies ultimately suffer. The overall goal of a telestroke consultation is to restore the stroke chain of survival and to maximize patient recovery by delivering a timely assessment, making an accurate diagnosis, determining eligibility for short-term therapy, and delivering the chosen treatment. Beginning with a patient's early recognition of stroke symptoms and culminating in a successful telestroke consultation, each step along the way is crucial to the final outcome. Table 3 depicts possible steps and target times for the telestroke chain of survival. The spoke emergency physician performs a quick assessment, recognizes an acute stroke syndrome, and activates the telestroke hotline at the hub site (Figures 1 and 2). Developing an algorithm for the step-by-step conduct of a telestroke consultation is important to developing a telestroke standard of care. In ideal practice, the spoke and hub centers should use the same stroke alert algorithm to create continuity of care throughout an acute stroke evaluation.

ILLUSTRATIVE TELESTROKE CASE

A 75-year-old female resident of a rural community identified the sudden onset of left facial droop, slurred speech, and weakness and numbness of the left arm and leg at 3:30 PM. She presented to the local emergency department of the spoke hospital at 4:21 PM, at which time the emergency department physician examined her and initiated a stroke alert. Blood samples were drawn, CT was completed, and the spoke center activated the telestroke hub hotline. The hub center's on-call stroke neurologist responded. After the patient had undergone CT, the telestroke camera system was placed in front of the patient and the consultation began at 5:08 PM. The patient and her family interacted with the stroke neurologist via the camera system, answered questions, and engaged in the consultation. The spoke emergency department nurse assisted the stroke neurologist with the examination and the laboratory results. The stroke neurologist zoomed in on the cardiac monitor to

e the patient's electrocardiographic results, heart rate, blood pressure, respiratory rate, and oxygen saturations. During the AV telemedicine examination, the stroke neurologist simultaneously accessed the CT by a Digital Imaging and Communications in Medicine system. Through examination via the AV camera system, the NIH Stroke Scale score was determined to be 6. After the clinical, laboratory, and CT examinations were complete, the neurologist requested the presence of the emergency physician and the daughter at the bedside to discuss the plan for care. At 5:53 PM the stroke neurologist reviewed the observations and recommended the administration of tPA. The spoke emergency department initiated tPA at 6:09 PM. The hub stroke neurologist dictated a consultation and faxed it to the spoke center emergency department.

FIGURE 1. A spoke hospital emergency physician at a mock patient's bedside is assisting the hub hospital stroke neurologist with the examination.

THE MEDICOLEGAL ISSUES

The practice of telemedicine in the United States is under the control of the individual states, requires state licensure, and is limited by state geographic boundaries. Internet-based, site-independent approaches to acute stroke care allow a physician-patient interaction to take place when the 2 parties are in different geographic locations anywhere in the world. The jurisdiction restrictions placed on telemedicine practice constrain the potential for regional, national, and international networks. Some telemedicine experts recommend that the practice of telemedicine be handled differently than the practice of face-to-face medicine, as related to licensure (ie, a national or a regional geographic multistate licensure model).[20]

The liability of telemedical procedures has to be regulated according to national laws. The fact that teleconsultation in acute stroke is similar to face-to-face on-site consultation should facilitate these regulations.[21] Some physicians are concerned that they would be vulnerable to a malpractice lawsuit in the event that technical problems impede a consultation and result in an adverse outcome.[22] Given that telemedicine practice is not new, the ethical and malpractice aspects have largely been confronted and resolved.[23,24]

THE ECONOMIC ISSUES

Telemedicine networks, whether urban or rural, require a substantial capital investment in equipment and technical support. Components of the total cost of development and maintenance of a telestroke network include the telemedicine equipment, information technology support, the necessary clinical and administrative personnel, personnel training and credentialing, and allowances for on-call coverage. Most telemedicine programs are financially dependent on public sector financing in the form of grants and telecommunications subsidies, which are nearly always restricted to rural counties. As a consequence, many telemedicine programs tend to be associated with academic medical systems in states and provinces with large rural areas and physician specialist shortages. These issues are even more complex when considering the economics of telestroke networks.[26]

Obtaining direct revenue from insurance payers for telestroke consultations is difficult. Medicare will only reimburse for telemedicine that includes consultations (Table 4) if the patient is linked with the hub vascular neurologist by live 2-way video communication and in instances when the spoke is located in an eligible geographic area. Medicare defines such eligible regions as rural health professional shortage areas and counties not

FIGURE 2. A hub hospital stroke neurologist and research coordinator are conducting a 2-way audiovisual telestroke consultation with the spoke hospital.

TABLE 4. **Medicare Reimbursement for Telemedicine Consultation**[a,b]

CPT code	Consultation duration (min)	Reimbursement amount (US $)
99241	15	45.92
99242	30	85.33
99243	40	117.08
99244	60	171.59
99245	80	211.74

[a] CPT = *Current Procedural Terminology*.
[b] For further information, see the telemedicine overview at Centers for Medicare & Medicaid Services (http://www.cms.hhs.gov/Telemedicine).

classified as a metropolitan statistical area. Although these restrictive circumstances exist in most states,[27] New York's state-based telestroke program has been bolstered by approval of Medicaid reimbursement for both ends of the consultation.[3] Confirmatory trials of telestroke efficacy coupled with cost-effectiveness analyses will provide health care policy makers with the data necessary to proceed with national telestroke reimbursement plans.

Historically, third-party payers have been slow to recognize teleconsultation activities for reimbursement; however, survey data indicate that the United States is progressing toward expanded private reimbursement for telemedicine services.[27,28] California, Louisiana, Kentucky, Texas, and Oklahoma have introduced legislation regarding mandatory private payer reimbursement for telemedicine.[28] Private reimbursement for telemedicine consultations was found to be generally comparable to that of traditional face-to-face consultations. Although surveys have recognized that small improvements in private reimbursement have occurred, this favorable change alone is insufficient to foster the creation of broader telemedicine networks.

No detailed, high-quality analyses of the cost-effectiveness of telemedicine for stroke have been performed, which has been a barrier to making a case for a uniform system for reimbursement for stroke teleconsultation.[26] Systematic reviews of cost-benefit studies of telemedicine in general in 2001-2002 reported that most did not meet acceptable quality criteria, most were restricted to simple cost comparisons, and no study used cost utility analysis or included sensitivity analyses.[29,30]

Several investigators have conducted financial analyses of the implementation of rural and urban telemedicine programs. Only those analyses conducted from the societal perspective have demonstrated profitable returns on investments.[31-33] In Denmark, the budgetary impact and cost-effectiveness of the national use of thrombolysis for stroke administered via telemedicine was estimated. The results demonstrated that thrombolysis by telestroke network was dominant to conservative management.[34] Studies conducted from the societal perspective, compared with those conducted from an institutional perspective, have a tendency to overestimate the total revenue. For example, when telestroke consultations prevent unnecessary air or ground transfers, the savings accrued do not directly benefit the health care institution that is investing the capital. Therefore, from the sponsoring institution's perspective, there is a perception that telemedicine is not a financially profitable endeavor. In the absence of ongoing government grant support, any telestroke-sponsoring institution must devise a business model that produces a self-sustaining profitable or break-even program.

REVIEW OF THE DEVELOPMENT OF A STATE TELESTROKE NETWORK

The Stroke Telemedicine for Arizona Rural Residents (STARR) network currently consists of a 1-hub, 2-spoke telestroke system. The road to the creation and implementation of this network was arduous. In preparation, 2 Mayo Clinic physicians (B.M.D., B.J.B.) visited previously established telestroke networks and reviewed the available telestroke technologies and equipment in 2005. In addition, a statewide needs assessment was administered to all remotely located hospitals with emergency departments in Arizona. This survey illustrated the need for increased access to stroke expertise in Arizona's rural communities, assessed each institution's current stroke resources, and demonstrated that most institutions were willing to and capable of participating in a telestroke initiative.[19] In 2006, a collaboration was initiated between Mayo Clinic and the University of California, San Diego, Stroke Team Remote Evaluation Using a Digital Observation Camera (STRokE DOC) trial (clinicaltrials.gov identifier: NCT00283868).

The foundation was laid for a randomized controlled trial to test the feasibility of a telestroke consultation performed via BF Technologies' STRokE DOC camera system vs telephone consultation in Arizona. This study, STRokE DOC Arizona—The Initial Mayo Clinic Experience (TIME) (clinicaltrials.gov identifier: NCT00623350),[16] was arranged to be a validation study of the University of California, San Diego, STRokE DOC research trial. The STARR group directors applied for an Arizona Department of Health Services (ADHS) research grant in 2006 to support 1 year of STRokE DOC Arizona TIME research. In 2007 the group applied for additional grant funds to support expansion of the STARR network for 5 years. The STARR team developed relationships with various emergency physicians and remote hospital personnel to begin forming the necessary telestroke teams at all involved sites. Yuma and Kingman Regional Medical Centers were selected as the spoke sites for the STRokE DOC Arizona

IME trial and the overall STARR network. To initiate the spoke sites and complete necessary training, the STARR team conducted on-site visits and videoconferences. The ADHS grant made it possible to implement the telestroke system without imposing any start-up costs on the rural hospitals. As the project progressed, a series of part-time project managers were hired, and eventually a full-time project manager was brought onto the team. The STRokE DOC Arizona TIME trial commenced in December 2007. During the first year of operation, the STARR network used the BF Technologies camera system to perform telestroke consultations at the 2 spoke sites (Figure 3). The Digital Imaging and Communication in Medicine System was used for neuroimaging transmission. Four Mayo Clinic board-certified vascular neurologists shared the telestroke on-call duties (24 hours per day 7 days per week). A dedicated toll-free telestroke hotline and group paging system was established for the spoke centers to alert the on-call stroke neurologist. Although teleconsultations were generally easy to perform, occasional minor and major technological difficulties were noted.

From December 1, 2007, to May 31, 2008, the Mayo Clinic Hospital hub received approximately 16 hotline activations per month (2 per spoke center per week). Half of the calls did not meet stroke alert criteria on the basis of preliminary telephone screening. On average, 30% of all patients with stroke who received a full consultation were determined to be eligible for thrombolysis. Accordingly, thrombolysis administration for eligible patients with stroke increased 10- to 20-fold from the participating spoke hospitals' historic baseline in the first 6 months of the program (from approximately 0.5 to 1.0 per hospital per year to approximately 10 per hospital per year).

The STARR network experience has shown that a successful network is the product of hard-working, dedicated professionals at both the hub and spoke. Regular communication between hub and spoke is essential for maintaining enthusiasm for the project, good clinical practice guidelines, and troubleshooting of various logistical and technical complications that may arise. A weekly or monthly newsletter with updates, congratulations, and feedback is a useful mechanism for sustaining this open communication. Using the data derived from the Arizona state needs assessment,[19] the STARR network planned to expand by adding 4 additional spoke sites (Figure 4). When selecting new spokes for the network, the team considered the following aspects: size of the spoke hospital, volume of patients with stroke, regional need for stroke services, and desire and willingness of the spoke personnel to participate. Several options arise when exploring expansion opportunities for an existing telestroke network. For instance, the team considered new equipment options, addition of new support personnel to the team, development of a new method of operation, addition of new metropolitan PSC hubs,[35] and recruitment of additional vascular neurologists. Dividing the progression of the network into stages allows for revising and improving the existing network.

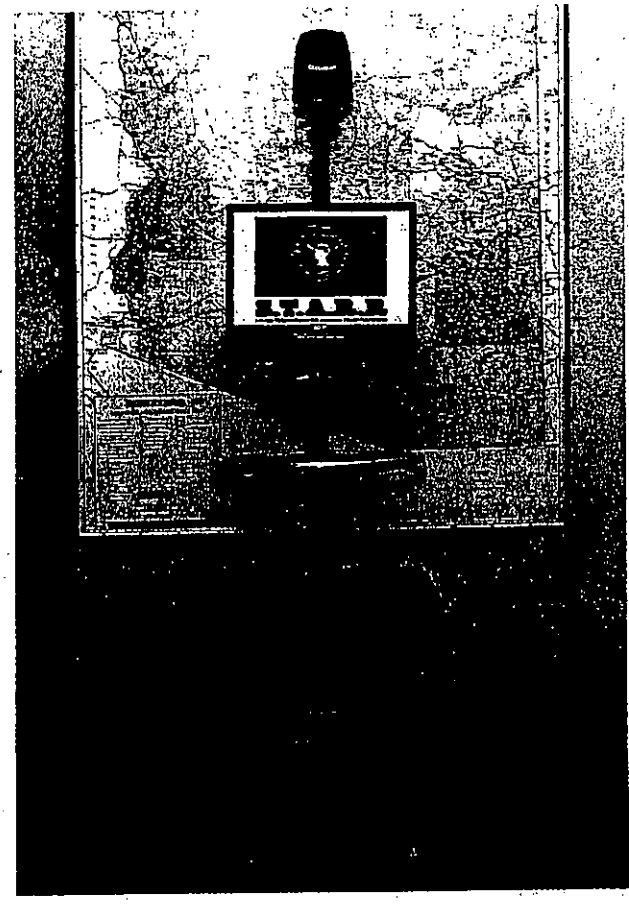

FIGURE 3. The BF Technologies (San Diego, CA) Stroke Team Remote Evaluation Using a Digital Observation Camera used for the Stroke Telemedicine for Arizona Rural Residents study.

