Approved: March 25, 2009
Date

MINUTES OF THE HOUSE VISION 2020 COMMITTEE

The meeting was called to order by Chairman Tom Sloan at 1:30 p.m. on February 16, 1, 2009, in Room 711 of the Docking State Office Building.

All members were present except:
Representative Clay Aurand- excused
Representative Mario Goico- excused
Representative Joe Seiwert- excused

Committee staff present:
Art Griggs, Office of the Revisor of Statutes
Scott Wells, Office of the Revisor of Statutes
Corey Carnahan, Kansas Legislative Research Department
Chris Courtwright, Kansas Legislative Research Department
Mary Koles, Committee Assistant

Conferees appearing before the Committee:
Marcia Nielsen, Kansas Health Policy Authority
Dale White, Horton Community Hospital

Others attending:
See attached list.

Marcia Nielsen, PhD, MPH, Executive Director, Kansas Health Policy Authority, described telemedicine and telehealth as a bridge to better coordinate services to improve health. The Medical Home concept and HIT/HIE (Health Information Technology/Health Information Exchange) and Kansas' work on these initiatives were addressed. Kansas is poised to benefit from the Economic Stimulus. Health information security and privacy was discussed (Attachment 1).

Chairman Sloan opened the meeting for questions from the committee. Questions were asked by Chairman Sloan and Representatives Bill Feuerborn and Tom Hawk. Dr. Nielsen responded.

Dale White, CEO, Horton Community Hospital, reviewed the findings shared during the telehealth hearings. He noted that reliable and appropriate use of technology does significantly improve life and reduce costs to the health care system. It is believed data exists to support this assertion but needs to be gathered in a common data base which will take time, collaboration, and resources. He proposed that a work group, including sub-task forces, be established under the guidance of the Kansas Health Policy Authority. A number of issues for the group to address were delineated (Attachment 2).

Chairman Sloan opened the meeting for questions. Questions were asked by Chairman Sloan and Representatives Pat George, Tom Hawk, and Lee Tafanelli. Mr. White responded.

Chairman Sloan thanked the conferees for their presentations and for sharing their insight about telemedicine and telehealth.

The next meeting is scheduled for February 25, 2009.

The meeting was adjourned at 2:35 p.m.

House Vision 2020 Committee Guest List

Date: Mon, Feb. 16, 2009

Name	Representing Client/Authority
Pat Vogelsberg	KMS
Matt Casey	GBA
Bruce Witt	PHS
Joe Mosimann	Hein Law Firm
Marce Carpenter	KAHP
Cynthia Smith	SCL Health System
Shanelle Dupree	KHPA
Chad Austin	KHA
Jamal Jones	UHG

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KANSAS HEALTH POLICY AUTHORITY

Marcia Nielsen

Development of the Kansas Medical Home Model

Background

The medical home concept and its focus on preventive care was one of three tenets of the Kansas Health Policy Authority's health reform package in 2007, with the goals of improving the quality of primary health care, promoting improved health status, and helping control the rising costs of health care. The KHPA Health Reform Recommendations integrated a number of policy options designed to advance the medical home model in Kansas, including:

- Defining a medical home in statute and encouraging Medicaid and HealthWave as well as State Employee Health Benefit Plan (SEHBP)beneficiaries to select a medical home for primary care services;
- Increasing Medicaid/HealthWave reimbursement for primary care services consistent with a medical home and "value-based health care";
- Developing and promoting a statewide Community Health Record for Medicaid/HealthWave beneficiaries and for the SEHBP recipients; and
- Adopting recommendations from Advanced ID Card Project for Medicaid/HealthWave beneficiaries and for SEHBP enrollees.

2008 Legislative Session

During the 2008 legislative session House Substitute for Senate Bill 81was passed and this legislation defined the medical home in Kansas statute. As stated in the statute, the Kansas definition of a medical home is "a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner." The bill also instructed that the KHPA should incorporate the use of the medical home model into Medicaid, HealthWave, the MediKan program, and the SEHBP. The KHPA was also instructed in the bill to develop systems and standards for implementation and administration of a medical home in Kansas.

Phase One in Operationalizing the Medical Home Concept in Kansas

The KHPA is now taking steps to operationalize the medical home concept. In June of this year, several KHPA staff attended the Commonwealth Fund's State Quality Improvement Institute, where they discussed strategies for developing and implementing the medical home in Kansas. KHPA is using an adapted Commonwealth Fund definition of the medical home with the emphasis on transforming the health care system from one that reacts once someone gets very sick to one that provides proactive, comprehensive, and coordinated care to keep people with chronic illnesses as healthy as possible and helping healthy people maintain their health through prevention and promotion activities. Currently less than 50 percent of Kansas children have a medical home

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

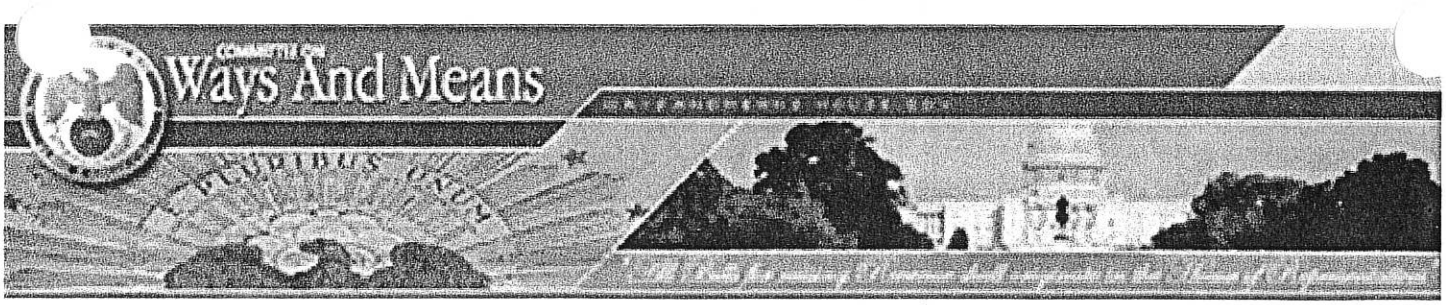
State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

