



**INFORMATION SYSTEMS ADVISORY
COMMITTEE**

February 22, 2007

MEETING MINUTES

**National Programs Building, Conference Room 1-1
5300 Homestead Road, NE
Albuquerque, New Mexico**

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Meeting Participants

IHS ISAC Members Attending:

Michael Belgarde, IHS, Navajo Area Office

Darren Buchanan, IHS Office of Environmental Health and Engineering (OEHE) Representative,
via televideo

Pat Cox, IHS Co-Chair, Oklahoma Area Office

Theresa Cullen, IHS Chief Information Officer (CIO)

Bill G. Lance, Tribal, Chickasaw Nation Health System, Oklahoma

Joe Lucero, IHS, Information Systems Coordinator Committee (ISC) Representative

Kathryn Lewis, IHS, Albuquerque Indian Health Center, Albuquerque Area

Madonna Long, IHS, Lower Brule Service Unit, Aberdeen Area

Clark Marquart, IHS Chief Medical Officer Representative, Portland Area

Wendie Murray (Kashevaroff Alternate), Tribal Self Governance Advisory Committee
Representative, Alaska

Reece Sherrill, Tribal Co-Chair, Choctaw Nation Health Services Authority, Oklahoma

Floyd Thompson, IHS, Gallup Indian Medical Center

Chuck Walt, Tribal, FonDuLac Reservation, Wisconsin, via conference call

IHS ISAC Members Absent:

Deanna Bauman, National Indian Health Board Member (due to illness)

Richard Hall, Tribal, Alaska Native Tribal Health Consortium (ANTHC), Alaska

Lois R. Niska, Tribal, Medical Director, Ni Mii Puu Health, Lapwai, Idaho

Vacant, IHS National Council of Executive Officers, Navajo Area

Vacant, National Council of Urban Indian Health Board Member

Vacant, National Clinical Councils Member

Other Attendees:

Mike Danielson, IHS, OIT Albuquerque

Ronald Fondren, Tribal, Chickasaw Nation Health Systems, Oklahoma

Carl Gervais, IHS, OIT Albuquerque, via tele-video

George Huggins, IHS, OIT Albuquerque

Rob McKinney, IHS, OIT Albuquerque

Leslie Racine, IHS, Statistician, Billings Area

Kathy Ray, IHS, Clinical Information Management Technical Advisory Committee

Christy Tayrien, Business Systems Analyst, DNC/IHS Contractor/OIT

Welcome and Election of Co-Chairs

ISAC Co-Chairs

Pat Cox and Reece Sherrill, Information Systems Advisory Committee (ISAC) Co-Chairs, welcomed the attendees to the meeting held at the Indian Health Service (IHS) National Programs Building in Albuquerque, New Mexico. First item of business was the election of a Tribal Co-Chair for the next two years. Pat Cox announced that he will be retiring at the end of April and resigning from the ISAC. This required the group to elect a new Federal Co-Chair to

serve his remaining term in office (one year). Summary of nominations, votes, and new Chairs follows:

Tribal Co-Chair

Bill Lance nominated Reece Sherrill, Pat Cox seconded the nomination, and the ISAC unanimously voted to elect Reece Sherrill as the Tribal Co-Chair for a second 2-year term.

Federal Co-Chair

Pat Cox nominated Madonna Long, Floyd Thompson seconded the nomination, and the ISAC voted to elect Madonna Long as the Federal Co-Chair to complete Pat Cox's term (one year).

Pat Cox asked Madonna Long if she would like to chair this ISAC meeting and she declined.