Although the ADHS grant funding will support network expansion for 5 years, transition to a self-sustaining business model is the expectation. This model would need to address internal (organizational, technical, and educational) and external (economic, legal, and market) business factors that are identified by other telestroke networks as being important.[36] The Arizona Telemedicine Program, a long-standing multidisciplinary medical and surgical statewide network, published its business model in 2005, which could serve as a starting point.[37]

RESEARCH ADVANCES IN STROKE TELEMEDICINE

Telephone guidance for acute stroke is not a novel approach to overcoming the shortage of stroke neurologists in

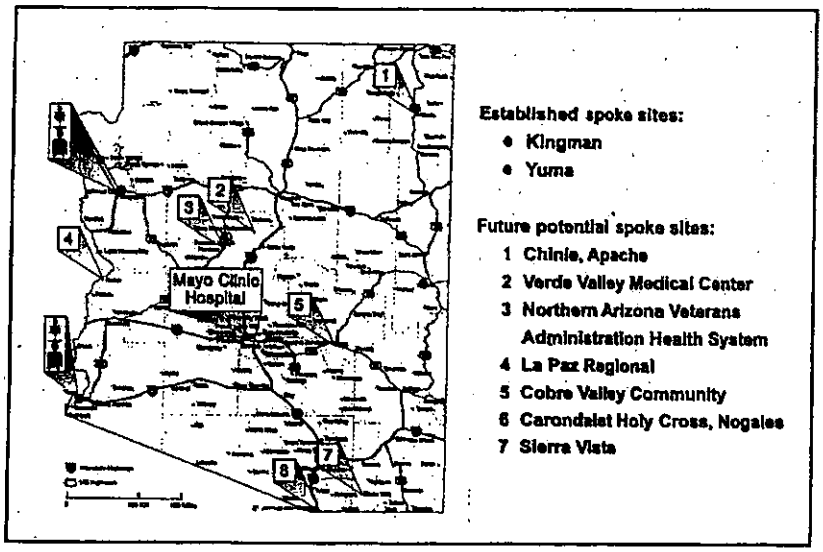

FIGURE 4. The Stroke Telemedicine for Arizona Rural Residents network map outlining hub and spoke (current and potential) hospitals.

both urban and rural environments. The telephone stroke consultation has a natural appeal in terms of its long history of use, universal availability, low cost, and simplicity. Frey et al[38] showed that a "drip and ship" (ie, intravenous thrombolysis initiated at remote hospital followed by transport to PSC) tPA treatment algorithm via telephone stroke consultation was as effective and time-efficient as standard face-to-face PSC evaluation of patients with stroke. Furthermore, Vaishnav et al[39] published a retrospective survey of rural patients who received thrombolysis by telephone-assisted stroke consultation. The authors concluded that this protocol was safe, practical, and effective with treatment times that did not differ significantly from published randomized controlled trials.

New stroke AV telemedicine consultation systems must be compared with standard, telephone-guided protocols. Randomized controlled trials that compare AV telemedicine with telephone stroke consultations include the University of California, San Diego, STRokE DOC trial (clinicaltrials.gov identifier: NCT00283868), Mayo Clinic STRokE DOC Arizona TIME (clinicaltrials.gov identifier: NCT00623350), and TRUST-tPA: Therapeutic Trial Evaluating Efficacy of Telemedicine (TELESTROKE) of Patients with Acute Stroke (clinicaltrials.gov identifier: NCT00279149). The University of California, San Diego, STRokE DOC study was the first of these 3 trials to be published and was made available online on August 3, 2008. Meyer et al[40] reported that correct decisions concerning suitability for thrombolysis were made more often in the telemedicine group than in the telephone group (98% vs 82%; odds ratio, 10.9; 95% confidence interval, 2.7-44.6; P=.0009). Stroke telemedicine consultations seem to result in more accurate decision making compared with telephone consultations. The completion of remaining trials and publication of the results will provide additional information about the comparison of telemedicine and telephone consultation in stroke care.

Through systematic review, 20 telestroke networks were identified (15 in North America and 5 in Europe) (Figure 5). Twelve of these networks have published their telestroke research experiences: Partners Telestroke Center,[41] Telemedic Project for Integrative Stroke Care,[3,42-48] Remote Evaluation of Acute Ischemic Stroke,[2,49-53] Telemedicine in Stroke in Swabia,[54] Maryland Brain Attack Center,[55] STARR,[16,19] University of Pittsburgh,[56] STRokE DOC,[10,40,57] Michigan Stroke Network,[58] Ontario Telehealth Network Telestroke Program,[4,59] University of Texas,[14] and Emergency Neurology Network-Stroke[60] (Table 5). Established networks with published data are relatively small in size and scope and receive manageable call frequencies. Few technical complications were reported. A high proportion of telestroke consultations resulted in thrombolysis. Quality outcome measures indicating a need for improvement included speed and efficiency of the consultation and care and rates of symptomatic intracranial hemorrhage in thrombolysis recipients.

THE FUTURE OF TELEMEDICINE IN THE NEUROSCIENCES

The future of telemedicine in the neurosciences encompasses clinical, research, and education applications. Most

United States

1 STARR, Mayo Clinic Arizona, Phoenix
2 STRokE DOC, University of California San Diego, San Diego
3 REACH, Medical College of Georgia, Augusta
4 Partners Telestroke Center, Massachusetts General Hospital, Boston
5 Maryland Brain Attack Center, University of Maryland, Baltimore
6 Michigan Stroke Network, St Joseph Mercy Hospital, Detroit
7 University of Texas Health Sciences Center, Houston
8 University of Pittsburgh Medical Center, Pittsburgh, PA
9 Utah Telehealth Network, University of Utah, Salt Lake City
10 University of California Los Angeles, Los Angeles
11 Renown Institute for Neuroscience, Reno, NV
12 Colorado Neurological Stroke Center, Englewood

Canada

13 Ontario Telehealth Network Telestroke Program, Toronto, ON
14 Alberta Provincial Stroke Strategy Telestroke Initiative, Calgary and Edmonton, AB
15 British Columbia Provincial Telestroke Initiative, Vancouver, BC

Europe

16 TEMPIS, Bavaria, Germany
17 TESS, Swabia, Germany
18 RUN-Stroke, France
19 STENO Stroke Network, University of Erlangen, Erlangen, Germany
20 Helsinki University Central Hospital, University of Helsinki, Helsinki, Finland

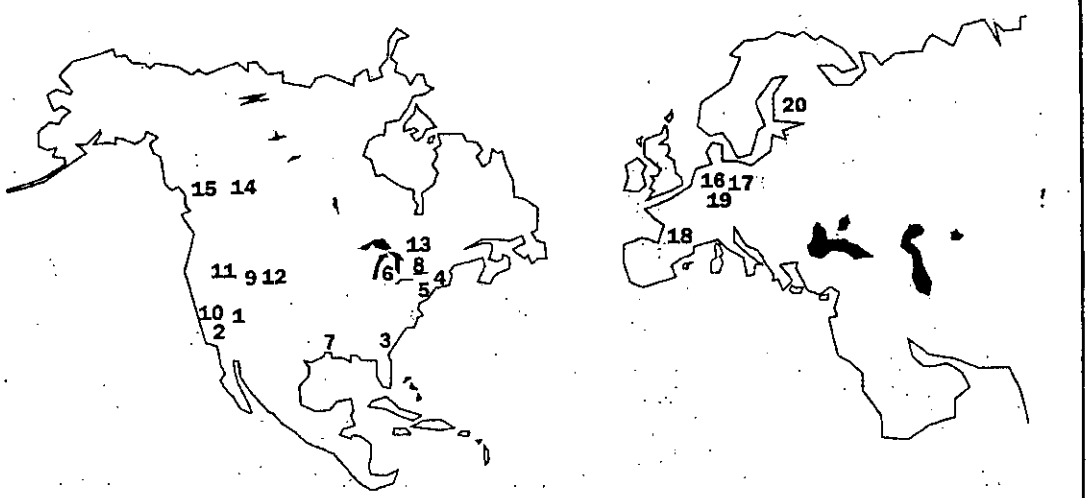

FIGURE 5. Map of current North American and European telestroke networks. REACH = Remote Evaluation of Acute Ischemic Stroke; RUN-Stroke = Emergency Neurology Network-Stroke; STARR = Stroke Telemedicine for Arizona Rural Residents; STENO = Stroke Network of University of Erlangen; STRokE DOC = Stroke Team Remote Evaluation Using a Digital Observation Camera; TEMPiS = Telemedic Project for Integrative Stroke Care; TESS = Telemedicine in Stroke in Swabia.

countries experience a perennial shortage of clinical neuroscience specialists outside metropolitan and urban sectors. Organizing regionally specific stroke systems of care that include telemedicine is an accepted solution to the global stroke epidemic.[61] In addition to consideration of telestroke applications, the use of telemedicine for all clinical neuroscience disciplines is being pursued on an international [62,63] Telemedicine is useful not only in the emergency department but also in the prehospital ambulance setting,[7] the intensive care unit, rehabilitation, and outpatient stroke prevention clinics.

A developed telestroke network may offer an excellent forum for collaborative clinical research between university stroke centers and smaller remote hospitals.[26] Hub hospitals engaged in acute stroke trials could use telemedicine to screen, obtain consent from, enroll, randomize,

TABLE 5. Telestroke Research Experiences of 12 Networks

	PTC[41]	TEMPiS[3,42-48]	REACH[2,49-53]	TESS[54]	Maryland Brain Attack Center[55]	STARR[16,19]	Univ of Pittsburgh Medical Center[56]	STRokE DOC[10,40,57]	Michigan Stroke Network[58]	Ontario Telehealth Network[4,59]	Univ of Texas HSC[14]	RUN-Stroke[60]
Location	Boston, MA	Bavaria, Germany	Augusta, GA	Swabia, Germany	Baltimore, MD	Phoenix, AZ	Pittsburgh, PA	San Diego, CA	Detroit, MI	Toronto, ON	Houston, TX	France
No. of hubs/spoke hospitals	NA/1	2/12	1/8	1/7	1/1	1/2	1/9	1/4	1/22	2/2	1/2	1/11
No. of teleconsultants	NA	5	5	4	5	4	NA	3	NA	6	3	NA
Study duration (mo)	27	20	26	18	36	6	15	44	9	34	13	NA
Study consultations performed	24	396	194	153	23	33	33	223	90	88	NA	1000
Rate of calls to hub per 24 h	0.03	NA	0.25	0.28	0.05	0.18	0.07	0.17	0.33	0.09	NA	NA
ED arrival to consultation (min)	70	NA	44	69	NA	85	NA	70	NA	NA	NA	NA
Mean consultation duration (min)	NA	15	NA	15	NA	55	NA	28	NA	NA	NA	NA
ED arrival to tPA (min)	106	78	105	NA	NA	124	70	110	NA	NA	85	NA
Stroke onset to tPA (min)	124	NA	111	NA	NA	158	NA	151	NA	NA	NA	NA
No. of tPA administrations	6	86	30	2	5	10	NA	56	16	27	14	NA
Evaluated patients receiving tPA (%)	40	22	16	1	24	30	NA	25	18	30	NA	NA
tPA protocol violations (%)	0	NA	NA	0	NA	40	6	14	NA	NA	NA	NA
SICH/ASICH (%)	16.7/16.7	8.5/NA	0/0	50/0	NA/NA	10/0	NA/NA	7/NA	NA/NA	NA/NA	NA/NA	0/0
Technical complications (%)	7	NA	3	0	9	67	NA	19	NA	NA	2	NA
Mimics (% of consultations)	33	12	9	26	NA	NA	NA	8	NA	NA	NA	NA
Consultations resulting in transfer (%)	27	5	72	NA	24	45	NA	66	36	NA	NA	NA

[a] ASICH = asymptomatic intracranial hemorrhage; ED = emergency department; HSC = Health Sciences Center; NA = not available; PTC = Partners Telestroke Center; REACH = Remote Evaluation of Acute Ischemic Stroke; RUN-Stroke = Emergency Neurology Network-Stroke; SICH = symptomatic intracranial hemorrhage; STARR = Stroke Telemedicine for Arizona Rural Residents; STRokE DOC = Stroke Team Remote Evaluation Using a Digital Observation Camera; TEMPiS = Telemedic Project for Integrative Stroke Care; TESS = Telemedicine in Stroke in Swabia; tPA = tissue plasminogen activator; Univ = university.

treat, and follow up patients. Spoke subinvestigators could partner with experienced hub hospital investigators to form a research team. On-site pharmacies would be needed at each spoke. For more complex experimental intra-arterial therapies, telemedicine could be used to identify eligible patients, obtain their consent, and randomize them before transport from spoke to hub hospital for definitive treatment.[11] Although several authors have suggested that telemedical assessment could realistically be used to select patients for clinical trials, its actual use for this purpose has not been reported.[7,11,21,26,64,65] Contributing factors could include the research inexperience of some spoke hospitals that do not apply to an IRB, long interhospital transport times, spoke reimbursement issues, and hub IRB discomfort with the oversight of off-site research.

The telemedicine system can also serve as an educational tool. Spoke initiation training, continuing medical education lectures, stroke education, and quality assessment and improvement meetings can be delivered via the network. For example, the network could serve as a platform from which to teach spoke centers about novel stroke therapies and their implementation.[11] Telementoring facilitates the training and supervision of physicians in acute stroke practice at both the hub and spoke hospitals.

CONCLUSION

Since Levine and Gorman proposed the application of telemedicine for stroke in 1999, the field has been advancing at an international level. The architecture and design of rural and urban telestroke networks are now better defined. The technology has been adapted to suit the needs of an emergency, time-sensitive, acute stroke encounter. Well-designed studies have shown that this consultative modality is valid, accurate, and reliable. Numerous telestroke networks exist worldwide, and most of these networks have published their implementation experiences and early outcome results. Importantly, sophisticated 2-way AV telestroke consultations are being rigorously compared with simple pragmatic telephone consultations in prospective randomized controlled trials. Successfully delivered promises of telestroke include remote instant expert stroke

noses, delivery of short-term therapies, and secondary prevention advice. Promises of telestroke applications that have been slower to materialize include widespread national and international telestroke networks that offer standardized evidence-based care, telestroke research networks for testing new stroke therapies, standardized measurements of telestroke quality of care, and acceptable guidelines for telestroke practice. The long-term sustainability and growth of telestroke practice remain threatened by unresolved legal, economic, and market factors. Telestroke practitioners and investigators should focus attention on analyzing and solving the business issues of the practice to allow further advances in the telestroke field and longevity of telestroke practice.