House Vision 2020, 2-16-2009 Attachment #1

and the Quality Institute will assist Kansas in developing strategies to improve our performance on that quality indicator. The KHPA team chose two indicators to measure progress of the medical home model: 1.Eighty-five percent of children in Kansas will have a medical home, and 2.Reduce avoidable hospitalizations for pediatric asthma in Kansas to no more than 82 per 100,000 children aged 0 to 17 years. A plan was laid out to meet these objectives, and includes multiple phases. Phase I activities include:

- Agency and KDHE staff met in July/August/September, 2008 to develop a draft blueprint to guide stakeholder discussions
- Beginning in September, key stakeholders began regular meetings in September to evaluate the applicability of national medical home principles and standards, develop potential pilot projects, and solicit feedback from primary care providers and consumers throughout the state with recommendations submitted to the KHPA Board in March.
- Health literacy criteria will also be selected as an element of the medical home concept
- A communications strategy will be formulated to facilitate medical home discussion among Kansas consumers, providers, and policymakers
- The "Medicaid Transformation Plan" for Kansas has been finalized and includes delineation of specific policies to promote adoption of a medical home for various Medicaid populations

The role of the KHPA will be to facilitate the development of a medical home model for Kansas based on feedback from and in collaboration with providers, consumers, health plans, and purchasers. The model should build on the research and findings from national leaders but acknowledge the challenges and opportunities in creating a medical home in rural and urban communities in Kansas.



Title IV - Health Information Technology for Economic and Clinical Health Act

Health Information Technology for Economic and Clinical Health Act or HITECH Act

Health information technology helps save lives and lower costs. This bill accomplishes four major goals that advance the use of health information technology (Health IT), such as electronic health records by:

- Requiring the government to take a leadership role to develop standards by 2010 that allow for the nationwide electronic exchange and use of health information to improve quality and coordination of care.
- Investing $20 billion in health information technology infrastructure and Medicare and Medicaid incentives to encourage doctors and hospitals to use HIT to electronically exchange patients' health information.
- Saving the government $10 billion, and generating additional savings throughout the health sector, through improvements in quality of care and care coordination, and reductions in medical errors and duplicative care.
- Strengthening Federal privacy and security law to protect identifiable health information from misuse as the health care sector increases use of Health IT.

As a result of this legislation, the Congressional Budget Office estimates that approximately 90 percent of doctors and 70 percent of hospitals will be using comprehensive electronic health records within the next decade.

Federal Leadership for the Nationwide Exchange of Health Information

The legislation codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) within the Department of Health and Human Services. This office is responsible for creating a nationwide health information technology infrastructure aimed at improving health care quality and care coordination.

The legislation establishes a transparent and open process for the development of standards that will allow for the nationwide electronic exchange of information between doctors, hospitals, patients, health plans, the government and others by the end of 2009. It establishes a voluntary certification process for health information technology products. The National Institute of Standards and Technology will provide for the testing of such products to determine if they meet the national standards that allow for the secure electronic exchange and use of health information.

After standards are adopted in 2009, the National Coordinator shall make available at a nominal fee an electronic health record, unless the Secretary determines that the needs and demands of providers are being substantially and adequately met by the marketplace. Nothing in the legislation requires that entities adopt or use the technology made available through this provision.

F ng for Infrastructure and Adoption of Health Information Technology

This legislation provides immediate funding for health information technology infrastructure, training, dissemination of best practices, telemedicine, inclusion of health information technology in clinical education, and State grants to promote health information technology.

In addition, the legislation provides significant financial incentives through the Medicare and Medicaid programs to encourage doctors and hospitals to adopt and use certified electronic health records. Physicians will be eligible for $40,000 to $65,000 for showing that they are meaningfully using health information technology, such as through the reporting of quality measures. Hospitals will be eligible for several million dollars in the Medicaid and Medicare programs to similarly use health information technology. Federally qualified health centers, rural health clinics, children's hospitals and others will be eligible for funding through the Medicaid program.

Incentive payments for both physicians and hospitals continue for several years, but are phased out over time. Eventually, Medicare payments are reduced for physicians and hospitals that do not use a certified electronic health records that allow them to electronically communicate with others.

The legislation also provides additional funds to States for low-interest loans to help providers finance health information technology and grants to regional health information exchanges to unite local providers. Grants are also offered for the development and adoption of electronic health records for providers other than physicians and hospitals.

Privacy and Security of Personal Health Information

This health information technology legislation improves and expands current Federal privacy and security protections for health information. As health care providers move to exchanging large amounts of health information electronically, it is important to ensure that such information remains private and secure. The bill accomplishes this by:

Establishing a Federal breach notification requirement for health information that is not encrypted or otherwise made indecipherable. It requires that an individual be notified if there is an unauthorized disclosure or use of their health information.

Ensuring that new entities that were not contemplated when the Federal privacy rules were written, as well as those entities that do work on behalf of providers and insurers, are subject to the same privacy and security rules as providers and health insurers.

Providing transparency to patients by allowing them to request an audit trail showing all disclosures of their health information made through an electronic record.

Shutting down the secondary market that has emerged around the sale and mining of patient health information by prohibiting the sale of an individual's health information without their authorization.

Requiring that providers attain authorization from a patient in order to use their health information for marketing and fundraising activities.

Strengthening enforcement of Federal privacy and security laws by increasing penalties for violations and providing greater resources for enforcement and oversight activities.

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Telemedicine, Health Information Technology, and Medical Homes: What do they have in common?

