

# Utah Digital Health Commission Meeting Minutes

Thursday January 8, 2009

10:00 a.m. -12:00 p.m.

Room 101

Utah Department of Health

288 North 1460 West

Salt Lake City, Utah

## Minutes

**Members Present:** Joseph Cramer (Chair), Brad LeBaron (Vice Chair), Scott Barlow, Rulon Barlow, Chet Loftis, Jan Root, Nancy Staggers, Natalie Gochnour, Mark Munger , Deb LaMarche , Mark Probst, and **Via Telephone :** Dennis Moser

**Guests:** Representative Ronda Rudd Menlove (Utah Legislature), Dr. David Sundwall (UDOH), Reid Barker (Utah Pharmacists Association), Don Beckwith (UDOH), Marc Bennett (HealthInsight), Via Telephone : Stephen Clyde (Utah State University), David M. Davis (UFIA), George Delavan (UDOH), Sharon Donnelly (HealthInsight), , Barry Nangle (UDOH), Karl Perry (DOPL), Jon Reid (UDOH), William Stockdale (UDOH), Noel Taxin (DOPL), Thomas Vaughn (Legislative Research)

**Staff Members:** Wu Xu and Humaira Shah (UDOH, Office of Public Health Informatics)

### Introduction and Update:

Joe Cramer welcomed everyone and recognized Representative Ronda Rudd Menlove. He then asked for approval of the November minutes and Scott Barlow moved it and Brad LeBaron seconded. They are approved. He then welcomed Stephen Clyde.

**Mr. Stephen Clyde** talked about the Cache Valley E-health initiative. The primary objectives were to lower health cost and increase the publicity of rural health. He discussed their strategic plan that consists of seven parallel tracks. There are planning and coordination, technology review, vision building and conceptual analysis. Their primary accomplishment was to build the teams that are going to handle the conceptual analysis and feasibility studies. They hired one student to work on technology review and added four more students. Another thing that is being worked on is a grant application that's due in a couple of weeks. Dr. Cramer recognized their work and mentioned that every city or town may want to consider looking at the lesson that USU has taught.

Representative Rhonda Menlove mentioned that she talked to Speaker Dave Clark. He was interested in meeting with Mr. Clyde to talk about what he's doing in terms of looking at a pilot in Washington County. She said that he would like to talk to Mr. Clyde about it as part of the health care reform initiative. Jan Root mentioned to Mr. Clyde that one of the things that she talked about is the clinical health information exchange being ready to test now, so if there are clinics, hospital, etc, they are ready to start accepting testing. Mr. Clyde mentioned that they didn't want to re-invent any technology that exists or was currently being developed and cHIE fulfils an important role in facilitating the exchange of medical health record information between medical practitioners.

Dr. Cramer said to Steve that he wanted to make sure they interacted with Intermountain Healthcare (since the Logan Regional Hospital is in the community) and hoped that Intermountain was a critical part of their team. He then recognized the Executive Director of the Department of Health, Dr. Sundwall and mentioned he is grateful for his leadership and support of the commission.

### **e-Health Review Area 1: e-Prescribing Clinical Health Information Exchange:**

Representative Menlove invited Thomas Vaughn from the office of Legislative Council and Research to share a draft bill on e-prescribing. They had been doing research in the area of e-prescribing and see e-Prescribing as the next step after digital health records.

Jan Root commented that a goal as a legislation would be to continue finding ways to utilize technology to provide higher quality health care, to reduce costs, reduce errors, provide better services etc. It's an effort that she has a great deal of commitment to and it is using technology to facilitate better and less costly healthcare.

Mr. Vaughn said he looked at some research on the Internet and wanted to introduce the mandate that the practitioner would have to participate in e-prescribing. The way it's drafted, you have to give an option to the patient, and inform them about the service and see if they are interested. He said that they limited it to basically everything that's done by prescription and then gave some enforcement authority to the DOPL.

Deb LaMarch asked if that's how it's commonly done and if it needed to be part of the law? Jan thought it was very common but the trouble with the DEA controlled substances was that they had separate rules. She said that they reviewed their draft for electronic prescribing and that it was a great idea but pretty challenging for physicians to implement. Scott then asked if she thought that their draft was going to fix this? Jan replied that the major challenge is identity of the physician.

Mr. Vaughn added that they are a large group in Utah County and that they e-prescribe with their physicians. The problem they run into was the DEA issue and the smaller pharmacies couldn't afford the fees when it's subscribing to the services out there that crave this vehicle. His suspicion was that you're going to create hardship on all the smaller pharmacies that simply can't afford those connection fees.