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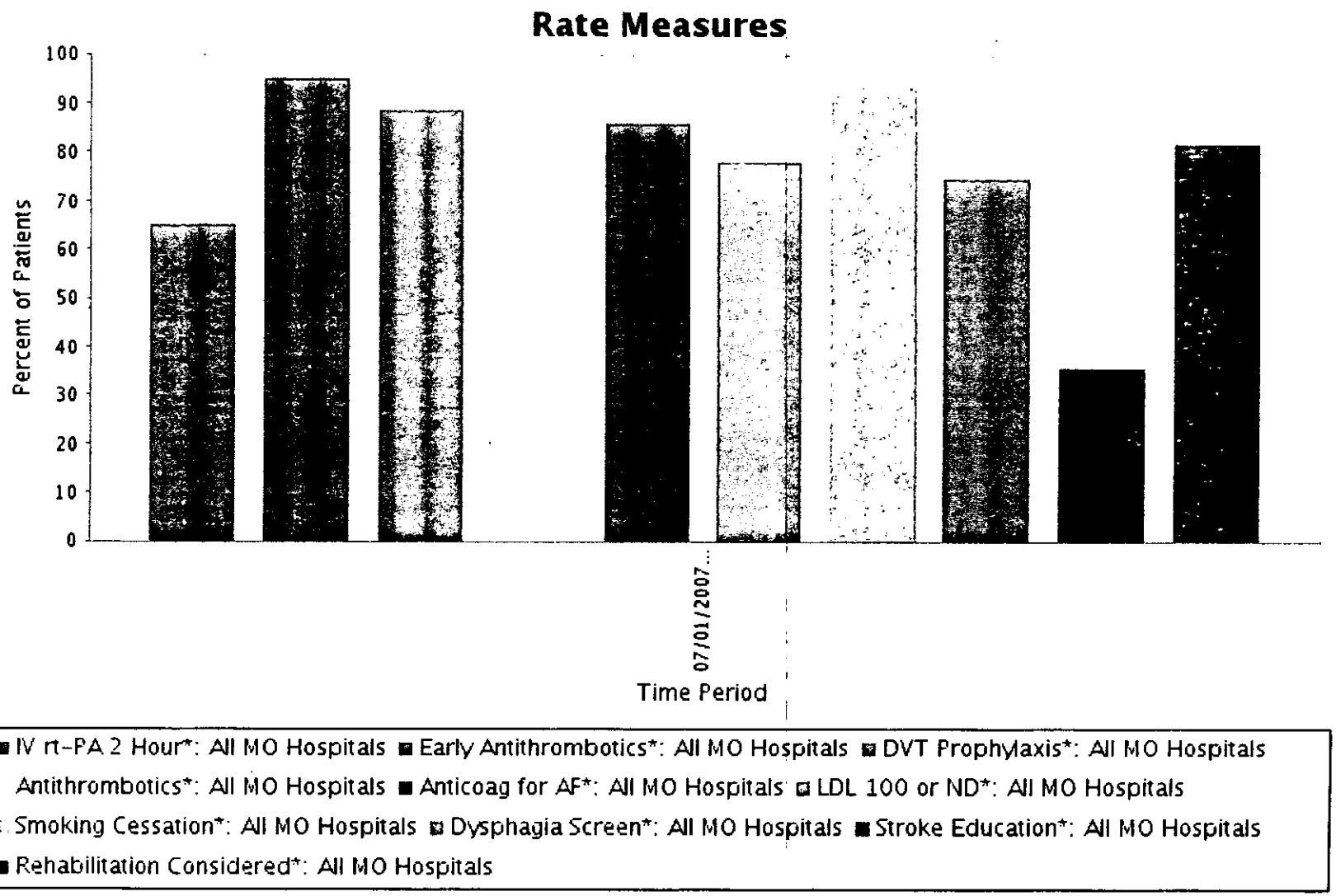
Get With The Guidelines

Slides

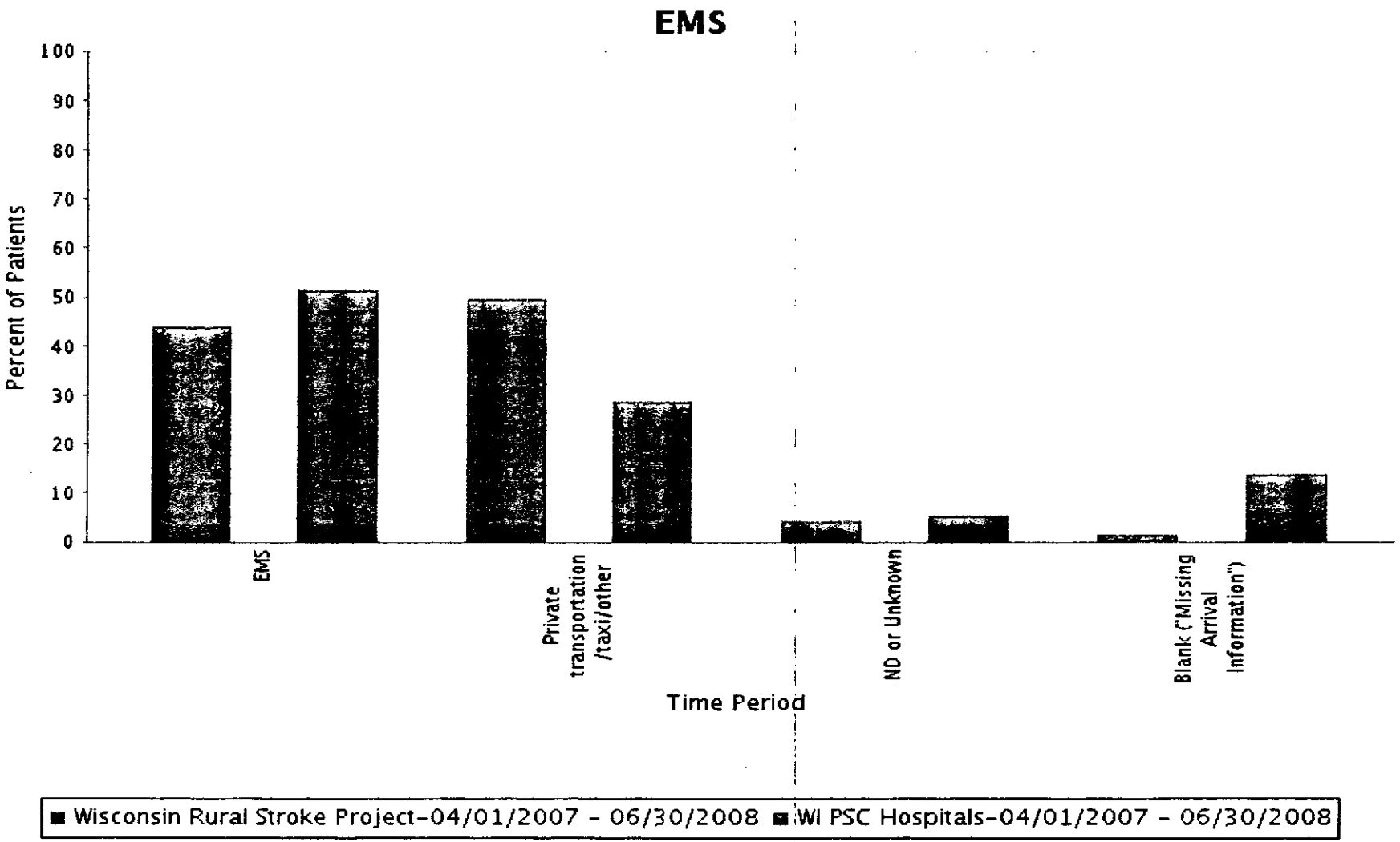
1. Missouri Stroke Consensus Measures
2. Wisconsin breakdown of patients by arrival mode, rural vs. urban
3. Wisconsin breakdown of the diagnosis of patients presenting in rural hospitals

Missouri Hospitals participating in Get With The Guidelines

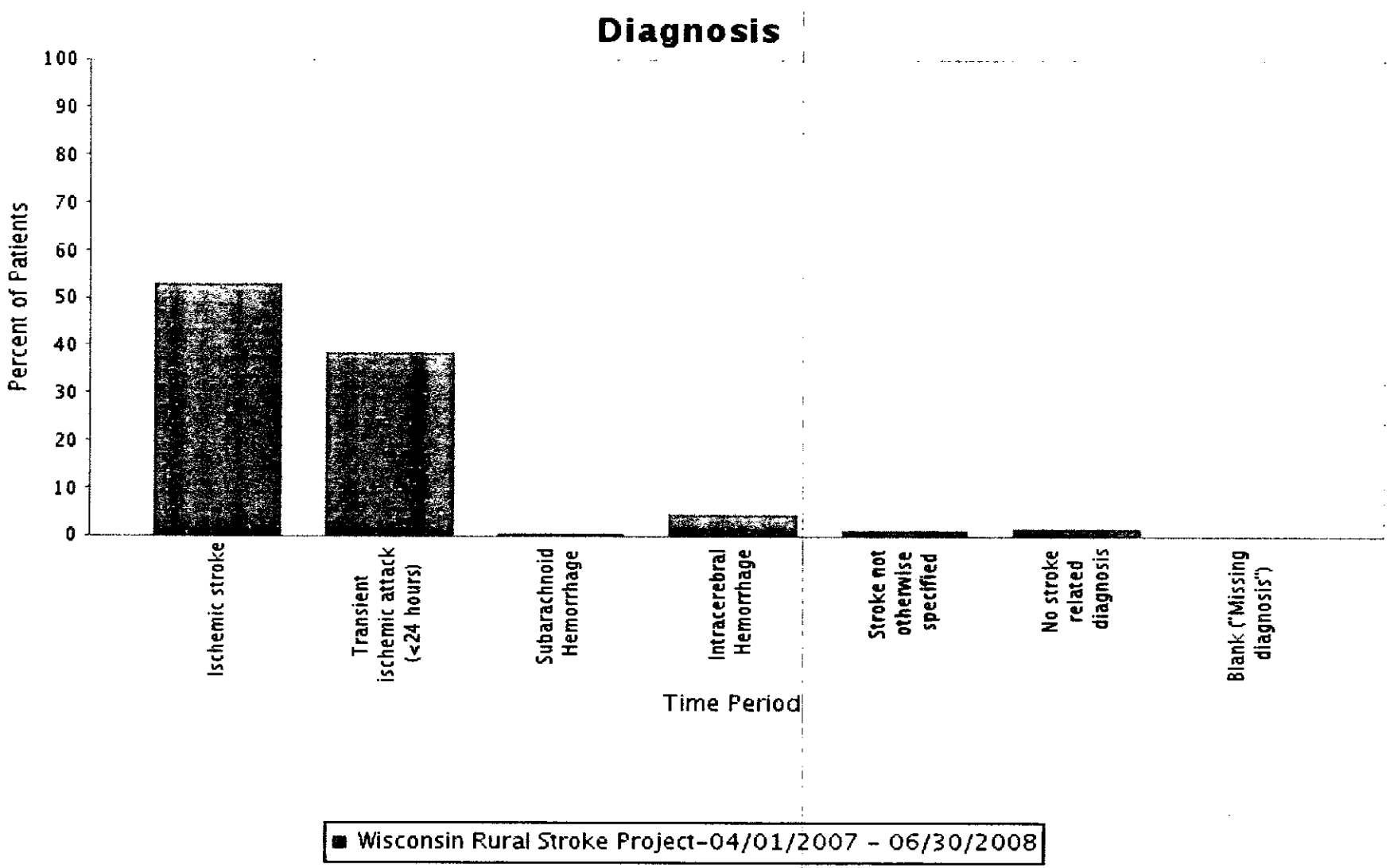
Data from 7/07 – 6/08 including 4640 patients
Stroke Consensus Measures
(Lowest performing areas in MO are giving tPA and providing stroke education)



Wisconsin - breakdown of arrival to ED
Critical Access Hospitals vs. Primary Stroke Centers
(More patients enter the emergency dept by personal transport in the rural setting and more call 911 in urban locations)



Wisconsin-
Breakdown of stroke patients by diagnosis in the rural setting.



Senate Appropriations Committee

February 13, 2009

Chairman Holmberg and Committee Members:

Thank you for the opportunity to speak with you today regarding health information technology and SB2332. I am Kimber Wraalstad, President/CEO of Presentation Medical Center in Rolla and a member of the North Dakota Health Information Technology Steering Committee.

I would like to speak to four issues:

1. Impact of Health Information Technology to Patient Care

2. Bottineau/Rolla/Stanley and Northwest Alliance for Information Technology Projects

3. Cost of Health Information Technology

4. The Rationale for the Proposed Grant

Thank you for your consideration and I will be happy to address any questions.

EMR Adoption Model Structure Ensures Objectivity

- All application capabilities within each stage must be operational before that stage can be achieved.
- All lower stages must have been achieved before a higher level is considered as achieved.
- A hospital can achieve Stages 3-6 if it has met all of the application requirements for a single patient care service (e.g. single nursing floor, cardiology service).
- Using the rules above, additional points are given for the implementation of applications in stages higher than the one fully achieved by the healthcare organization. In this fashion, other implementation paths than those prescribed by the stages can be taken into consideration for correlation with quality and financial research.

Stage	Description
7	• Clinical information can be readily shared via electronic transactions or exchange of electronic records with all entities within a regional health network (i.e., other hospitals, ambulatory clinics, sub-acute environments, employers, payers and patients).
6	• Full physician documentation/charting (structured templates) are implemented for at least one patient care service area. • A full complement of radiology PACS systems is implemented (i.e. all images, both digital and film-based, are available to physicians via an intranet or other secure network.)
5	• The closed loop medication administration environment is fully implemented in at least one patient care service area. The eMAR and bar coding or other auto-identification technology, such as radio frequency identification (RFID), are implemented and integrated with CPOE and pharmacy to maximize point-of-care patient safety processes for medication administration.
4	• Computerized practitioner/physician order entry (CPOE) for use by any clinician added to nursing and CDR environment. • Second-level of clinical decision support related to evidence-based medicine protocols implemented. • If one patient service area has implemented CPOE and completed previous stages, this stage has been achieved.
3	• Clinical documentation installed (e.g. vital signs, flow sheets, nursing notes, care plan charting, and/or the electronic medication administration record (eMAR) system are scored with extra points and are implemented and integrated with the CDR for at least one service in the hospital.) • First level of clinician decision support is implemented to conduct error checking with order entry (i.e. drug/drug, drug/food, drug/lab conflict checking normally found in the pharmacy). • Some level of medical image access from picture archive and communication systems (PACS) is available for access by physicians via the organization's intranet or other secure networks.
2	• Major ancillary clinical systems feed data to clinical data repository (CDR) that provides physician access for retrieving and reviewing results. • CDR contains a controlled medical vocabulary (CMV) and the clinical decision support system and rules engine for rudimentary conflict checking. • *Optional for extra points* - Information from document imaging systems may be linked to the CDR.
1	• Laboratory, pharmacy and radiology installed.
0	• Some clinical automation may exist. • Laboratory and/or pharmacy and/or radiology not installed.

SB2332 – Health Information Technology
Senate Appropriations Committee
Harvest Room
February 13, 2009, 10:00 a.m.

Mr. Chairman, and members of the committee, my name is Darrell Vanyo from Fargo. I am here in support of SB2332. Two years ago, legislation was passed providing for the formation of the Health Information Technology (HIT) Steering Committee. The legislation called for this committee to be appointed by the Governor and to be representative of various agencies, associations, providers, payers, and consumers throughout the state. I am a member of that steering committee and I am also co-chair of the Health Information Exchange (HIE) workgroup, a sub-committee of the HIT Steering Committee.

For the past two years, the HIE workgroup has discussed varied approaches to the state-wide exchange of health information, patient identification, security/privacy issues and the engagement of all providers and health agencies throughout the state. The workgroup has even reviewed a number of vendor solutions; but ultimately reached the conclusion that a funding source is necessary to build the foundation and jump start the entire process.