House Vision 2020 Committee

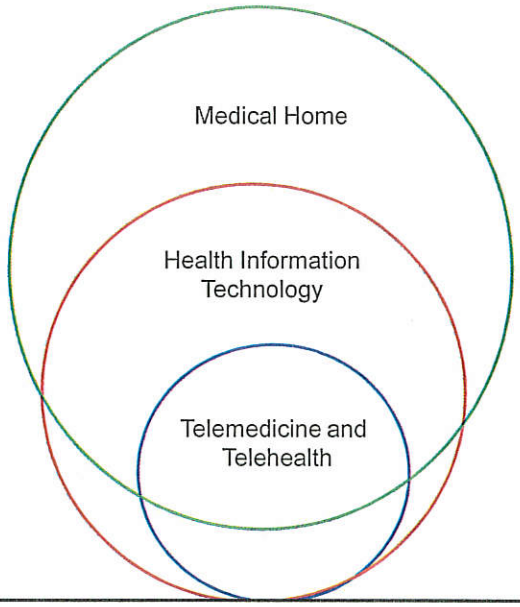
February 4, 2009

Marcia Nielsen, PhD, MPH
Executive Director
Kansas Health Policy Authority

1

KHPA

Goals & Dollars



Goals:
- **Improve health**
- **Improve coordination of care**
- **Reduce duplication of services**
- **Save system dollars**

Dollars:
- **Provider $ stretched**
- **State $ non-existent**
- **Federal $ through stimulus package**

2

Federal Stimulus Package

- Includes four goals for HIT/HIE:
  - (1) Enact standards by 2010 that allow for the nationwide electronic exchange and use of health information
  - (2) Invest $20 billion in health information technology infrastructure and Medicare and Medicaid incentives to encourage doctors and hospitals to use HIT to electronically exchange patients' health information.

Ways and Means Committee, January 19, 2009

Federal Stimulus Package

- (3) Save the government $10 billion, and generate additional savings throughout the health sector, through improvements in *quality of care and care coordination, and reductions in medical errors and duplicative care.*
- (4) Strengthen Federal privacy and security law to protect identifiable health information from misuse as the health care sector increases use of HIT.

Ways and Means Committee, Jan. 19 2009

Why should that matter to Vision 2020?

- Legislation to provide immediate funding for health information technology infrastructure, training, dissemination of best practices, *telemedicine*, inclusion of health information technology in clinical education, and State grants to promote health information technology.
- *Saving the government $10 billion*, and generate additional savings throughout the health sector, through improvements in *quality of care and care coordination*, and reductions in medical errors and duplicative care.

5

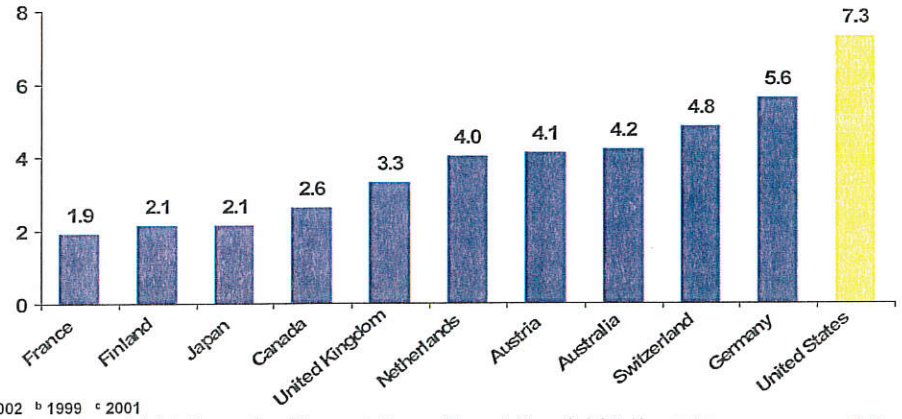
Background: Health Care Challenges

6

EFFICIENCY

Percentage of National Health Expenditures Spent on Health Administration and Insurance, 2003

Net costs of health administration and health insurance as percent of national health expenditures

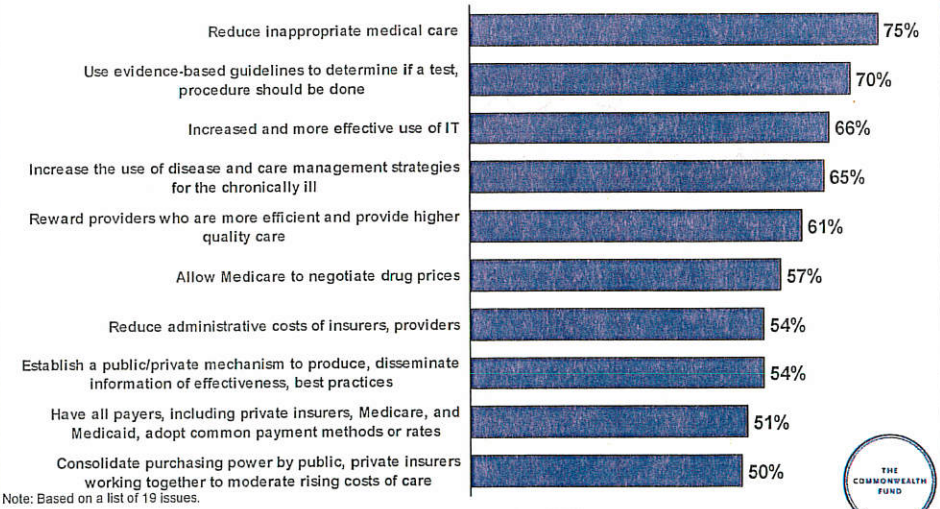


[a] 2002 [b] 1999 [c] 2001
* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
Data: OECD Health Data 2005.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Health Care Opinion Leaders: Views on Controlling Rising Health Care Costs