Joe said that with the bill in front of them, why don't they have Dr. Mark Munger talk about e-prescribing.

Dr. Sundwall said that when he met with representative Menlove on this bill, he was very pleased. This is because he told her his experience representing public health on national government association and state e-health alliance. He added that they have so much to be proud of in Utah and they're one of what CDC calls one of the fabulous four except for e-prescribing. He said that as we continue to deserve our reputation, to fill in on health information technology, this is the next logical step.

Mark Munger gave an overview of where we are from a federal standpoint as well as a physician and pharmacist standpoint. E-prescribing is prescribing conducted vs. either a PDA (personal digital

assistance) or smart phones, or on a web browser on a desktop application. There's a potential to avoid more than two million adverse drug events per year. More than a hundred and thirty thousand-life threatening drug events per year and the estimated cost is twenty seven billion dollars in cost saving per year. There are almost nine hundred million prescription related telephone calls annually between physicians and pharmacies and third party payers. If those numbers can be decreased then it will improve the healthcare.

The current use of e-prescribing is that approximately 65% of Americans use legend drugs that require prescription. The National center for Vital and Health Statistics estimates right there are 5-18% of prescriptions that are done by e-prescribing across the United States. There are problems because first there is a lack of standards throughout the industry. There are HIPPA rules and it's a problem if using e-prescribing is violating those rules. DEA rules on controlled substances have been brought up a couple times. There's a disconnect between the CMS incentives for MD's and e-prescribing in increase pharmacy fees, which means that pharmacies may not want to participate as much as medicine would want to move forward with prescribing.

He talked about CMS and it defines e-prescribing as an accurate error free and understandable prescription directly sent to the pharmacy. In the 2006 IOM report, e-prescribing was stated as a means to improve patient safety. It is currently an option for both physicians and pharmacies under the Medicare Modernization Act of 2003, however new drug plans participating in the current prescription benefit must support electronic prescribing, which means communication in the same way as practitioners, pharmacies and other entities in the health care field. These are the goals for CMS and electronic prescribing: to the extent practical; the standards would not impose undue administrative burden on prescribing health professionals on dispensing pharmacies and pharmacists. The second was that standards would be compatible with current legislation and with general health information technology standards. Standards would permit electronic exchange of drug labeling and drug listing information by the FDA. CMS did a pilot study that was done at five separate places. Testing criteria was: are the right data being sent? Are the data usable and accurate? Are the data well understood at all points of the transaction? Did the initial standards work well together and how can they be improved? How long did it take to conduct each transaction? Can all appropriate drugs and other therapies be ordered through e-prescribing? There were also six standards tested.

He then spoke about DEA rules on e-prescribing and controlled substances. The practitioner must authenticate himself to a system using a two-factor authentication. Once he does that, the system has to shutdown every two minutes, so if the physician doesn't use it within those two minutes, then he has to re-authenticate himself into the system. The practitioner on each prescription has to state their name and DEA number, etc. and sign off that they did. The substance rule is going to affect how we deal with legend drugs. The system may not allow any other person but the authenticated user to sign the prescription. For many physicians that is not the way it's being done by office staff or nurses or others. Electronic prescription system must transmit the prescription immediately upon the signature of the practitioner. The service provider must ensure that the prescription is signed as received. You must retain a prescription for five years from the date of issuance. The contents of the prescription must not be altered during the transmission. In 2009, prescribers using e-prescribing equipment will receive incentive payments of 2% for Medicare, and it goes down 1% in 2010, and by 2011 there are no incentives. He thanked Reid Barker for his support and help in the last three weeks. e-Prescripts

appear to be very well accepted by the pharmacy community. Those that are doing it decrease human errors.

Dr. Sundwall mentioned that he talked to Representative Menlove and he would like to see the legislation moving forward. Rulin Barlow added that this could be a step in the right direction. Marc Probst mentioned that he thought it was legislation they needed to pursue, and that it was difficult to attain the benefits Mark Munger was talking about. He thought that the 30 cents per transaction that the physicians have to pay would get wiped away. He said the problem was that they are going to be out of business in the long run before we can get e-prescribing, and it will lower down the cost in the long run. Physicians are not going to window out to a separate application even for 2% to do this process, its got to work within their systems. That becomes a challenge because there are hundreds of different physician practice management systems in the state of Utah. He loved the direction it was going and was very supportive.