To date, external funding for health care providers has come by way of very limited federal and Blue Cross Blue Shield of North Dakota grant monies. Blue Cross Blue Shield of ND has awarded $1.4 million toward 32 funded projects over the past 8 years and North Dakota health care facilities have received over $9 million in federal grants

since 1999. While this may sound impressive, these funds have provided only seed money to support partial investments for technology. Only recently, have the proposed variations of the Federal Economic Stimulus Bill referenced the inclusion of $2 billion dollars for HIT loans, grants and technical assistance. There are further inclusions for up to $17 billion in Medicare and Medicaid payment incentives to be paid out through 2014 for those health providers making use of HIT/HIE. Beginning in 2014, these incentives will give way to penalties being invoked for those providers not on board with health information exchange.

So why is this a problem for the state? First, there is talk that the federal monies may only come if there are state matching funds. Without the state appropriating dollars for the next biennium, North Dakota stands to lose significant federal dollars for the advancement of HIT. Second, the burden for health providers to take on this additional expense is very significant – particularly for the smaller rural providers who are struggling to keep their doors open. They really do need a helping hand to access funding, albeit on the state or federal level. Third, the exchange of health information electronically requires that there be electronically stored information. Today throughout North Dakota, 38% of rural hospitals, 47% of primary care clinics, 16% of public health units, and 23% of long term care facilities do not have electronic medical records (EMR). EMR's are the basic foundation needed to springboard all providers toward the use of HIT/HIE. As indicated by providers, the most significant barrier to implementing EMR's is the lack of funding and current reimbursement. If HIE is to be statewide, all

providers need assistance, in varied degrees, to get to a level playing field. To that end, external dollars are necessary or providers will find themselves in a financial death spiral.

In conclusion, I would like to also address the need for a statewide HIT director and office, which of course requires a portion of the appropriation being requested.

Every state that has had any success in moving toward the statewide exchange of health information has had a statewide director and has had a significant infusion of dollars from the state. Every good cause requires strong and dedicated leadership. The volunteers making up the current HIT Steering Committee have dedicated countless hours to this effort over the past two years. Their continued dedication will still be needed in the future. However, the task of coordinating the efforts of all throughout the state in order to evaluate vendors, make decisions about those vendors, oversee implementation efforts, administer the flow of grant monies to providers and agencies, and coordinate activities so that all current systems within a providers office can be integrated into a statewide system allowing for the secure exchange of health information can only be done well and expeditiously with a dedicated director.

I hope this has helped you better understand the rationale for this bill. I ask for your support of SB2332 and the requested appropriation. Thank you.

Same to Gwen to Home Human Services

Health Information Technology Definitions

NAHIT, ONCHIT Announce Health Information Technology Definitions

The National Alliance for Health Information Technology (NAHIT) has finalized definitions for six critical health information technology terms, according to an announcement on the NAHIT Web site.

HHS' Office of the National Coordinator for Health Information Technology (ONCHIT) sponsored the definitions project.

Project participants determined that dual interpretations of health information exchange (HIE) as both a process and an entity, created the need for a sixth term—health information organization (HIO). The additional term clarifies the difference between the process of information exchange and the oversight and accountability functions necessary to support it.

The finalized definitions include:

- **Electronic medical record:** An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.
- **Electronic health record:** 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.
- **Personal health record:** 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.
- **Health information exchange:** The electronic movement of health-related information among organizations according to nationally recognized standards.
- **Health information organization:** An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.
- **Regional health information organization:** A health information organization that brings together health care stakeholders within a defined geographic area and governshealth information exchange among them for the purpose of improving health and care in that community.

To read NAHIT's report to ONCHIT, including the definitions, visit: http://www.nahit.org/images/pdfs/HITTermsFinalReport_051508.pdf.

To read the HAHIT announcement go to http://www.nahit.org/.

ND Senate Appropriations Committee Hearing – SB2332

3

Friday, February 13, 2009

Good morning Chairman Holmberg and members of the Senate Appropriations Committee.

Thank you for this opportunity to speak on behalf of the ND HIT Steering Committee with regard to Senate Bill No. 2332 introduced by Senators Lee and Robinson and Representatives Weisz and Kaldor.

My name is Lynette Dickson; I am a Program Director at the Center for Rural Health, University of North Dakota and have been serving as the Chair of the Steering Committee. This Committee has 22 members in addition to over 45 additional stakeholders that serve in five work groups (HIE, Communication/Education; Legislative/Policy; Privacy/Security; Finance/Resources).

My colleagues have shared information with regard to their area of expertise and involvement with HIT Steering Committee. I would like to provide background information with regard to how the request was developed for SB 2332. We have prepared this document which provides more detail with regard to the requested appropriation (Handout).

Since the committee was legislatively created in 2007 without appropriation we were determined to not let our state fall further behind so we continued to meet on a regular basis to learn from other states, educate ourselves on lessons learned on local EMR implementation as well as how other state level health information exchange(HIE) models are working. In the past three years, the Center for Rural Health has supported this statewide effort by using approximately $90,000 federal funds from HRSA grants, we administer. These funds have supported monthly conference calls, website development and maintenance, face to face meetings, speaker fees, printing/copying of handouts as well as a statewide HIT survey, analysis and final report (handout). In addition BCBSND has provided financial support; ND Healthcare Review, Minot conducted the statewide survey of clinics not to mention the numerous in-kind contributions through the member organizations volunteer efforts. With extraordinary dedication and effort on behalf of North Dakota this has taken place.

Kory Mertz, Policy Associate with National Congress on State Legislators (NCSL) shared with me yesterday that the "vast majority of states have established an office working on health IT efforts" which is naturally conducive to moving things forward.

The Steering Committee is proposing in this Bill that a state office be established which is dedicated to this effort with full time staff, with the appropriate background and expertise, which would work with the existing Steering Committee serving as an Advisory Group to allow the much needed work to be done in a more accelerated manner. Therefore the Department of Health developed an estimated cost of hiring a HIT Officer, Project Assistant and a portion for operating expenses for a **total of $273,726.**

Second – The proposed grant program was developed based on the 1) need demonstrated in the HIT statewide surveys; 2) the experience of the CRH administering HIT grants; and 3) the work of the HIT Funding and Resource Work Group, who researched and reviewed ten other state supported HIT grant programs such as MN, AZ, NY and FL to name a few.

On the handout you will see the basic components with regard to eligible health care facilities, a required matching fund (25% with 10% cash match and 15% in-kind match); require collaboration between three *(at minimum)* or more eligible health care entities which are not owned by any one entity, with the intent of facilitating collaboration; and [redacted]igible technology to be purchased or upgraded would be required to be standards based and meet interoperability specifications of an approved certification body.

The grant program would have three levels:

<u>1) Readiness and Planning Grants:</u>
Total number of grants to be funded: 20 (minimum of three facilities)
Minimum number of participating facilities: 60
Amount of each grant: $45,000 x 20
Total Readiness and Planning Grants: $900,000

<u>2) Implementation Grants</u>
A. Electronic Medical Records (or related technology) Implementation Projects
Total number of grants to be funded: 4 (minimum of three facilities)
Minimum number of participating facilities: 12
Amount of each grant: $900,000
Total number of Implementation Grants: $3,600,000

B. Telehealth Implementation Pilot Projects
Total number of grants to be funded: 3 (minimum of three facilities)
[redacted]inimum number of participating facilities: 9
[redacted]mount of each grant: $50,000 x 3 = $150,000

3) Health Information Exchange (HIE) Collaborative Grants
Total number of grants to be funded: 2 (minimum of three facilities)
Minimum number of participating facilities: 6
Amount of each grant: $500,000 x 2
Total HIE Grants: $1,000,000
Total Amount of Grants: $5,650,000

Total Appropriation $5,923,726

The need, as my colleagues and the survey results have demonstrated, far out ways the available funding given the number of facilities and the range of HIT applications. This concludes my testimony, thank you again for this opportunity to speak on behalf of the Steering Committee. I would be pleased to respond to any questions.

February 6, 2009

North Dakota
Health Information Technology

Connecting North Dakota for a healthier future

PROPOSED REQUEST for APPROPRIATION – 2009 Legislative Session

1) Establish the ND Health Information Technology (HIT) Office to be located within the ND Department of Health.

This DOH-HIT Office will exist to:

- Serve and maintain relationships with ND HIT Steering Committee (Advisory Committee) and other public and private partners for the purpose of insuring coordination of information systems planning, development, implementation and electronic exchange of information.
- Identify improvements in the management and use of public health and health care data to assess and improve the health status of North Dakota, through collaborative efforts.
- Serve as liaison between state agencies (e.g. DOH, DHS and ITD) and the HIT Steering Committee (Advisory Committee) and other
- Bridge gaps and link public health professional staff and clinical staff to the technology staff. The position assures linking internal and external partners around public health data and informatics issues to support better use of data to guide public health and health care practice.
- Provide oversight for administration of the grant program.

2) Create two positions to staff the ND HIT Office:

HIT Officer

This position reports to the State Medical Officer, Department of Health.

Knowledge, Skills and Ability:

This position is supervisory staff in the DOH- Health Information Technology Office and oversees the performance of the project assistant and support staff. This position will be leading a wide range of planning, assessment, policy development, and other activities related to informatics, the incumbent will be required to possess strong core planning skills, and informatics skills, including a working knowledge of the various planning methodologies for defining the needs for information system applications and the data standards necessary for HIT interoperability.

The incumbent is also required to be skilled in group facilitation, consensus-building, communications strategies, and translating complex HIT terms and concepts for non-IT staff.

This position must also have: strong interpersonal communication skills, with an ability to generate consensus among a variety of different perspectives; project management skills necessary to plan, organize and manage projects; and a high level of skill in the use of computers for data processing, presentations, and report writing. A sound understanding of public health, health care systems, health data, and health data standards is required. The incumbent must be able to work closely on teams and lead or participate in respectful joint decision-making.

Project Assistant

This position reports to the HIT Officer/Director

Knowledge, Skills and Ability:

- Knowledge and experience with grant program development, RFP and contracting processes.
- Excellent ability to organize and develop and accomplish short and long range goals and objectives.
- Excellent written and verbal communication skills in providing technical assistance.
- Ability to prepare and review reports and papers on the results of grant projects and other activities.

Direct operation of the DOH-HIT Office and administer grant program:
(Cost based on 24 months)
Personnel – Salary/Fringe (Based on 24 months): $247,322
HIT Officer/Director (100% FTE) and Project Assistant (50% FTE)
Operating (phone, travel, rent, printing, etc.): $26,250

Total DOH Administrative Cost: $273,726

3) Amend the existing statute to change the ND HIT Steering Committee (same members) to the ND HIT Advisory Group which will provide direction to the DOH-HIT Office and Grant Program.

4) Establish a Grant Program

Grant Program Title:
Improving Access, Quality and Patient Safety through Health Information Technology (HIT)
The overarching goal for this grant program is to improve access, quality and patient safety, through the effective adoption and implementation of electronic exchange of health information within and among health care facilities in a given region (e.g. electronic health records, regional health information exchange, telehealth, etc.).

Eligible health care entities: All rural health clinics and community health centers; hospitals; licensed nursing facilities; local public health units, EMS, ambulance services and nonprofit entities(with the purpose of providing health information exchange coordination governed by a representative and other providers of health or health care services) approved by the ND HIT Steering Committee.

All proposed grant projects will *require collaboration between three (at minimum) or more eligible health care entities which are not owned by any one entity.* The intent of the grant program is to facilitate the formation of collaborative efforts between distinct corporate entities.

Matching Funds: Grant funds shall be awarded on a 25% match basis for the total grant amount awarded. Applicants shall be required to provide 10% in the form of cash match and 15% in-kind match, such as staff or services.

Proposed Funding Period: July 1, 2009-June 30, 2011

Eligible Technology Solutions: All grantees will be required to purchase or upgrade new health IT products, that are standards based (e.g. Healthcare Information Technology Standards Panel [HITSP)]) and meet interoperability specifications of approved certification bodies for the specific type of technology being purchased (e.g. Certification Commission for Health Information Technology (CCHIT) for EMRs; National EMS Information System[NEMSIS] for EMS systems).

I. *Readiness Assessment and Planning Grants*:
Purpose: To support the structured planning activities that will prepare for successful adoption/implementation of technology solutions. Activities may include: initial stages of collaboration with partners, readiness assessment, development of education/training programs for healthcare professionals and staff, workflow analysis within individual health care facilities as well as between community/regional facilities, business planning, determining specific network HIT functions.
Total Number of Grants to be Funded: 20 *(Minimum of three facilities per grant)*
Amount of Each Grant: $45,000

Total Planning Grants Funded: $900,000

II. Implementation Grants

A. Electronic Medical Records (or related technology) **Implementation Projects**

Purpose: To support communities/networks who can clearly demonstrate they have completed a structured planning process and are in the position, at the time of submitting an application, to begin implementation of electronic health record, e-prescribing or other related technology , including NEMSIS technology.

Total Number of Grants to be Funded: 4 *(Minimum of three facilities per grant)*

Amount of Each Grant: $900,000

Total EMR Grants Funded: $3,600,000

B. Telehealth Implementation Pilot Projects

Purpose: To support communities/regions who can clearly demonstrate the completion of the planning and readiness phase and are in the position to begin implementation of a new or expanded telehealth program (e.g. teledialysis, telestroke, telemental health, etc.)

Total Number of Grants to be Funded: 3 *(Minimum of three facilities per grant)*

Amount of each Grant: $50,000

Total Telehealth Grants Funded:$150,000

III. Health Information Exchange(HIE) Collaborative Grants

Purpose: To support existing or newly established collaborative who can clearly demonstrate the completion of the planning and readiness phase and are in the position to begin to connect and facilitate the exchange of health information between eligible health care entities in a selected geographical region.

Total Number of Grants to be Funded: 2 *(Minimum of three facilities per grant)*

Amount of each Grant: $500,000

Total HIE Grants Funded: $1,000,000

Total Amount of Grants: $5,650,000

TOTAL APPROPRIATION $5,923,726

Definitions

Health Information Technology: The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing and use of healthcare information, data, and knowledge for communication and decision making.

Electronic medical record: An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Electronic health record: 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.

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

For more information contact: Lynette Dickson, Chair ND HIT Steering Committee
Direct line: 701-777-6049 Email: ldickson@medicine.nodak.edu

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Testimony in Support of Engrossed SB No. 2332
House Human Services Committee
March 16, 2009

Chairman Weisz and Committee Members, I'm Dean Haas and I represent the North Dakota Medical Association.

The North Dakota Medical Association supports SB No. 2332 as a vehicle for assisting our North Dakota health systems develop and coordinate health information technology. Health information technology is fast becoming a key component of state and federal efforts to improve health care and is a means for facilitating quality improvement and cost control. Appropriate, well-coordinated health information technology strategies can bring together vital pieces of patient data essential for providing quality care. In addition, the federal government has recently adopted initiatives in the stimulus bill to boost health information technology.