"How effective do you think each of these approaches would be to control rising costs and improve the quality of care?" Percent saying "extremely/very effective"



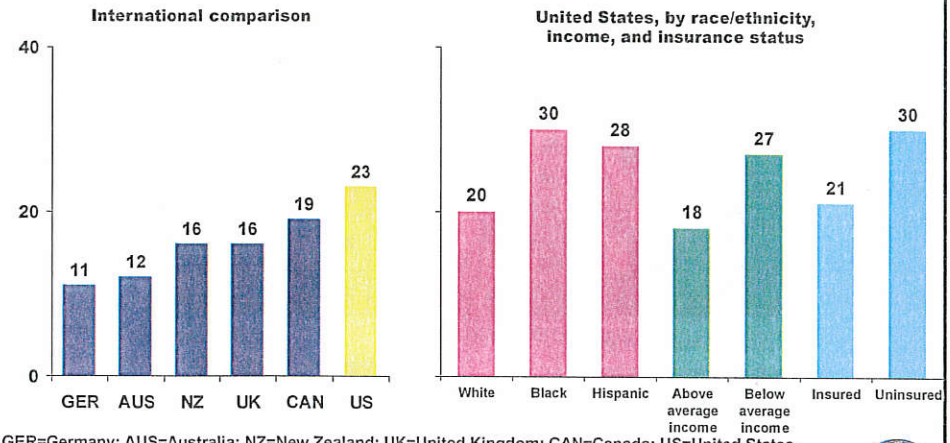
Note: Based on a list of 19 issues.

Source: The Commonwealth Fund Health Care Opinion Leaders Survey, Jan. 2007.

EFFICIENCY

Test Results or Medical Record Not Available at Time of Appointment, Among Sicker Adults, 2005

Percent reporting test results/records not available at time of appointment in past two years



GER=Germany; AUS=Australia; NZ=New Zealand; UK=United Kingdom; CAN=Canada; US=United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.

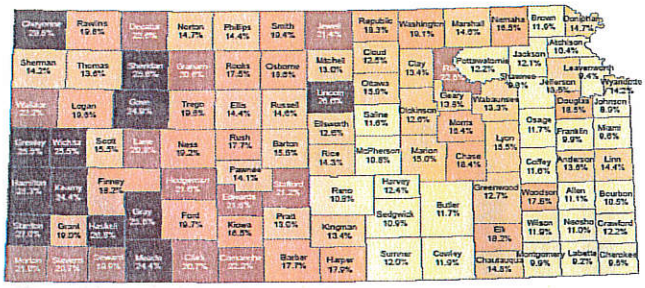
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Getting Value for Money: Health System Transformation

- Transparency; public information on clinical quality, patient-centered care, and efficiency by provider; insurance premiums, medical outlays, and provider payment rates
- Payment systems that reward quality and efficiency; transition to population and care episode payment system
- Patient-centered medical home; Integrated delivery systems and accountable physician group practices
- Adoption of health information technology; creation of state-based health insurance exchange
- National Institute of Clinical Excellence; invest in comparative cost-effectiveness research; evidence-based decision-making
- Investment in high performance primary care workforce
- Health services research and technical assistance to spread best practices
- Public-private collaboration; national aims; uniform policies; simplification; purchasing power

Where are the uninsured in Kansas?

Percent of People Under 65 without Health Insurance by Kansas County
2005



Source: Institute for Policy & Social Research; data from the U.S. Census Bureau, Small Area Health Insurance Estimates, 2005.