Mr. Vaughn asked Dr. Sundwall if you need legislative authority to do a consortium like that? Dr. Sundwall answered that if you move a bill like this and if there were court language, the direction from the committee in a report can be very affective. He said that some problems he is having is with statute and bills that are pending. He wouldn't disagree with statute because it could help move things quicker. Scott said that the legal question that needs to be considered in the trust element of all of this is where you're including pricing with an outside party. He thought legal work needed to be done because you are going to be bringing competitors together to leverage their collective buying power on an outside vendor.

Chet said that generally the laws are different depending on whether you're buying or selling. They call buying monopoly power which essentially means that your coming together to purchase as opposed to if you're the sellers coming together; they then look at it differently and you have opportunities under the state action doctrine to come together that way. Mark Munger responded and said you do and it's a small number of pharmacies that are participating in that but nonetheless there is some authority. He then offered some points. One is on point number two, when and if the controlled substance DEA rule goes into affect, it needs to be changed quickly because then everything will be opened for controlled substances except for this law which would then be a state statute that would hold it back. Point number 3 is being comprehensive in the bill is not really necessary because by the pharmacy practice act, the pharmacy has to do what you say, and that's accept and dispense the prescription.

Dr. Cramer mentioned that he was forewarned that because of limitations of announcements, the commission could not make formal recommendations on this and can make informal recommendations due to the fact that it is not a public meeting. He asked to have an informal vote of support that's for this legislature and particularly representative Menlove and her efforts to move this forward. Chet Loftis asked what the ratio of legend drugs to controlled substances was and Wu Xu answered that it's 10%. Dr. Cramer asked what schedule these controlled substances were? Marc Munger said schedule 2-5.

Nancy mentioned that she would really be in support of the language that deals with per standard of care about telehealth or in person. Jan Root said that they were ready to begin gathering data in data testing. She explained that how costly it is depends on your decision, whether or not you trust the

vendor to post your data for you, etc. She mentioned that they are bringing up MPI, which is master person index, bringing up hospitals and physicians as well. e-prescribing is a component of it, EMR light is offered and there are three tools that are included in the CHIE package. The first one is EMR light; if you don't have an EMR you can use this tool and its included in the membership fee. There is a virtual health record. Then there is also a registry and report. Those are the three major tools. Dr. Cramer asked when as a clinician could he say he wants this? Jan said right now. Health Insight did a good job of tracking whose got what EMR, so with Sharon's help they are trying to pull together roots of people that all use All-Scripts or Greenway, etc. and approach the vendors as a group and say we want you to connect and we want to negotiate a statewide rate. They are working on trying to identify champions within the different vendors community users to pull those scripts together and approach those vendors as a group. Marc Probst asked what the rate is and Jan said for 2009 there are no membership fees, partly because of the million dollars from the state.

Reid Barker asked where we are when it comes down to actual accessibility by a pharmacy for the virtual health record? Jan said yes a pharmacist would have to just be another user so they could sign up. The whole idea is to keep it really low cost. There is a lot of payer support; the goal is to improve quality of care.

### **Telehealth Reimbursement Summit:**

Deb LaMarch talked about the summit saying that it was put together in short notice and well over 70 people came, they were insurers, health care providers, billing managers, public health people policy experts, etc. In 1999 they developed an electronic billing standard with UHIN for telehealth so it would support reimbursement. At the time they didn't have critical mass for telehealth at all and had a couple of sites that did a couple things but didn't really take off for clinical purposes. Over the years it's taken off for continuing education for medical professionals and all sorts of planning but patient care has lagged behind and part of that is due to limited reimbursement. For the first half they talked about providing background then the VA talked about its system. It's a capitated system and they have been doing a lot of telehealth with remote and home clinics. A goal they had was if a patient is seen for something that physicians or health care providers be reimbursed at the same level. She mentioned that the panel was great because they described their applications and how they could be cost effective, and how they can improve health care. An example is telestroke program, it's a potentially life saving or altering telehealth application, its done in emergency basis. She mentioned that they had a payer's panel, John T. Nelson moderated and had three panels from insurers, and she thanked Chet for participating from Regence Blue Cross. She said they had a discussion on the next steps and key points. She mentioned a recommendation that they work with organizations like the Utah health insurance association and the medical directors from the insurers.

### **UDOH Executive Director's Priorities:**

Dr. Sundwall began by asking how Utah ranked health wise? The annual rankings come from the united health foundation. He mentioned that the commission has a healthy attitude but there are challenges and things that we could do better on. He is interested in geographic disparity and said that Utah is a state that has a frontier meaning big distances between some small population groups. He mentioned things that something could be done about like the smoking rate. We have the lowest smoking rate but it went up 19% and it's a challenge. Infectious diseases dropped and Utah did better there. Dr. Sundwall thought that the two things that are real public health challenges are our

immunization rates remaining bad and our obesity rate. Immunization was 49 then they went down to 20<sup>th</sup> and now back to 39. We increased in obesity 28% in the last 5 years.