Despite documented advantages and federal support for HIT initiatives, physician adoption of HIT nationally has been slow. Research on HIT adoption rates indicates that concerns about high cost, uncertainty of return on investment after adoption, and worry over the usability and obsolescence of new technologies rank highest among reasons HIT has not yet been adopted. Doubts about the privacy and security of patient data, practice compliance with HIPAA legislation, and the potential for inappropriate disclosure of patient information to third parties rank just behind financial concerns. Initiatives such as that provided in SB No. 2332 provide incentives and the means to overcome these barriers.

The North Dakota Medical Association is a member of the ND Health Information Technology Steering Committee created last legislative session to facilitate the adoption and use of health information technology and exchange to improve health care quality, patient safety and overall efficiency of health care and public health services in North Dakota (NDCC 23-01-31). SB 2332 would re-establish that committee and authorize it make recommendations for implementing a statewide interoperable health information infrastructure, develop a grant program to assist in the planning and implementation of HIT projects, and establish an entity for accepting and expending contributions, gifts and grants from the federal government.

We request that the committee vote a "Do Pass" on Engrossed SB 2332 and re-refer the bill to the Appropriations Committee for further consideration of the appropriation language and consideration of provisions of the federal stimulus bill, HR 1, the "American Recovery and Reinvestment Act of 2009," which includes funding to strengthen the HIT infrastructure, and provides grants to states for health information exchanges and loan programs. A summary of the HIT provisions of the stimulus bill is attached.

Health information technology (HIT)

Provides approximately $19 billion for Medicare and Medicaid Health Information Technology (HIT) incentives over five years.

- Creates statutory authority for the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS; President Bush created ONCHIT by Executive Order in 2004.
- Establishes HIT Policy and Standards Committees that are comprised of public and private stakeholders (e.g., physicians) to provide recommendations on the HIT policy framework, standards, implementation specifications, and certification criteria for electronic exchange and use of health information.
- HHS to adopt through the rule-making process an initial set of standards, implementation specifications, and certification criteria by Dec. 31, 2009.
- ONCHIT will be authorized to make available an HIT system to providers for a nominal fee.
- Provides financial incentives through the Medicare program to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) in a meaningful way (as defined by the Secretary and may include reporting quality measures). Authorizes ONCHIT to provide competitive grants to states for loans to providers.
- Medicare incentive payments will be based on an amount equal to 75% of the Secretary's estimate of allowable charges, up to $15,000 for the first payment year. Incentive payments would be reduced in subsequent years: $12,000, $8,000, $4,000, and $2000, ending in 2015. Physicians who report using an EHR that is also capable of e-prescribing will no longer be eligible for the e-prescribing bonuses established by the Medicare Improvements for Patients and Providers Act (MIPPA); they will be eligible for HIT incentives only to avoid "double-dipping."
- Early adopters (including those who have already implemented HIT systems) whose first payment year is 2011 or 2012 will be eligible for an initial, larger incentive payment up to $18,000. In 2014, the payment limit for new adopters will be $12,000.
- For eligible professionals in a rural health professional shortage area, the incentive payment amounts will be increased by 10 percent.
- Also provides incentives for eligible physicians, hospitals, Federally-qualified health centers, rural health clinics, and other providers under Medicaid.
- Physicians who do not adopt/use a certified HIT system will face reduction in their Medicare fee schedule payments of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. E-prescribing penalties sunset after 2014.
- Both bills allow HHS to increase penalties beginning in 2019, but penalties cannot exceed -5%. Exceptions will be made on a case-by-case basis for significant hardships (e.g., rural areas without sufficient Internet access).
- Federal privacy and security laws (HIPAA) were expanded to protect patient health information, including: defining which actions constitute a breach (including some inadvertent disclosures), imposing restrictions on certain disclosures, sales, and marketing of protected health information, requiring an accounting of disclosures to a patient upon request, authorizing increased civil monetary penalties for HIPAA violations, and granting authority to state attorneys general to enforce HIPAA.

#2

January 24, 2009

North Dakota
Health Information Technology

Connecting North Dakota for a healthier future

PROPOSED REQUEST for APPROPRIATION – 2009 Legislative Session

1) Establish the ND Health Information Technology (HIT) Office to be located within the ND Department of Health.

This DOH-HIT Office will exist to:

- Serve and maintain relationships with ND HIT Steering Committee (Advisory Committee) and other public and private partners for the purpose of insuring coordination of information systems planning, development, implementation and electronic exchange of information.
- Identify improvements in the management and use of public health and health care data to assess and improve the health status of North Dakota, through collaborative efforts.
- Serve as liaison between state agencies (e.g. DOH, DHS and ITD) and the HIT Steering Committee (Advisory Committee) and other
- Bridge gaps and link public health professional staff and clinical staff to the technology staff. The position assures linking internal and external partners around public health data and informatics issues to support better use of data to guide public health and health care practice.
- Provide oversight for administration of the grant program.

2) Create two positions to staff the ND HIT Office:

HIT Officer

This position reports to the State Medical Officer, Department of Health.

Knowledge, Skills and Ability:

This position is supervisory staff in the DOH- Health Information Technology Office and oversees the performance of the project assistant and support staff. This position will be leading a wide range of planning, assessment, policy development, and other activities related to informatics, the incumbent will be required to possess strong core planning skills, and informatics skills, including a working knowledge of the various planning methodologies for defining the needs for information system applications and the data standards necessary for HIT interoperability.

The incumbent is also required to be skilled in group facilitation, consensus-building, communications strategies, and translating complex HIT terms and concepts for non-IT staff.

This position must also have: strong interpersonal communication skills, with an ability to generate consensus among a variety of different perspectives; project management skills necessary to plan, organize and manage projects; and a high level of skill in the use of computers for data processing, presentations, and report writing. A sound understanding of public health, health care systems, health data, and health data standards is required. The incumbent must be able to work closely on teams and lead or participate in respectful joint decision-making.

Project Assistant

This position reports to the HIT Officer/Director

Knowledge, Skills and Ability:

- Knowledge and experience with grant program development, RFP and contracting processes.
- Excellent ability to organize and develop and accomplish short and long range goals and objectives.
- Excellent written and verbal communication skills in providing technical assistance.
- Ability to prepare and review reports and papers on the results of grant projects and other activities.

Nancy

Direct operation of the DOH-HIT Office and administer grant program:
(Cost based on 24 months)
Personnel – Salary/Fringe (Based on 24 months): $247,322
HIT Officer/Director (100% FTE) and Project Assistant (50% FTE)
Operating (phone, travel, rent, printing, etc.): $26,250

Total DOH Administrative Cost: $273,726

3) Amend the existing statute to change the ND HIT Steering Committee (same members) to the ND HIT Advisory Group which will provide direction to the DOH-HIT Office and Grant Program.

4) Establish a Grant Program

Grant Program Title:
Improving Access, Quality and Patient Safety through Health Information Technology (HIT)
The overarching goal for this grant program is to improve access, quality and patient safety, through the effective adoption and implementation of electronic exchange of health information within and among health care facilities in a given region (e.g. electronic health records, regional health information exchange, telehealth, etc.).

Eligible health care entities: All rural health clinics and community health centers; hospitals; licensed nursing facilities; local public health units and nonprofit entities(with the purpose of providing health information exchange coordination governed by a representative and other providers of health or health care services) approved by the ND HIT Steering Committee.

All proposed grant projects will *require collaboration between three (at minimum) or more eligible health care entities which are not owned by any one entity*. The intent of the grant program is to facilitate the formation of collaborative efforts between distinct corporate entities.

Matching Funds: Grant funds shall be awarded on a 25% match basis for the total grant amount awarded. Applicants shall be required to provide 10% in the form of cash match and 15% in-kind match, such as staff or services.

Proposed Funding Period: July 1, 2009-June 30, 2011

Eligible Technology Solutions: All grantees will be required to purchase or upgrade new health IT products, that apply Healthcare Information Technology Standards Panel(HITSP) interoperability specifications and have Certification Commission for Health Information Technology (CCHIT) certification.

I. *Readiness Assessment and Planning Grants*:
Purpose: To support the structured planning activities that will prepare for successful adoption/implementation of technology solutions. Activities may include: initial stages of collaboration with partners, readiness assessment, development of education/training programs for healthcare professionals and staff, workflow analysis within individual health care facilities as well as between community/regional facilities, business planning, determining specific network HIT functions.
Total Number of Grants to be Funded: 20 *(Minimum of three facilities per grant)*
Amount of Each Grant: $45,000

Total Planning Grants Funded: $900,000

II. Implementation Grants

A. Electronic Medical Records (or related technology) **Implementation Projects**

Purpose: To support communities/networks who can clearly demonstrate they have completed a structured planning process and are in the position, at the time of submitting an application, to begin implementation of electronic health record, e-prescribing or other related technology.

Total Number of Grants to be Funded: 4 *(Minimum of three facilities per grant)*

Amount of Each Grant: $900,000

Total EMR Grants Funded: $3,600,000

B. Telehealth Implementation Pilot Projects

Purpose: To support communities/regions who can clearly demonstrate the completion of the planning and readiness phase and are in the position to begin implementation of a new or expanded telehealth program (e.g. teledialysis, telestroke, telemental health, etc.)

Total Number of Grants to be Funded: 3 *(Minimum of three facilities per grant)*

Amount of each Grant: $50,000

Total Telehealth Grants Funded:$150,000

III. Health Information Exchange(HIE) Collaborative Grants

Purpose: To support existing or newly established collaborative who can clearly demonstrate the completion of the planning and readiness phase and are in the position to begin to connect and facilitate the exchange of health information between eligible health care entities in a selected geographical region.

Total Number of Grants to be Funded: 2 *(Minimum of three facilities per grant)*

Amount of each Grant: $500,000

Total HIE Grants Funded: $1,000,000

Total Amount of Grants: $5,650,000

TOTAL APPROPRIATION $5,923,726

Definitions

Health Information Technology: The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing and use of healthcare information, data, and knowledge for communication and decision making.

Electronic medical record: An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Electronic health record: 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.

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

#3

American Heart Association. | American Stroke Association.
Learn and Live.

Senate Bill 2332

House Human Services Committee

Chairman Wiesz and members of the House Human Services Committee. I am June Herman, Senior Director of Government Relations for the American Heart Association in North Dakota. I am here today asking for your committee's support of SB 2332 and reinstating some of the important appropriations that Senate Human Services felt important with this bill.

SB 2332 as originally introduced established the following:

- Formalizes a Health IT advisory group and Health IT office within the Department of Health ($500,000)
- Health IT funding – ($5,423,572) (see attachment)

Also attached to my testimony is a proposed amendment for your consideration that reinstates the original appropriations as passed by Senate Human Services.

The American Heart Association's support of SB 2332 has been from a patient perspective. Acute events such as heart attack, cardiac arrest and stroke rely on access to health care and effective and timely access to larger facilities with broader capabilities. It is important that rural communities are able to maintain access to critical access hospitals when basic care is essential, and prompt transfer when advance treatments can greatly improve patient outcomes. Health IT is a core structure to ensure both rural hospitals remain viable and to share vital patient record information when advance treatment is in the interest of the patient.

In the next several weeks more will be known on federal stimulus funds directed to Health IT, the degree of any state match requirements, and the gap in ND hospital technology in order to compete for federal HIT funding. Support is still very much needed to get the facilities, especially rural, to a level of Eletronic Health Record (EHR) adoption in order to be a 'meaningful user' to apply for federal funding. (Definition still to be defined by the Sec. DHHS). So far the discussion has been that the hospital must use a certified EHR, be able to exchange quality data(what data TBD), be part of a health information exchange(what is HIE TBD), and e-prescribing (clinics only); which will be a requirement to be eligible to access the Medicare/Medicaid incentive dollars. Also important to note, if physicians and hospitals are not 'meaningful users' of EHR the incentive program will be phased in to penalties for not adopting.

Included in the original SB 2332 request is another important building block for improved stroke care, as within it is the potential to fund special telemedicine projects, such as tele-stroke services to provide acute stroke care. With a stroke, time lost is brain lost. SB 2332 provides for the granting opportunities for tele-medicine efforts. Given hospital survey responses showing high interest in tele-stroke, the granting program provides the opportunity for the piloting of tele-stroke capabilities in the state, connecting "hub" hospitals with "spoke" hospitals. In other words, grants providing public good beyond the capacity of individual efforts, as we learned during Lincoln day celebrations yesterday.

Telestroke networks are feasible and rapidly deployable at institutions that have well coordinated clinical and IT expertise available, and should meet the implementation timetable connected to federal stimulus funding.

In conclusion, I ask for your "Do Pass" recommendation on SB 2332, amended back to the original appropriation request. We can then look to the additional information that will become available, and through House Appropriations or conference committee, adjust appropriations to a level that best leverages North Dakota resources and capabilities. I would be happy to answer any questions you may have at this time.