KU INSTITUTE FOR POLICY & SOCIAL RESEARCH
The University of Kansas

Percent Uninsured

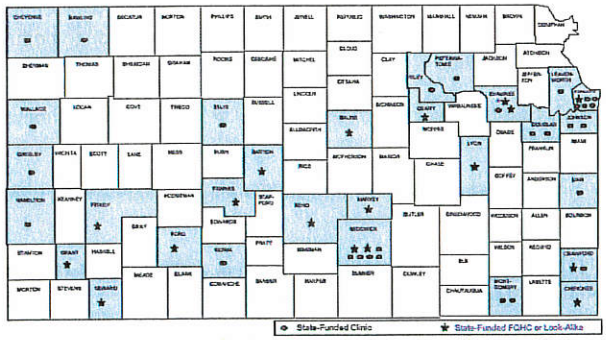
Kansas 12.4%

- 8.9 - 12.4
- 12.5 - 15.8
- 15.9 - 19.7
- 19.8 - 22.6
- 22.7 - 29.5

11

Safety Net Clinic locations in Kansas

2009 State-funded Clinic Sites by County

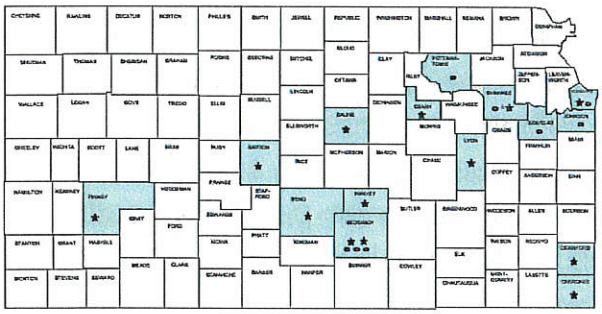


Barton: Bix Care Project
Chanute: Community Health Center of Southeast Kansas
Cheyenne: Cheyenne County Hospital Clinics
Crawford: Community Health Center of Southeast Kansas
Mercy Health System
Douglas: Health Care Access
Heartland Clinic
Ellis: First Care Clinic
Finney: United Methodist Mexican-American Ministries
Ford: United Methodist Mexican-American Ministries
Geary: Konza Prairie Community Health Center
Grant: United Methodist Mexican-American Ministries
Greeley: Greeley County Family Practice
Hamilton: Hamilton County Family Practice
Harvey: Health Ministries Clinic (Look-Alike)
Johnson: Health Partnership Clinic of Johnson County
Mercy and Trust Medical Missions
Kiowa: Kiowa County Hospital Clinics
Leavenworth: St. Vincent Clinic (Caritas)
Linn: Mercy Health System
Lyon: Flint Hills Community Health Center
Montgomery: Mercy Health System
Montgomery County Community Clinic
Pawnee: We Care Project
Pottawatomie: Community Health Ministry
Rawlins: Rawlins County Health Department
Reno: Prairie Care Community Health Center
Riley: Riley County-Manhattan Health Department
Saline: Bono Family Healthcare
Sedgwick: Center for Health and Wellness
E.C. Tyree Health and Dental Clinic
Good Samaritan Clinic
Graceland Health and Dental Clinic
Guadalupe Clinic
Healthy Options Clinic
Hunter Health Clinic
Seward: United Methodist Mexican-American Ministries
Shawnee: Medar Clinics
Shawnee County Health Agency
Walker: Watson County Family Practice
Wyandotte: Duchesne Clinic (Caritas)
Mercy and Trust Medical Missions
Silver City Health Center
Southwest Blvd. Family Health Care
Swope Health Services
Turner Haven Children's Clinic
***Statewide:** Kansas Statewide Farmworker Health Program

12

Medicaid Dental Providers in Kansas

2009 State-funded Dental Clinic Sites by County



Barton: We Care Project
Cherokee: Community Health Center of Southeast Kansas
Crawford: Community Health Center of Southeast Kansas
Douglas: Health Care Access
Finney: United Methodist Mexican-American Ministries
Geary: Konza Prairie Community Health Center
Harvey: Health Ministries Clinic (Lock-Alike)
Johnson: Health Partnership Clinic of Johnson County
Lyon: Flint Hills Community Health Center
Pottawatomie: Community Health Ministry
Reno: PrairieStar Community Health Center
Saline: Salina Family Healthcare
Sedgwick: Center for Health and Wellness
E.C. Tyree Health and Dental Clinic
GraceMed Health and Dental Clinic
Healthy Options Clinic
Hunter Health Clinic
Shawnee: Mirian Clinics
Wyandotte: Southwest Blvd. Family Health Care
Swope Health Services
*Statewide: Kansas Statewide Farmworker Health Program

★ State-Funded FQHC or Look-Alike
● State-Funded Clinic

2009 Health Reform Priorities

Statewide Clean Indoor Air

- Smoking is the number one preventable cause of death in Kansas. Each year, tobacco causes over 4,000 Kansas deaths, including 370 deaths attributable to second-hand smoke.
- Tobacco generates nearly $930 million in health care costs annually.
- If the current trend continues, 54,000 Kansas youth are projected to die from smoking.
- 83% of Kansans believe smoking is a serious health hazard.
- At least 36 states, including neighboring states, have imposed restrictions on smoking in public places.

Increased Tobacco User Fees

- A 10% increase in the price of a pack of cigarettes is associated with a 4% drop in tobacco use.
- Half of all Kansas smokers started smoking before the age of 14. Among teens, a cigarette price increase has been shown to result in a 7% reduction in smoking.
- The current excise tax on a pack of cigarettes in Kansas is $.79 but tobacco use costs Kansans the equivalent of $.86 per pack of cigarettes sold to pay for the tobacco-related illnesses of Medicaid recipients alone. KHPA recommends increasing the tobacco user fee by $.75 per pack, which would provide approximately $68.7 million in revenues in fiscal year 2010.

Increased Access to Affordable Health Care & Health & Wellness

- Medicaid for Poor Parents: KHPA recommends expanding Medicaid to include parents earning up to federal poverty level, $1,467 per month for a family of three.
- Improving access to affordable health insurance for small businesses and young adults.
- Implementing a statewide Community Health Record.
- Providing additional funding for breast and cervical screening, and expand the program to include screening for prostate and colorectal cancer to prevent illness and death from failure to timely detect those diseases; expanding the coordinated school health program; providing wellness grants for small businesses.
- Providing tobacco cessation programs for Medicaid recipients.

Senate Bill 81: Defining Medical Home

- "a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner."

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Operationalizing the Medical Home Concept

Goal: Create a medical home model(s) for Kansas

- Internal Working Group
- All Stakeholders Group
  - Principles subgroup
  - Marketing/Messaging subgroup
  - Pilot Projects subgroup
- Payment reforms and incentives built into pilots

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Medical Home-Key Elements

- Team approach to care
- Registries for the top few diagnoses
- Active care coordination
- Prospective data collection
- Partnership with community resources
- Advanced patient education and self management support

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How Will I Know One When I See One?

- Commitment to care for the whole person
- Demonstrated use of tools and systems including registries and eventually EHR
- New NCQA medical home recognition program (PPC)
- Patient satisfaction and health outcomes

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PCMH-PPC Proposed Content and Scoring

Standard 1: Access and Communication	Pt
A. Has written standards for patient access and patient communication**	4
B. Uses data to show it meets its standards for patient access and communication**	5
	9

Standard 2: Patient Tracking and Registry Functions	Pt
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	6
E. Uses data to identify important diagnoses and conditions in practice**	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pt
A. Adopts and implements evidence-based guidelines for three conditions **	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pt
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	3
B. Survey of patients' care experience	
C. Reports performance across the practice or by physician **	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

** Priority Elements

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Health Information Technology (HIT) & Health Information Exchange (HIE)

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Statewide Community Health Record