He mentioned that he met with the governor and he wanted to expand health insurance coverage for people and he appreciated that of the governor. The two things that were passed in the law were the standard settings, the cHIE and the quality and cost reporting data. He mentioned his effort to create a statewide public health system. He put this concept of E-health equals Utah before the governor. It was promoting electronic medical records and establishing this national electronic disease surveillance system and he called it NEDSS. Utah is one of the six states that does not have NEDSS but will demonstrate it soon. He discussed the goal that they would like to achieve and what they envisioned for e-health in Utah is ongoing formalized linkages in population data, clinical data and genetic data. This would be the idea where you actually link populations like the vital records, clinical data from the EMR's and genetic data. The second goal is better assessment of the incidence of and prevalence of disease and disability. The third one is formalizing research relationships in the department of health and institutions such as the U of U, Utah State, and BYU. He thanked everyone for service on the commission.

### **HIT Transformation and Value Exchange:**

Marc Bennet gave a reminder that on the chartered value exchange, we have health information technology transformation as one of the priorities. It's about improving the health care system that we work with and it should happen in dramatic ways to achieve better results. It was divided into two groups, efficiency and outcomes. He explained that efficiency is getting our health care system to operate a lot more efficiently and that encompasses things like only doing what adds value for the patients and doing those things in the most efficient way possible. Outcomes are we have great outcomes comparatively in relation to what's possible and what patients need in a health care system. He said at the chartered value exchange they believe that some things have to be worked on simultaneously to pull it off. Other two primary focuses of the chartered value exchange are transparency and changing the payment in systems. He explained that the system needs a lot more data on how it operates, so public transparency. The payment had issues because the system encouraged wrong things like volume over quality and value. It discourages effective use of primary care providers from playing a useful role with consumers in discussion about what they really need to improve their health versus what the provider is going to get paid for.

Dr. Cramer commented that his instinct with the chartered exchange is that it's a community effort with various stakeholders involved, and making sure that integrated with the other activities going on. Mr. Bennet mentioned that the chartered value exchange is built around four primary groups of stakeholders and they include providers. Dr. Cramer recognized the presence of Sharon Donnelly and then thanked Marc.

### **Digital Health Services for Community and Family Health Services:**

George Delavan explained that he wanted to give an overview of where he thought our division was and the programs in our division and there are about 25. Two basic things are needed in regards to digital health. He explained that some programs in our division generate a data that we really need to share with the rest of the medical community, most specifically primary health care providers. Some examples of data that we generate are managing the state immunization records. We also generate new born screening data so between our division and the lab we form the newborn blood screening,

and we would like to make that, along with hearing screening easily available to healthcare providers.

He explained the need to regenerate this information and get it out there to the people that need to use it. He mentioned that they have registries like the NEDSS system that Dr. Sundwall mentioned, which is sort of a system for reporting communicable diseases. He said they have other systems where they collect other kinds of disease information for disease surveillance. They are partnering with UHIN to move the process forward and to get information from us to the outside world, and information could come in easily too. Joe thanked George. He asked for commissioner's reflections on what happened. He said that this is possible partially because of Office of Public Health Informatics' support.

### **Other Business:**

Jan said she liked the discussion about the proposed law, and it was fun to hear about it along with the summaries of the DEA rules.

Natalie talked about the legislative session, and said it would be helpful to know to a degree that anytime the commission could be helpful to the executive director or to the cHIE to help move the ball along.

Dr. Cramer said that maybe something we'd want to do between the three or four individuals is have that conversation and say, how can we be of help during this legislation.

Dr. Sundwall said he saw a big list of bills and surprisingly there's a large number of health bills, a number of them are related to reform. We don't see the creativity we've seen before. He asked Dr. Cramer if he would spend a little time with Deb Turner to walk through the list of bills and see which ones are e-health relevant.

Marc Probst said from a federal perspective a lot's going to happen in 2009. We're going to see a renewed momentum from the Obama administration.

Dr. Sundwall mentioned that he was director of government relations for the National Association of State Health Officers and they are clearly very alert to whatever's happening.

Rulon Barlow thought it was great to see the open quorum by Marc, Reid and Chet all chime in now at this stage instead of fixing it later.

Dr. Cramer concluded the meeting.