PROPOSED AMENDMENTS TO SENATE BILL NO. 2332

Page 3, line 2, replace "$500,000" with "$5,923,572"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:
This amendment reinstates the original appropriation amount approved by Senate Human Services from the general fund for the costs of the health information technology office in the State Department of Health from $500,000 to $5,923,572

The Health Information Technology for Economic and Clinical Health (HITECH) Act

(HIT Stimulus Dollars)

2009 Non-Stimulus Related State Loan Fund Request: ~~$6.5 million [$400,000-$400,800]~~	1/1/2010 State Loan Program ~~Request: $1 million [$5:$1]~~	10/1/2010 State Planning and Implementation Grants ~~Request: $3.5 million [$10:$1 - FFY2011]~~ ~~Request: $1:5 million [$7:$1 - FFY2012]~~ Request: $? [$3:1 - FFY2013] TBD 2011	10/1/2010Medicare/Medicaid Hospital/MD ~~Incentive~~ Payments ~~Can access FFY2011~~ ~~Penalties begin~~ in FY2015	
Low interest loan fund established by	Competitive grants to states to establish	Competitive grants to states to facilitate and	Base amounts to hospitals and MDs who are	
legislature to ensure healthcare entities	loan programs for healthcare providers	expand electronic Health Information Exchange	meaningul users of certified EHR technology.	
are prepared to meet criteria to qualify	to purchase and upgrade Electronic	(HIE)		
for Medicare/Medicaid incentives.	Health Record (EHR) technology, train		Criteria to apply:	
	personnel in its use and improve	Criteria to apply:	Must demonstrate the use of certified EHR	
Criteria/Guidelines to apply:	security of information exchange.	Must submit plan describing activities to be	technology in a meaningful manner (to include	
Will be determined by HIT Director and		carried out to facilitate and expand HIE	e-prescribing for MDs).	
Advisory Committee and will mirror	Criteria to apply:	according to national standards and		
federal requirements	Must establish an Health Information	implementation specifications.	Must demonstrate purpose of exchanging	
	Technology (HIT) loan fund		health information to improve health care quality	
		Must submit to annual federal evaluation to		
	Must annually submit a strategic plan	to ensure activities have resulted in	Must demonstrate technology is being used to	
	describing intended uses of funds and	improvement in healthcare quality, decrease	report clinical quality measures mandated.	
	providing assurances that loans are being	in healthcare costs and improved security of		
	provided only to those health care providers	health information exchange.	PPS Hospitals - Medicare	CAH - Medicare
	that submit reports on required quality		Beginning FY2011 - hospitals can apply for	Reasonable cost based
	measures and that certified EHR		$2 million base award + $200 per discharge for	reimbursement based on
	technology obtained and supported by		each discharge over 1,150 through 23,000.	enhanced share to match
	the loan is for the exchange of health		All payments are adjusted by the Hospital's	Medicare share calculated for
	information to improve quality of care.		Medicare share, which takes into account charity	acute-care hospitals.
			care.	Enhanced share may not
	Loans are repayable over period of 10 yrs		100%- FY1/ 75%-FY2/ 50%-FY3/ 25%-FY4	exceed 100%.
	No awards allowed prior to 1/1/2010		Penalties begin in 2015 if EHR not implemented	Penalties begin in 2015.
			MDs - Medicare	Medicaid
			Beginning in 2011 - MDs can apply for 75% of	100% match to qualified
			allowed Part B charges during reporting year	providers including MDs,
			but is capped.	dentists, NPs, PAs who are not
			$15,000- FY1/ $12,000 - FY2/ $8,000-FY3	hospital-based and have 30%
			$4,000 - FY4/ $2,000 - FY5	Medicaid volume. Match also
			Penalties begin in 2015 if EHR not implemented	to acute care hospitals with
			Hospital-based physicians not eligible	at least 10% volume capped
				State to determine.

Must use in meaningul manner and be certified.

#2

90948.0206
Title.

Prepared by the Legislative Council staff for
Representatives Skarphol and Svedjan
April 25, 2009

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

That the House recede from its amendments on pages 1258-1260 of the Senate Journal and pages 1126 and 1127 of the House Journal and that Engrossed Senate Bill No. 2332 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 6-09 and two new sections to chapter 23-01 of the North Dakota Century Code, relating to Bank of North Dakota loan funds for health information technology, creation of a health information technology office, and health information exchange grants; to amend and reenact section 23-01-31 of the North Dakota Century Code, relating to the North Dakota health information technology steering committee; to provide an appropriation; to provide for transfers; to provide for a report to the legislative council; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology loan fund - Appropriation.

1. The health information technology loan fund is established in the Bank for the purpose of providing loans to health care providers to purchase and upgrade electronic health record technology, train personnel in its use, and improve security of information exchange. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care providers as approved by the health information technology office in accordance with the criteria established by the health information technology steering committee under section 23-01-31. A loan made under this fund must be repayable over a period of ten years.

3. The Bank shall administer the health information technology loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office may approve the application of a qualified applicant that meets the criteria established by the health information technology steering committee. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under

this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may take a subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 2. AMENDMENT. Section 23-01-31 of the North Dakota Century Code is amended and reenacted as follows:

23-01-31. North Dakota health information technology steering committee - Duties - Loan and grant programs.

1. The North Dakota health information technology steering committee consists of the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and nine individuals appointed by the governor ~~to represent state government interests,~~ and ~~individuals appointed by~~ the state health officer to represent health information technology stakeholders.

2. The health information technology steering committee shall:

   a. Apply for federal funds that may be available to assist the state, health care entities, and health care providers in implementing and improving health information technology.

   b. Establish a health information technology loan program to provide loans to health care providers for the purpose of purchasing and upgrading certified electronic health record technology, training personnel in the use of such technology, and improving the secure electronic exchange of health information under section 1 of this Act.

   c. Establish a grant program for the health information technology office to provide grants from the electronic health information exchange grant fund to facilitate and expand electronic health information exchange.

   d. Establish an application process and eligibility criteria for loans and grants under subdivisions b and c.

   e. Consult with the information technology department regarding the health information technology infrastructure of the state.

SECTION 3. Two new sections to chapter 23-01 of the North Dakota Century Code are created and enacted as follows:

Health information technology office. The health information technology office is created in the state department of health. The health information technology steering committee and the information technology department shall make recommendations to the health information technology office for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards, promote the adoption and use of electronic health records and other health information technologies, and promote interoperability of health information systems for the purpose of improving health care quality, patient safety, and the overall efficiency of health care and public health services. The health information technology office shall accept and process applications for loans from the health information technology loan fund as provided under section 1 of this Act and section 23-01-31 and for grants from the electronic health information exchange grant fund. The health information technology office shall provide or arrange for administrative services to assist the health information technology steering committee.

Electronic health information exchange grant fund.

1. There is created an electronic health information exchange grant fund. The fund consists of moneys deposited in the fund from federal or other sources or moneys transferred into the fund as directed by the legislative assembly. The health information technology office shall administer this grant fund as provided by the health information technology steering committee and shall distribute funds accordingly. The grants must be used to facilitate and expand electronic health information exchange. Moneys in the fund may be used, subject to legislative appropriations, for grants as provided under this section and the costs of administration of the fund.

2. A grant applicant shall submit an application to the health information technology office, which shall determine the applicant's eligibility based upon criteria established by the health information technology steering committee.

3. This section does not create an entitlement to any funds available for grants under this section. The health information technology office may award these grants to the extent funds are available and, within the office's discretion, to the extent such applications are approved.

SECTION 4. HEALTH INFORMATION TECHNOLOGY OFFICE AND HEALTH INFORMATION TECHNOLOGY STEERING COMMITTEE - REPORT TO LEGISLATIVE COUNCIL. Before October 2010 the health information technology office and health information technology steering committee shall report to the legislative council on the status of the health information technology activities.

SECTION 5. BANK OF NORTH DAKOTA TRANSFERS. The industrial commission shall transfer, during the period beginning with the effective date of this Act and ending June 30, 2011, as requested by the state health officer, up to $1,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology loan fund to meet any required match for federal funds and up to $5,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the electronic health information exchange grant fund to meet any required match for federal funds.

SECTION 6. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the state department of health for the purpose of defraying the costs of the health information technology office and advisory committee, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 7. APPROPRIATION. There is appropriated out of any moneys in the electronic health information exchange grant fund, not otherwise appropriated, the sum of $38,500,000, or so much of the sum as may be necessary, including up to $35,000,000 of federal funds deposited in the fund from the federal American Recovery and Reinvestment Act of 2009 to the state department of health for the purpose of providing grants to facilitate and expand electronic health information exchange, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 8. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

#3

ND Health Information Technology Steering Committee – (Member List)

VISION

Implement a statewide health information technology and exchange infrastructure.

MISSION

Facilitate the adoption and use of health information technology and exchange to improve healthcare quality, patient safety and overall efficiency of healthcare and public health services in North Dakota.

Website *http://ruralhealth.und.edu/projects/sorh/hit.php*

Chair - Steering Committee
Lynette Dickson, MS, LRD, Program Director
Center for Rural Health
University of North Dakota
School of Medicine and Health Sciences
Phone: (701) 777-6049
E-mail: ldickson@medicine.nodak.edu
Representing rural healthcare facilities, organizations and communities

Terry Dwelle, MD, State Health Officer
North Dakota Department of Health
Phone: (701) 328-2372
E-mail: tdwelle@state.nd.us
Representing Department of Health

Ray Gruby, MD, CEO
Gruby Technologies
Phone: (701) 223-9113
E-mail: raymond@grubytechnologies.com
Representing technology businesses

Bruce Levi, Executive Director
North Dakota Medical Association
Phone: (701) 223-9475
E-mail: blevi@ndmed.com
Representing physician

Barb Groutt, CEO
North Dakota Healthcare Review
Phone: (701) 857-9747
E-mail: BGROUTT@ndqio.sdps.org
Representing Medicare's Quality Improvement Organization

Doug Kjos, Programmer/Analyst
North Dakota Healthcare Review
Phone: (701) 857-9747
E-mail: dkjos@ndqio.sdps.org
Representing Medicare's Quality Improvement Organization

Senator Judy Lee
1822 Brentwood
West Fargo, North Dakota
E-mail: jlee@nd.gov
Representing state legislature

Janis Cheney, Executive Director
North Dakota AARP
Phone: (701) 355-3641
E-mail: jscheney@aarp.org
Representing consumers

Craig Hewitt, CIO
MeritCare Health System, Fargo
Phone: (701) 234-6174
E-mail: Craig.Hewitt@Meritcare.com
Representing tertiary hospitals

Mark Grove, Administrator
Great Plains Clinic, Dickinson
Phone: (701) 456-5161
E-mail: markgrove@greatplainsclinic.com
Representing clinics

Lisa Feldner, CIO
State of North Dakota, Information Technology Department
Phone: 701-328-3193
E-mail: lfeldner@nd.gov
Representing state government interests

Tami Wahl, Policy Advisor HHS
Governor's Office
Phone: 701-328-2207
Email: tlwahl@nd.gov
Representing government interests

Cathy Houle, MD
West River Regional Medical Center
Hettinger, North Dakota
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cathyh@mail.ctctel.com
Representing rural physicians

Kimber Wraalstad, President/CEO
Presentation Medical Center
Rolla, North Dakota
Phone: (701) 477-3161
Email: kimberw@utma.com
Representing rural hospitals

Continued on back page > > >

3/11/2009

Arnold (Chip) Thomas, President
North Dakota Healthcare Association
Phone: (701) 224-9732
E-mail: athomas@ndha.org
Representing rural and urban hospitals

Steering Committee members, also serving as Chair and/or Co-chair of one of the five work groups

WORK GROUPS

Health Information Exchange Work Group
Chair - Darrell Vanyo, CIO
Blue Cross Blue Shield of North Dakota
Phone: (701) 282-1294
E-mail: darrell.vanyo@bcbsnd.com
Representing third-party payers

Co-Chair - Chad Peterson, IT Director
Northwood Deaconess Health System
Phone: (701) 587-6435
E-mail: chad.peterson@ndhc.net
Representing a rural hospital, long term care facility and community health center

Policy/Legislative Work Group
Chair - Nancy Willis, VP Marketing
St. Alexius Medical Center
900 East Broadway Ave
Bismarck, ND
Phone: (701) 530-7615
Email: nwillis@primecare.org
Representing tertiary hospitals

Co-Chair - Dana Halvorson, Legislative Assistant
(Liaison to the Steering Committee)
Senator Kent Conrad's Office
Phone: (202)-224-2043
E-mail: Dana_Halvorson@conrad.senate.gov
Representing federal government interests

Communication/Education - Work Group
Chair - Laurie Peters, RHIT, Past-President
North Dakota Health Information Management Association
Phone: (701)748-3485
E-mail: lpeters@westriv.com
Representing health information management workforce

Privacy/Security - Work Group
Chair - Jennifer Witham, IT Director
North Dakota Department of Human Services
Phone: 701-328-2570
E-mail: sowitj@nd.gov
Representing Department of Human Services

Finance/Resources - Work Group
Co-Chair – Lynette Dickson, Program Director
Center for Rural Health
University of North Dakota
School of Medicine and Health Sciences
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#4

90948.0209
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 28, 2009

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

That the House recede from its amendments as printed on pages 1258-1260 of the Senate Journal and pages 1126 and 1127 of the House Journal and that Engrossed Senate Bill No. 2332 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 6-09, a new section to chapter 23-01, and three new sections to chapter 54-59 of the North Dakota Century Code, relating to Bank of North Dakota loan funds for health information technology, application for federal funds, creation of a health information technology steering committee and a health information technology office, and health information exchange grants; to repeal section 23-01-31 of the North Dakota Century Code, relating to the health information technology steering committee; to provide an appropriation; to provide for transfers; to provide for a report to the legislative council; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology loan fund - Appropriation.

1. The health information technology loan fund is established in the Bank for the purpose of providing loans to health care providers to purchase and upgrade electronic health record technology, train personnel in its use, and improve security of information exchange. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care providers as approved by the health information technology office in accordance with the criteria established by the health information technology steering committee under section 3 of this Act. A loan made under this fund must be repayable over a period of ten years.

3. The Bank shall administer the health information technology loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office may approve the application of a qualified applicant that meets the criteria established by the health information technology steering committee. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan

fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may take a subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 2. A new section to chapter 23-01 of the North Dakota Century Code is created and enacted as follows:

Health information technology - Application for federal funds. The state department of health shall apply for federal funds that may be available to assist health care providers and the state in implementing and improving health information technology, including funding for health information technology loans under section 1 of this Act and electronic health information exchange grants under section 5 of this Act.

SECTION 3. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology steering committee - Duties - Loan and grant programs.

1. The health information technology steering committee consists of the department's chief information officer or the chief information officer's designee, the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and individuals appointed by the governor and the state health officer to represent health information technology stakeholders.

2. The health information technology steering committee shall:

   a. Establish a health information technology loan program to provide loans to health care providers for the purpose of purchasing and upgrading certified electronic health record technology, training personnel in the use of such technology, and improving the secure electronic exchange of health information under section 1 of this Act.

   b. Establish a grant program for the health information technology office to provide grants from the electronic health information exchange grant fund to facilitate and expand electronic health information exchange.

   c. Establish an application process and eligibility criteria for loans and grants under subdivisions a and b. The eligibility criteria for the grant program under subdivision b must provide that if an applicant uses grant funds for network services, the applicant shall contract with the department for the department to provide the network services.

SECTION 4. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office. The health information technology office is created in the department. The health information technology steering committee shall make recommendations to the health information technology office for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards, promote the adoption and use of electronic health records and other health information technologies, and promote interoperability of health information systems for the purpose of improving health care quality, patient safety, and the overall efficiency of health care and public health

services. The health information technology office shall accept and process applications for loans from the health information technology loan fund as provided under sections 1 and 3 of this Act and for grants from the electronic health information exchange grant fund. The health information technology office shall provide or arrange for administrative services to assist the health information technology steering committee.

SECTION 5. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Electronic health information exchange grant fund.

1. There is created an electronic health information exchange grant fund. The fund consists of moneys deposited in the fund from federal or other sources or moneys transferred into the fund as directed by the legislative assembly. The health information technology office shall administer this grant fund as provided by the health information technology steering committee and shall distribute funds accordingly. The grants must be used to facilitate and expand electronic health information exchange. Moneys in the fund may be used, subject to legislative appropriations, for grants as provided under this section and the costs of administration of the fund.