- Health Information Technology and Exchange:
  - Facilitate sharing, exchange of health records
  - Promote safety and improve quality
  - Improve efficiency and promote cost savings
- Two ongoing pilot projects
  - Wichita: HealthWave managed care providers
  - KC Area: State employees participating in employer sponsored initiative
- Expand statewide for Medicaid and SEHP
- Enhancement Request FY 2010: $1,096,000 (AF); $383,600 (SGF)

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Importance of HIT/HIE

- Need for Health Information Exchange/ Health Information Technology (HIE/HIT)
  - Promote efficiencies in the delivery of health care
  - Improve quality of care
  - Improve patient safety
  - Potential for achieving long term cost savings
- HIT/HIE fosters coordination of care and implementation of medical home model of care
- *Includes telemedicine and telehealth*

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Federal HIT/HIE Initiatives

HIT/HIE at the Federal Level

- President Bush placed a significant focus on HIT/HIE Initiatives – President Obama to build from this work
- Created the Office National Coordinator for Health Information Technology (ONCHIT) in 2004
  - **National Health Information Network (NHIN):** Issued four contracts to develop (architecture and prototype network for secure information sharing)
  - **Formation of the American Health Information Community (AHIC):** Created to serve as a national standards and policy body to make recommendations to the federal government on how to achieve interoperable electronic health records that assure privacy and security

HIT/HIE at the Federal Level (Con't)

- Other HIT/HIE initiatives
  - Call for widespread adoption of Electronic Health Records (EHR) by 2014
  - President Bush's Aug 2006 Executive Order requiring Government departments and agencies involved in health care to:
    - Adopt HIT standards
    - Work with common quality measures
    - Make price and quality information transparent to consumers
    - Create positive incentives to reward high quality health care

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Kansas Initiatives

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Progression of HIT/HIE in Kansas

Governor's Health Care Cost Containment Commission (H4C)
November 2004

⇩

Kansas HIT/HIE Policy Initiative
Fall 2005

⇩

Kansas HIE Commission
March 2006

⇩

E-Health Advisory Council
(Advisory to KHPA Board and Governor)
Spring 2008

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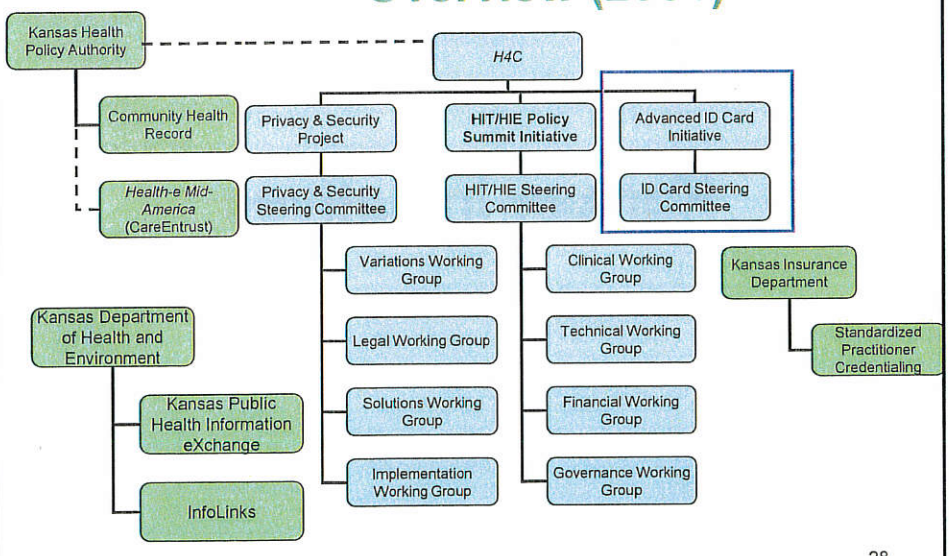
Kansas HIE Initiatives Overview (2004)



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Kansas: Health Care Cost Containment Commission (H4C)

- **History:** Established in November 2004 by Gov Sebelius, under direction of Lt. Gov John Moore
- **Charge:** Recommend solutions to improve patient care and lower costs by (1) reducing duplicative and inefficient administration processes and (2) developing strategies for efficient and effective use of health information
- **Results:** Development of a statewide shared vision for HIT/HIE – the "HIE Roadmap"

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HIT/HIE Policy Initiatives: Roadmap

- **Charge:** Develop shared vision for adoption of HIT & interoperability in KS; draft set of key principles & high level actions for statewide E-Health Information strategy
- **Work Groups:** Make recommendations on HIE infrastructure
  - **Governance:** develop sustainable governance model (oversight, coordination, direction)
  - **Clinical:** recommend data elements to be exchanged
  - **Technical:** assess HIE capability, identify gaps/barriers to address
  - **Financial:** develop sustainable financial model for infrastructure development and ongoing HIE
  - **Security and Privacy:** (Health Information Security and Privacy Collaboration or "HISPC") – develop implementation plan to address barriers to interoperable HIE
- **Financial Support:** Sunflower Foundation, United Methodist Health Ministry Fund, Kansas Health Foundation, and Kansas Health Policy Authority

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Roadmap Recommendations

- Create public-private coordinating entity
  - *E-Health Advisory council (KHPA & Governor) serving in this role*
- Provide consumer/stakeholder education
  - *Kansas Health Online*
- Leverage existing resources
  - *Medicaid and State Employee Health Plan pilots*
  - *Push for statewide Community Health Record (CHR)*
- Demonstrate impact of HIE and foster incremental change
  - *CHR pilots; challenges re: interoperability, sustainable funding, ROI*
- Address privacy and security barriers
  - *Kansas HISPC Initiative*
- Seek funding from multiple sources
  - *Seeking foundation support for HIT/medical home initiatives*

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Health Information Exchange Commission (HIEC)

- **History:** Governor's Executive Order established the Commission Feb, 2007
- **Charge:** To serve as a leadership and advisory group for HIE/HIT in Kansas
- **Results:**
  - Report of the HIEC delivered to the Governor for her consideration
  - HIEC Recommended:
    - Establishment of a public/private coordinating entity
      - *E-Health Advisory council (KHPA & Governor) serving in this role*
    - Resource support for HIT/HIE efforts in Kansas
      - *Budget enhancement requests for statewide community health record and HIT/HIE resource center not supported by legislature*

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E-Health Advisory Council

- **History:** Given KHPA's statutory charge to coordinate health care for Kansas, Governor requested KHPA to guide development and administration of statewide health information technology and exchange
- **Charge: KHPA Board and Governor create** the E-Health Information Advisory Council to implement:
  - Statewide Community Health Record
  - Develop and implement resource center for providers wishing to implement HIT/HIE
  - Develop policy recommendations to advance HIT/HIE in Kansas

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Community Health Record Pilot Project

Development & Utilization of HIT and HIE in Kansas

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Kansas Medicaid Community Health Record (CHR)

- **Location:** Sedgwick County, KS
- **Pilot Population:** Medicaid Managed Care
- **Purpose:** To improve the quality, safety, and cost-effectiveness of care
- **Timeline:**
  - Launched in Feb 2006
  - Currently implemented in 20 sites
  - Submitted a budget enhancement request of $50,000 SGF for FY 2009 to expand program to 20 additional sites in Sedgwick County
  - Statewide expansion included in KHPA Board health reform recommendations for 2008 legislative session

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Kansas Medicaid CHR Pilot (Con't)

- **Utilization:** Medicaid providers accessed 7,487 records for 4,620 unique patients in 2007
- **Functions:**
  - Web-based tool via Cerner designed platform
  - Online provider access to 12+ months of aggregated claims data and health transactions regarding a patient's office visits, hospitalizations, medications, immunizations, and lead screening data
  - Real-time e-prescribing function alerts providers of contraindication to prescribed therapy, generic alternatives, preferred drug lists, and whether it is a high or low cost drug.

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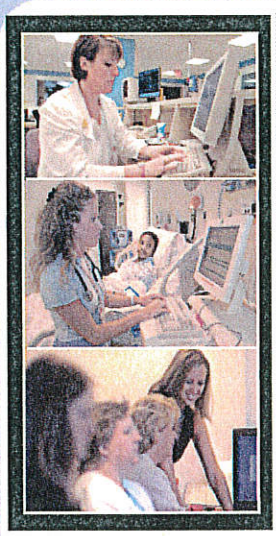
Three Types Of Electronic Health Records



- **Provider Electronic Health/Medical Record (EHR or EMR)**
  - Legal medical record owned and used by providers to manage their own patient population
  - Used across multiple venues of care within an enterprise for multiple conditions
- **Community Health Record (CHR)**
  - "Community owned" record that serves a "politically viable" geography, region, or health system network
  - Crosses traditional provider system's boundaries
  - Derives summary information from multiple sources
  - Ties into a national health infrastructure
  - Enables bio-health, public health, outcomes management
- **Personal Health Record (PHR)**
  - Personally-managed health data
  - Populated with data from CHRs and EMRs
  - Wellness programs/condition mgmt.

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Key Features & Benefits

- **Provides a quick summary of key activity information**
- **Web-based, easy to deploy and easy to learn**
- **Patient-centered record of aggregated health data**
- **Enables both aggregated and "shared only" views of the information**
- **Contains extendable services, e.g. in-box, eRx, etc.**
- **Stepping-stone towards a full EMR**

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Sedgwick County Pilot Timeline

- **Phase I – February, 2006**
  - Community Health Record
    - *FirstGuard Medicaid Members*
    - *Demographics, Claimed Visits, Dispensed Medications, Immunizations*
    - *12 months of historical claims data; continue data uploads through 2006*
  - Master Person Index
    - *Unique Person Identifier*
  - Documentation
    - *Allergies*
    - *Kan Be Healthy*
- **Phase II – May, 2006**
  - HealthConnect Members
  - ePrescribing roll-out (SureScripts Connection – June, 2006)
  - Lead Screening Results
- **Phase III – January, 2007**
  - Transitioned MCO's
    - *UniCare & Children's Mercy Family Health Partners*
  - New Functionality
    - *Change Password Capability, Add Patient, EPSDT Enhancements, etc.*

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KHPA Kansas Health Policy Authority

CareEntrust: Kansas City Health Exchange

- **Location and Participants**:
  - Non-profit organization comprised of around 20 of Kansas City's leading employers and health care organizations including Kansas State Employee Health Plan (for KC residents)
- **Purpose:**
  - To develop and manage the CHR as a means to improving patient safety and avoiding costly and wasteful health care practices
- **Timeline:**
  - Developed a business plan for a Regional Health Information Exchange that governs and manages a CHR for Wyandotte, Leavenworth, and Johnson Counties – Kansas SEHP

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CareEntrust: Kansas City Health Exchange (Cont')

- **Community Health Record Details:**
  - Consists of a central data repository that stores comprehensive, person-centric health data for provider access
  - Aggregates information from health plans, pharmacy benefit managers, laboratories, and immunization registry data
- **Target Population:** employees & dependents of the 20 participating employers

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Health Information Security and Privacy Collaboration

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Health Information Security and Privacy Collaboration (HISPC)

- **Funding:** Federal Health and Human Service Grant funded through RTI International
  - Partnership with the National Governor's Association
- **Purpose:** Statewide assessment of business practices and policies around HIE; identify barriers to interoperable HIE; develop solutions
- **HISPC I, II, and III in Kansas:**
  - Sponsored by Governor's Health Care Cost Containment Commission (H4C)
    - One of 34 states awarded subcontract
    - **Timeline:** May 2006 through March 2007
  - **Public-Private Project Team:** KHI – project manager, KU Center for Health Informatics, and KHPA, Mid-America Coalition on Healthcare, Lathrop & Gage, other stakeholders

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Tying it all together

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Future of these Initiatives

- Obama Administration: Role for federal leadership re: interoperability and privacy protections
- States: Budget challenges (enhancements and staff support)
- Potential for Kansas: Use federal stimulus package dollars to:
  - Incentivize the use of electronic health information
  - Support the use of telemedicine and telehealth as part of HIT-HIE efforts
  - Use both HIT and telemedicine to create a medical home model of care that serves all Kansans.