2. A grant applicant shall submit an application to the health information technology office, which shall determine the applicant's eligibility based upon criteria established by the health information technology steering committee.

3. This section does not create an entitlement to any funds available for grants under this section. The health information technology office may award these grants to the extent funds are available and, within the office's discretion, to the extent such applications are approved.

SECTION 6. REPEAL. Section 23-01-31 of the North Dakota Century Code is repealed.

SECTION 7. HEALTH INFORMATION TECHNOLOGY OFFICE AND HEALTH INFORMATION TECHNOLOGY STEERING COMMITTEE - REPORT TO LEGISLATIVE COUNCIL. During the 2009-10 interim, the health information technology office and health information technology steering committee shall make periodic reports to the legislative council on the status of health information technology activities.

SECTION 8. BANK OF NORTH DAKOTA TRANSFERS. The industrial commission shall transfer, during the period beginning with the effective date of this Act and ending June 30, 2011, as requested by the state health officer, up to $6,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology loan fund to meet any required match for federal funds and up to $2,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the electronic health information exchange grant fund to meet any required match for federal funds.

SECTION 9. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $350,000, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the costs of the health information technology office and steering committee, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 10. APPROPRIATION. There is appropriated out of any moneys in the electronic health information exchange grant fund, not otherwise appropriated, the

sum of $22,000,000, or so much of the sum as may be necessary, including up to $20,000,000 of federal funds deposited in the fund from the federal American Recovery and Reinvestment Act of 2009 to the information technology department for the purpose of providing grants to facilitate and expand electronic health information exchange, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 11. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

#5

90948.0210
Title.

Prepared by the Legislative Council staff for
Representative Skarphol
April 29, 2009

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

That the House recede from its amendments as printed on pages 1258-1260 of the Senate Journal and pages 1126 and 1127 of the House Journal and that Engrossed Senate Bill No. 2332 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 6-09 and three new sections to chapter 54-59 of the North Dakota Century Code, relating to Bank of North Dakota loan funds for health information technology, creation of a health information technology advisory committee and a health information technology office, and health information exchange grants; to repeal section 23-01-31 of the North Dakota Century Code, relating to the North Dakota health information technology steering committee; to provide an appropriation; to provide for transfers; to provide for a report to the budget section; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology loan fund - Appropriation.

1. The health information technology loan fund is established in the Bank for the purpose of providing loans to health care providers to purchase and upgrade electronic health record technology, train personnel in its use, and improve security of information exchange. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care providers as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology office director under section 3 of this Act. A loan made under this fund must be repayable over a period of ten years.

3. The Bank shall administer the health information technology loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may take a subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 2. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology advisory committee - Duties.

1. The health information technology advisory committee consists of the department's chief information officer or the chief information officer's designee, the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and individuals appointed by the governor and the state health officer to represent a broad range of public and private health information technology stakeholders.

2. The health information technology advisory committee shall collaborate with and make recommendations to the health information technology office, as provided under sections 1, 3, and 4 of this Act.

3. As requested by the health information technology advisory committee, the department shall provide or arrange for administrative services to assist the health information technology advisory committee.

4. The health information technology advisory committee may employ an executive director who serves at the pleasure of and under the direct supervision of the health information technology advisory committee. The executive director may employ personnel as necessary for the administration of this section.

SECTION 3. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Duties - Loan and grant programs.

1. The health information technology office is created in the department. The health information technology advisory committee shall make recommendations to the health information technology office for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards, promote the adoption and use of electronic health records and other health information technologies, and promote interoperability of health information systems for the purpose of improving health care quality, patient safety, and the overall efficiency of health care and public health services.

2. The health information technology office director, in collaboration with the health information technology advisory committee, shall:

   a. Apply for federal funds that may be available to assist the state and health care providers in implementing and improving health information technology.

b. Establish a health information technology loan program to provide loans to health care providers for the purpose of purchasing and upgrading certified electronic health record technology, training personnel in the use of such technology, and improving the secure electronic exchange of health information under section 1 of this Act.

c. Facilitate and expand electronic health information exchange in the state, directly or by awarding grants.

d. Establish an application process and eligibility criteria for and accept and process applications for loans and grants under subdivisions b and c.

SECTION 4. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Electronic health information exchange fund.

1. There is created an electronic health information exchange fund. The fund consists of moneys deposited in the fund from federal or other sources or moneys transferred into the fund as directed by the legislative assembly. The health information technology office shall administer this fund and shall distribute moneys in the fund accordingly. The moneys in the fund must be used to facilitate and expand electronic health information exchange. Moneys in the fund may be used, subject to legislative appropriations, for grants as provided under this section and the costs of administration of the fund.

2. A grant applicant shall submit an application to the health information technology office, which shall determine the applicant's eligibility based upon criteria established by the health information technology office director in collaboration with the health information technology advisory committee.

3. This section does not create an entitlement to any funds available for grants under this section. The health information technology office may award these grants to the extent funds are available and, within the office's discretion, to the extent such applications are approved.

SECTION 5. REPEAL. Section 23-01-31 of the North Dakota Century Code is repealed.

SECTION 6. HEALTH INFORMATION TECHNOLOGY OFFICE AND HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE - REPORT TO BUDGET SECTION. During the 2009-10 interim, the health information technology office and health information technology advisory committee shall provide periodic reports to the budget section on the status of health information technology activities.

SECTION 7. BANK OF NORTH DAKOTA TRANSFERS. The industrial commission shall transfer, during the period beginning with the effective date of this Act and ending June 30, 2011, as requested by the health information technology office director, up to $1,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology loan fund to meet any required match for federal funds and up to $5,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the electronic health information exchange fund to meet any required match for federal funds.

SECTION 8. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $350,000, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the costs of the health information technology advisory committee and the health information technology office, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 9. APPROPRIATION. There is appropriated out of any moneys in the electronic health information exchange fund, not otherwise appropriated, the sum of $38,500,000, or so much of the sum as may be necessary, including up to $35,000,000 of federal funds deposited in the fund from the federal American Recovery and Reinvestment Act of 2009 to the information technology department for the purpose of facilitating and expanding electronic health information exchange, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 10. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

4-29-09

#6

All funding opportunities will need to tie into the overall health information technology plan as established by the federal or national health coordinator.

The same would be said in the state—any funding is tied to a state plan as developed by the executive director and advisory committee.

Any product or service for which the funds are used will be required to adhere to federal certification standards as set forth in any contracts for those products and services.

Note: There currently is a federal certification standard in effect. That will be the baseline moving forward.

Craig Hewitt, Meritcare senior vice president and CIO

#7

90948.0211
Title.

Prepared by the Legislative Council staff for
Conference Committee
April 29, 2009

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

That the House recede from its amendments as printed on pages 1258-1260 of the Senate Journal and pages 1126 and 1127 of the House Journal and that Engrossed Senate Bill No. 2332 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 6-09 and three new sections to chapter 54-59 of the North Dakota Century Code, relating to Bank of North Dakota loan funds for health information technology, creation of a health information technology advisory committee and a health information technology office, and health information exchange grants; to repeal section 23-01-31 of the North Dakota Century Code, relating to the North Dakota health information technology steering committee; to provide an appropriation; to provide for transfers; to provide for a report to the budget section and the legislative council; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology loan fund - Appropriation.

1. The health information technology loan fund is established in the Bank for the purpose of providing loans to health care providers to purchase and upgrade electronic health record technology, train personnel in its use, improve security of information exchange, and for other purposes as established by the health information technology office, in collaboration with the health information technology advisory committee. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care providers as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology office director under section 3 of this Act. A loan made under this fund must be repayable over a period that may not exceed ten years.

3. The Bank shall administer the health information technology loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the

Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may take a subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 2. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology advisory committee - Duties.

1. The health information technology advisory committee consists of the department's chief information officer or the chief information officer's designee, the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and individuals appointed by the governor and the state health officer to represent a broad range of public and private health information technology stakeholders.

2. The health information technology advisory committee shall collaborate with and make recommendations to the health information technology office, as provided under sections 1, 3, and 4 of this Act.

3. As requested by the health information technology advisory committee, the department shall provide or arrange for administrative services to assist the health information technology advisory committee.

4. The health information technology advisory committee may employ an executive director who serves at the pleasure of and under the direct supervision of the health information technology advisory committee. The executive director may employ personnel as necessary for the administration of this section.

SECTION 3. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Duties - Loan and grant programs.

1. The health information technology office is created in the department. The health information technology advisory committee shall make recommendations to the health information technology office for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards, promote the adoption and use of electronic health records and other health information technologies, and promote interoperability of health information systems for the purpose of improving health care quality, patient safety, and the overall efficiency of health care and public health services.

2. The health information technology office director, in collaboration with the health information technology advisory committee, shall:

a. Apply for federal funds that may be available to assist the state and health care providers in implementing and improving health information technology.

b. Establish a health information technology loan program to provide loans to health care providers for the purpose of purchasing and upgrading certified electronic health record technology, training personnel in the use of such technology, and improving the secure electronic exchange of health information under section 1 of this Act.

c. Facilitate and expand electronic health information exchange in the state, directly or by awarding grants.

d. Establish an application process and eligibility criteria for and accept and process applications for loans and grants under subdivisions b and c. The eligibility criteria must be consistent with federal requirements associated with federal funds received under subdivision a.

SECTION 4. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Electronic health information exchange fund.

1. There is created an electronic health information exchange fund. The fund consists of moneys deposited in the fund from federal or other sources or moneys transferred into the fund as directed by the legislative assembly. The health information technology office shall administer this fund and shall distribute moneys in the fund accordingly. The moneys in the fund must be used to facilitate and expand electronic health information exchange. Moneys in the fund may be used, subject to legislative appropriations, for grants as provided under this section and the costs of administration of the fund.

2. A grant applicant shall submit an application to the health information technology office, which shall determine the applicant's eligibility based upon criteria established by the health information technology office director in collaboration with the health information technology advisory committee.

3. This section does not create an entitlement to any funds available for grants under this section. The health information technology office may award these grants to the extent funds are available and, within the office's discretion, to the extent such applications are approved.

SECTION 5. REPEAL. Section 23-01-31 of the North Dakota Century Code is repealed.

SECTION 6. HEALTH INFORMATION TECHNOLOGY OFFICE AND HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE - REPORT TO BUDGET SECTION. During the 2009-10 interim, the health information technology office and health information technology advisory committee shall provide periodic reports to the legislative council and the budget section on the status of health information technology activities.

SECTION 7. BANK OF NORTH DAKOTA TRANSFERS. The industrial commission shall transfer, during the period beginning with the effective date of this Act and ending June 30, 2011, as requested by the health information technology office director, up to $6,000,000 from the current earnings and the accumulated undivided

profits of the Bank of North Dakota to the health information technology loan fund to meet any required match for federal funds and up to $2,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the electronic health information exchange fund to meet any required match for federal funds.

SECTION 8. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $350,000, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the costs of the health information technology advisory committee and the health information technology office, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 9. APPROPRIATION. There is appropriated out of any moneys in the electronic health information exchange fund, not otherwise appropriated, the sum of $22,000,000, or so much of the sum as may be necessary, including up to $20,000,000 of federal funds deposited in the fund from the federal American Recovery and Reinvestment Act of 2009 to the information technology department for the purpose of providing grants to facilitate and expand electronic health information exchange, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 10. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

North Dakota Health care facilities	Number	Estimated Range for EHR	Average	Total Needed	Current Amendment	Potential w/ Fed Grants	If no grants rcvd	
large hospitals (to complete/certify etc.)	6		$ 500,000	$ 3,000,000				
rural hospitals(36 Critical Access Hospital)	37	$400,000-$850,000	$ 650,000	$ 24,050,000	$6 M for (5:1) match	$ 36,000,000	$ 10,000,000	Loans
Estimated private practice physicians	350	$25,000-$60,000	$ 48,000	$ 16,800,000			$ 8,500,000	Loans
state hospital (?)	1	$400,000-$850,000	$ 650,000	$ 650,000				
Local public health units	28	$100,000-$200,000	$ 150,000	$ 4,200,000				
nursing facilities not affiliated w/hospital (estimate)	60	$75,000-$225,000	$ 175,000	$ 10,500,000				
Health Information Exchange statewide (estimate)		$12,000,000 -$15,000,000		$ 13,500,000	$2 M for (10:1)	$ 22,000,000	$ 8,000,000	
basic care - not affiliated w/ another facility	32	$100,000-$200,000	$ 150,000	$ 4,800,000				
assisted living - not affiliated w/ nursing facility and/or hospital	6	$100,000-$200,000	$ 150,000	$ 90,000				
Rehab hospitals (?)	2	$400,000-$850,000	$ 650,000	$ 13,500,000				
				$ 91,090,000		**$ 58,000,000**	**$ 26,500,000**	
							Phase 1	

Sen. Lee
4-30-09

#8

North Dakota H[redacted]are facilities	#	Estimated Range for EHR	[redacted]rage	Total Needed	Current Amendment	Potential w/ Fed Gra	If no gra[redacted]rcvd	
large hospitals (to complete/certify etc.)	6		$500,000	$ 3,000,000				
rural hospitals(36 Critical Access Hospital)	37	$400,000-$850,000	$650,000	$ 24,050,000	$6 M for (5:1) match	$ 36,000,000	$ 15,000,000	Loans
Estimated private practice physicians	350	$25,000-$60,000	$ 48,000	$ 16,800,000				
state hospital (?)	1	$400,000-$850,000	$650,000	$ 650,000				
Local public health units	28	$100,000-$200,000	$150,000	$ 4,200,000				
nursing facilities not affiliated w/hospital (estimate)	60	$75,000-$225,000	$175,000	$ 10,500,000				
Health Information Exchange statewide (estimate)		$12,000,000 -$15,000,000		$ 13,500,000	$2 M for (10:1)	$ 22,000,000	$ 8,000,000	
basic care - not affiliated w/ another facility	32	$100,000-$200,000	$150,000	$ 4,800,000				
assisted living - not affiliated w/ nursing facility and/or hospital	6	$100,000-$200,000	$150,000	$ 90,000				
Rehab hospitals (?)	2	$400,000-$850,000	$650,000	$ 13,500,000				
				$ 91,090,000		**$ 58,000,000**	**$ 23,000,000**	
							Phase 1	

4.30-09
Additional

#9

#10

90948.0213
Title.

Prepared by the Legislative Council staff for
Representative Skarphol
April 30, 2009

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2332

That the House recede from its amendments as printed on pages 1258-1260 of the Senate Journal and pages 1126 and 1127 of the House Journal and that Engrossed Senate Bill No. 2332 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact two new sections to chapter 6-09 and three new sections to chapter 54-59 of the North Dakota Century Code, relating to Bank of North Dakota loan funds for health information technology, creation of a health information technology advisory committee and a health information technology office, and health information exchange grants; to repeal section 23-01-31 of the North Dakota Century Code, relating to the North Dakota health information technology steering committee; to provide an appropriation; to provide for transfers; to provide for a report to the budget section and the legislative council; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology loan fund - Appropriation.