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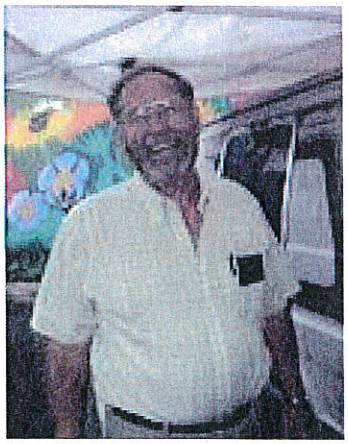
Representative Tom Sloan upon hearing that the federal stimulus package contains funds to promote HIT/HIE and telemedicine



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TO: House Vision 2020 Committee

FROM: Dale White

DATE: February 16, 2009

RE: Tele-health in Kansas

Mr. Chairman and members of the committee, I would like to thank you for the opportunity to participate in these hearings regarding the utilization of tele-health technology to better our healthcare system in Kansas.

Over the course of the hearings on tele-health, we have heard about the diversity of programs being used to deliver vital services to Kansans. We have also heard from multiple sources that represent stakeholders who support this tool for the delivery of services. It has been very exciting to hear that applications we only dreamed of 16 or 17 years ago, when I first began working on telemedicine in Kansas, are today being delivered with competence and confidence. We heard from Dr. Elizabeth Cowboy of Via Christi on how their e-ICU program was not only delivering instantaneous high quality assistance to outlying hospitals but also significantly reducing mortality and morbidity while doing so. Dr. Cowboy stated that they have demonstrated a 54% reduction in mortality where this application is being delivered. Translated, that means that 54 out of 100 Kansans who would have died without this technology – lived. I found that to be nothing short of stunning. The representative from the home care industry indicated that by utilizing the technology, hospital days were cut in about half and the need for institutionalization was sharply reduced. This was similarly represented by the testimony of the individual representing the developmentally disabled/mental health

House Vision 2020
2-16-2009
Attachment 2-1

monitoring program. By doing in home monitoring their data indicated that the use of this technology helped those who were previously institutionalized live much more independently and safely without constant personnel in home attendants. These and other examples demonstrate not only a significant improvement in quality of life, but a significant reduction in expenditures to our healthcare system; and by extension, savings to taxpayers and those who pay private insurance premiums.

Chairman Sloan hit the nail on the head when he asked about supportive data and wondered aloud if the data was held in a common clearing house or did it reside in data "silos". At this point we believe there is much data that has and can be gathered in the near term to support these and other observations but we would need time and resources to do so.

The information dilemma is not in itself unexpected when taken into consideration that up until now the use of the technology has been an individual or small group labor of love that has been funded through various grants and other government and private sources. Now that the technology has been proven reliable and appropriate, it seems clear that a common database needs to be created that gathers information and lessons learned so that others may begin to realize the benefits of tele-health without any trepidation.

To accomplish this will take some time and collaboration from those who have been conferees and others who have labored to develop the various uses and delivery systems of this technology. Brad Williams cited a report that identified this as a "transformative" time for the technology. We have indeed reached a "tipping point". If we do our job well the implications from a humanitarian, financial savings, and economic/community development stand point would give Kansas a significant edge.

Therefore, we would humbly suggest that a work group be established of representatives from the list of conferees along with 2 or 3 representatives of the State Legislature under the guidance of the Kansas Health Policy Authority. KHPA could play a significant role in coordinating and facilitating this process. We would begin exploring answers to the following issues.

Policy Issues:

1. Develop common definition of appropriate terms and procedures (e.g., telemedicine, tele-health monitoring, E-ICU care).

2. Develop list of current programs that now exist in the State that fit this definition.

3. Review services that are currently reimbursed by Medicare, Medicaid and private insurers in and out of the state.

4. Based on 1 through 3 develop recommendations and agreement of what services, type of provider and location that are or could be considered for reimbursement, by Medicare, Medicaid and private insurers.

5. Based on 1 thru 4 Review the telemedicine credentialing standards established by Medicare and applicable survey data in order to determine standardized credentialing requirements for those individuals and/or entities who deliver telemedicine/tele-health services in the state of Kansas.

6. Collect, or identify process to collect, data necessary to make determinations on the effectiveness (including health care, quality of life and cost) of such services.

7. Develop standardization of quality control measurements.

8. Identify best location/organization for the repository, formatting and distribution of data.

9. Based on 6 thru 8 - develop a plan for data sharing so that the decision-making models of the health care providers and public and private insurers are collaborated and facilitated.

10. Address the implementation rates and cost-effective modeling for new technologies and recommend appropriate education, data collection, and other steps.

11. Study how the health information technology provisions contained in the federal economic stimulus legislation will benefit our ability to expand the adoption of these technologies in Kansas.

12. Other issues as identified.

We would also recommend that sub-task forces be established to explore and make recommendations on individual, focused issues to the tele-health workgroup, as needed. This would allow utilization of focused expertise and help prevent the work group form bogging down on technical issues.

If the committee agrees with the aforementioned plan, we will begin establishing the task force and provide an update to the committee prior to adjournment of the 2009 Kansas legislative session. Our work would then continue throughout the year and we would report back to the committee at the beginning of the next legislative session to report our progress, make recommendations, and receive further directives.

Thank you for your consideration of my comments.