1. The health information technology loan fund is established in the Bank for the purpose of providing loans to health care providers to purchase and upgrade electronic health record technology, train personnel in its use, improve security of information exchange, and for other purposes as established by the health information technology office, in collaboration with the health information technology advisory committee. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care providers as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology office director under section 4 of this Act. A loan made under this fund must be repayable over a period that may not exceed ten years.

3. The Bank shall administer the health information technology loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the

Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may take a subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 2. A new section to chapter 6-09 of the North Dakota Century Code is created and enacted as follows:

Health information technology planning loan fund - Appropriation.

1. The health information technology planning loan fund is established in the Bank for the purpose of providing low-interest loans to health care entities to assist those entities in improving their health information technology infrastructure. This fund is a revolving loan fund. All moneys transferred into the fund, interest upon moneys in the fund, and collections of interest and principal on loans made from the fund are appropriated for disbursement according to this section.

2. The Bank shall make loans from this fund to health care entities as approved by the health information technology office director, in collaboration with the health information technology advisory committee, in accordance with the criteria established by the health information technology director under section 4 of this Act.

3. The Bank shall administer the health information technology planning loan fund. Funds in the loan fund may be used for loans as provided under this section and the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the revolving loan fund maintained under this section.

4. An application for a loan under this section must be made to the health information technology office. The health information technology office director, in collaboration with the health information technology advisory committee, may approve the application of a qualified applicant that meets the criteria established by the health information technology office director. The health information technology office shall forward approved applications to the Bank. Upon approval of the application by the Bank, the Bank shall make the loan from the revolving loan fund as provided under this section.

5. The Bank may do all acts necessary to negotiate loans and preserve security as deemed necessary, to exercise any right of redemption, and to bring suit in order to collect interest and principal due the revolving loan fund under mortgages, contracts, and notes executed to obtain loans under this section. If the applicant's plan for financing provides for a loan of funds from sources other than the state of North Dakota, the Bank may make a loan subordinate security interest. The Bank may recover from the revolving loan fund amounts actually expended by the Bank for legal fees and to effect a redemption.

SECTION 3. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology advisory committee - Duties.

1. The health information technology advisory committee consists of the department's chief information officer or the chief information officer's designee, the state health officer or the state health officer's designee, the governor or the governor's designee, the executive director of the department of human services or the executive director's designee, and individuals appointed by the governor and the state health officer to represent a broad range of public and private health information technology stakeholders.

2. The health information technology advisory committee shall collaborate with and make recommendations to the health information technology office, as provided under sections 1, 2, 4, and 5 of this Act.

3. As requested by the health information technology advisory committee, the department shall provide or arrange for administrative services to assist the health information technology advisory committee.

4. The health information technology advisory committee may employ an executive director who serves at the pleasure of and under the direct supervision of the health information technology advisory committee. The executive director may employ personnel as necessary for the administration of this section.

SECTION 4. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Duties - Loan and grant programs.

1. The health information technology office is created in the department. The health information technology advisory committee shall make recommendations to the health information technology office for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards, promote the adoption and use of electronic health records and other health information technologies, and promote interoperability of health information systems for the purpose of improving health care quality, patient safety, and the overall efficiency of health care and public health services.

2. The health information technology office director, in collaboration with the health information technology advisory committee, shall:

   a. Apply for federal funds that may be available to assist the state and health care providers in implementing and improving health information technology.

   b. Establish a health information technology loan program to provide loans to health care providers for the purpose of purchasing and upgrading certified electronic health record technology, training personnel in the use of such technology, improving the secure electronic exchange of health information, and for any other purpose under section 1 of this Act.

   c. Establish a health information technology planning loan program to provide low-interest loans to health care entities to assist those entities in improving their health information technology infrastructure under section 2 of this Act.

d. Facilitate and expand electronic health information exchange in the state, directly or by awarding grants.

e. Establish an application process and eligibility criteria for and accept and process applications for loans and grants under subdivisions b, c, and d. The eligibility criteria must be consistent with federal requirements associated with federal funds received under subdivision a. The eligibility criteria for loans under subdivision c must include a requirement that the recipient's approved health information technology be strategically aligned with the state's health information technology plan and the associated federal standards and that the recipient have passed an onsite electronic medical record readiness assessment conducted by an assessment team determined by the health information technology advisory committee and the health information technology office director.

SECTION 5. A new section to chapter 54-59 of the North Dakota Century Code is created and enacted as follows:

Health information technology office - Electronic health information exchange fund.

1. There is created an electronic health information exchange fund. The fund consists of moneys deposited in the fund from federal or other sources or moneys transferred into the fund as directed by the legislative assembly. The health information technology office shall administer this fund and shall distribute moneys in the fund accordingly. The moneys in the fund must be used to facilitate and expand electronic health information exchange. Moneys in the fund may be used, subject to legislative appropriations, to provide services directly, for grants as provided under this section, and for the costs of administration of the fund.

2. A grant applicant shall submit an application to the health information technology office, which shall determine the applicant's eligibility based upon criteria established by the health information technology office director in collaboration with the health information technology advisory committee.

3. This section does not create an entitlement to any funds available for grants under this section. The health information technology office may award these grants to the extent funds are available and, within the office's discretion, to the extent such applications are approved.

SECTION 6. REPEAL. Section 23-01-31 of the North Dakota Century Code is repealed.

SECTION 7. HEALTH INFORMATION TECHNOLOGY OFFICE AND HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE - REPORT TO LEGISLATIVE COUNCIL AND BUDGET SECTION. During the 2009-10 interim, the health information technology office and health information technology advisory committee shall provide periodic reports to the legislative council and the budget section on the status of health information technology activities.

SECTION 8. BANK OF NORTH DAKOTA TRANSFERS. The industrial commission shall transfer, during the period beginning with the effective date of this Act and ending June 30, 2011, as requested by the health information technology office director, up to $8,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology loan fund to meet any required match for federal funds or to the electronic health information exchange fund to meet any required match for federal funds or as directed, a portion to

both funds to meet any required match for federal funds. The health information technology office director shall request fund transfers from the Bank only as necessary to comply with federal requirements and to meet cash flow needs of the funds.

SECTION 9. CONTINGENT BANK OF NORTH DAKOTA TRANSFER. If actual general fund revenues for the period July 1, 2009, through September 30, 2009, exceed estimated general fund revenues for that period by at least $22,500,000, as determined by the office of management and budget, based on the legislative estimates made at the close of the 2009 legislative session and upon certification by the health information technology office director to the director of the office of management and budget of a demonstrated need for health information technology planning loans, the industrial commission shall transfer, as requested by the health information technology office director, up to $5,000,000 from the current earnings and the accumulated undivided profits of the Bank of North Dakota to the health information technology planning loan fund, for the biennium beginning July 1, 2009, and ending June 30, 2011. The health information technology office director shall request transfers from the Bank only as necessary to meet cash flow needs of the fund.

SECTION 10. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $350,000, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the costs of the health information technology advisory committee and the health information technology office, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 11. APPROPRIATION. There is appropriated out of any moneys in the electronic health information exchange fund, not otherwise appropriated, the sum of $88,000,000, or so much of the sum as may be necessary, including up to $80,000,000 of federal funds deposited in the fund from the federal American Recovery and Reinvestment Act of 2009 to the information technology department for the purposes established under section 5 of this Act, for the period beginning with the effective date of this Act and ending June 30, 2011.

SECTION 12. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Additional Information

North Dakota
Health Information Technology

Connecting ND for a healthier future

Why Should the NORTH DAKOTA Invest in Health Information Technology (IT)?

REASON #1

North Dakota citizens deserve to have their health information available to all providers across the continuum of care. Health IT alone will not transform health care, but it does have the potential to stimulate changes in health care that will enhance ***quality of care*** and ***patient safety***, stabilize or decrease costs, reduce waste and inefficiencies.

REASON #2

North Dakota health care facilities are significantly lagging behind, compared to other states, with the adoption of health IT. Federal stimulus funds provide an unprecedented opportunity to advance health IT in North Dakota, but state investment is required to compete for most of the federal funding opportunities.

REASON #3

Hospitals and physicians need to act swiftly to adopt EHR to maximize the Medicare/Medicaid incentives expected to begin distribution (Federal FY2011) to qualified providers who are a "meaningful EHR user". However the stimulus package does not provide up-front funding for rural providers to implement electronic health records (EHR).

REASON #4

Penalties begin in 2015 if a hospital/physician does NOT achieve meaningful use of an EHR. Failure to make this investment will have additional ***long-term implications for reimbursement***.

The following table identifies the (estimated) potential financial impact to North Dakota Critical Access Hospitals (CAH) that fail to become a meaningful EHR user by 2015 (ND has 36 CAHs).

	Per CAH	Per CAH	ND CAH
	Annual	20 Years	20 Years
Impact	$16,000	$320,000	$11,200,000

REASON #5

State investment in health IT is an investment in economic development and viability of rural communities. Rural hospitals typically serve as the healthcare 'hub' of a community and are most often the largest employer in the community. If hospitals and physicians are not able to become a 'meaningful EHR user' they will be ***subject to financial penalties***. Rural facilities are already struggling under current reimbursement structures.

REASON #6

State investment in health IT is an investment in health care workforce recruitment and retention. New health care professionals that are recruited to North Dakota (rural and urban communities) want access to technology that supports their practice in order to deliver the best care to their patients in an efficient manner. Also, in order to retain the current health care workforce it is critical that they have available the technology to better access their patient's health information and share information with other clinicians, as needed, to improve the continuity of care.

NOTE: ND currently has 48 counties (90%) designated as health professional areas. Survey results of medical students, radiology technician students and clinical laboratory students (over 85%) indicated that it was extremely or very important when deciding where to practice that a facility have health IT (e.g. EHR, computed radiography, electronic laboratory system, picture archiving communications system).

April 22, 2009

North Dakota
Health Information Technology

Connecting North Dakota for a healthier future

Who Will Provide Oversight of the Loan Program?

With the establishment of the ND Health Information Technology (HIT) Office, to be located within the Information Technology Department, a Director will be selected by the Advisory Committee (which includes the Governor's designee, state health officer and others appointees) **and together will:**

1) Develop criteria for the application guidance that mirror the federal requirements, fit within the state plan (to be developed) **and use successful models from other states;**

2) Develop process and review criteria for loans;

3) Monitor the progress of loan recipients by setting reporting requirements which comply with federal guidelines.

**Bank of North Dakota (BND) would conduct the fiscal analysis of applicant information after the technical and program parameters have been reviewed and deemed eligible by the Advisory Committee; the fiscal management of the loan would be the responsibility of BND.

an Program

he overarching goal for a loan and/or grant program is to improve access, quality and patient safety, through the effective adoption and implementation of electronic exchange of health information within and among health care facilities in North Dakota (e.g. electronic health records, regional health information exchange, telehealth, etc.).

Eligible health care entities: All rural health clinics and community health centers; hospitals; licensed nursing facilities; local public health units, EMS, ambulance services and nonprofit entities(with the purpose of providing health information exchange coordination governed by a representative and other providers of health or health care services) approved by the ND HIT Advisory Committee.

All proposed loan/grant projects will *require collaboration between three (at minimum) or more eligible health care entities which are not owned by any one entity and fit within the state HIE plan(to be developed).* The intent of the grant program is to facilitate the formation of collaborative efforts between distinct corporate entities. 20% match basis for the total grant amount awarded. Applicants shall be required to provide 15% in the form of cash match and 15% in-kind match, such as staff or services.

Eligible Technology Solutions: All loan recipients will be required to purchase or upgrade new health IT products, that are standards based (e.g. Healthcare Information Technology Standards Panel [HITSP]) and meet interoperability specifications of approved certification bodies for the specific type of technology being purchased (e.g. Certification Commission for Health Information Technology (CCHIT) for EMRs; National EMS Information System [NEMSIS] for EMS systems).

Demonstrate Readiness: All applicants will need to describe their readiness to support the successful adoption/implementation of technology solutions. Required activities may include: collaboration with partners, computer skills assessment; computer skills training for clinical and non-clinical staff, workflow analysis and redesign; establishment of a HIT team, etc.

SB 2332

Goal

To Implement Provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH); to access federal funding to promote the adoption, implementation and effective use of health information technology in North Dakota; to improve quality and effective delivery of healthcare and enhance patient safety.

SB 2332 Objectives

1. Access affordable capital for acquisition of electronic hardware and software for enhancing patient safety through reduction in handwriting and transcription errors;
2. Enable providers to electronically access patient records from multiple locations and throughout the episode of care;
3. Improve provider administrative efficiencies;
4. Enhance best medical practice research;
5. Promote purchase of information technology which provides inter and intra institutional connectivity; and
6. Remove capital obstacles for technological acquisition and implementation by independent medical practitioners and integrated care organizations;
7. Flexibility for leveraging Federal matching funds.

Amended Bill

1. Retains the current Information Technology Committee;
2. Retains the Governors Committee appointment authority;
3. Defines the functions and roles of the Information Technology Committee;
4. Sets the Committee size;
5. Authorizes, and funds the Department of Health to administratively support this program initiative;
6. Funds program operations;
7. Establishes a Committee charge: Take maximum advantage of the incentives contained in the Federal Stimulus program in the next two years to improve patient safety and the advancement of medical practice through adoption and implementation of information technology in the medical field;
8. Requires the Budget Section to review and authorize expenditure of funds appropriated for the purpose of this bill;
9. Requires a report to the appropriate legislative policy and budget committees on the status of this initiative prior to October, 2010;

10. Makes the funds appropriated available to medical providers;
11. Emergency Clause

Appropriation Request

	General	Federal
1. Program Staff and Operations:	$ 250,000	
2. Capital Fund	$ 2,000,000	$20,000,000

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Full Information Technology Conversion Estimates: $47 M

Physicians	
1. Solo Physician Computerization Cost Range	$25-60,000
2. Mean Range for Physician Computerization	$48,000
3. Estimated Private Practice Physicians	350
4. TOTAL	**$16.8 M**
State Wide Exchange	
1. State Wide Exchange Cost Range	$2.5-7.5 M
2. Mean Range for State Wide Exchange	$5.0 M
3. TOTAL	**$5.0 M**
Hospitals	
1. Individual Hospital Computerization Cost Range	$400-800,000
2. Mean Range for Hospital Computerization	$600,000
3. Number of Hospitals	42
4. TOTAL	**$25.2 M**