Chief Information Officer Report

Theresa Cullen, Chief Information Officer (CIO), Indian Health Service (IHS)

Presentation Slides can be found at: [CIO Update to ISAC -2-22-2007](#)

Dr. Cullen said she has been the IHS CIO for eight months now. She has found it to be quite an undertaking and emphasized it takes time to make changes/fixes. Highlights of her presentation and ISAC discussion follows:

FY2007 Budget

- Must be spent on what is contained in the President's budget
- Anything outside of the President's budget requires HHS approval
- OIT budget will go to operations and maintenance
- Everything else has to grind to a halt

OIT Involvement in Directors Initiatives

- Chronic Care
 - Use of Resource and Patient Management System/ Electronic Health Record (EHR)
 - Funds are going to EHR sites
 - Due to funding limitations, the CIO is asking groups that come to the table with proposals to use their own funds, not OIT's
 - EHR uses Diabetes Program funds
 - On the Electronic Dental Record (EDR), the OIT is contributing \$150,000 for a contract analyst to work with the Dental Program. The EDR has \$1.5 million per year that they are working with overall.
 - Use of iCARE for measures – measurement tool for case management, i.e., cardiovascular, etc. Reece Sherrill asked if we can work ORYX measures into iCare. Dr. Cullen said this was a good question. She would like to facilitate this, but it is political and she is not the one to propose it. Reece said when you have a Joint Commission on Accreditation of Healthcare Organization survey, the

surveyors do not understand GPRA, but they do understand ORYX. When comparing GPRA and ORYX data, the data does not look the same. Dr. Cullen asked for Dr. Clark Marquart's opinion and he said he would bring it up next week at the Chief Medical Officer meeting (see Action Item Section).

- Behavioral Health – uses funds IHS receives through the Stephens Bill.
 - Support for BH HIT application
- Health Promotion/ Disease Prevention
 - Development of appropriate measures
 - Involvement in patient education measures and documentation

Discussion:

Reece Sherrill and Pat Cox discussed Information Technology (IT) projects being fragmented when they are reduced to who has the money. Chuck Walt added it is disheartening to hear that our IHS IT program is fragmented and has to operate like this. He asked how the Veterans Health Administration (VHA) is set up to do software development. Dr. Cullen said the VHA has much more money and they are now under a line-item budget structure for IT. At IHS, she is reinforcing the solutions of RPMS and is trying to keep our IT program aligned with the ISAC priorities. Pat Cox said he sees things being pushed down to the local level that we don't have funds to accomplish, things that should be supported on a national level such as EHR. Wendie Murray emphasized developing our IHS policies and business processes, Capital Planning and Investment Control (CPIC) specifically, instead of operating under this system of who has the most money. Dr. Cullen talked about this being the first year IHS developed the budget based on performance measures and starting with a "zero-based" budget instead of just adding a percentage to the previous year's budget. She said this year's IT budget proposal came as a shock to IHS executives who, after seeing our budget Exhibit 300s, think they are too high.

- The group went through a lengthy discussion on the overall budget process and how IT is an afterthought. Reece said IT is a part of our organization's infrastructure; Pat Cox said IT is how we do business and is an integral part of health care. Bill Lance was concerned that just because a program like Dental has funding, why or how do they get to do what they want? Bill said if these programs have extra funding, then maybe IHS needs to reallocate their resources. Chuck Walt discussed the NextGen software his Tribe, FonDuLac uses and its cost. He discussed IT industry standards for IT spending and recommended IHS look at what our organization is spending on IT. His Tribe researched the industry standard for IT costs of health care and identified an IT cost of 8 percent of the total budget (Chuck said this figure's source was from insurance companies). Chuck discussed FonDuLac's successful collections and attributed it to the IT solution they have in place and adequate budget resources being allocated to IT. Dr. Cullen said Christy Tayrien, OIT, will write a history of the IT budget and provide documents ISAC has used in previous years to advocate for IT funds (see Action Item Section).

OMB, FHA and AHIC transparency - The impact on IHS

Who are these people and what are they doing to us?

- OMB- Office of Management and Budget
- FHA- Federal Health Architecture
 - Run through Office of National Coordinator (ONC)

- AHIC- American Health Informatics Committee (Community)
 - Chaired by Secretary Leavitt
 - Public/private committee
 - Federal Input via Federal Health IT Plenary Committee

OMB/ONC

- Interoperable Standards- IHS will conduct preliminary review of Healthcare Information Technology Standards Panel (HITSP) interoperability specifications version 1.2 delivered to American Health Information Community (AHIC) October 2006. (Ref: HITSP Interoperability Specifications: Electronic Health Record Laboratory Results Reporting HITSP/IS-01, Biosurveillance HITSP/IS-02, Consumer Empowerment HITSP/IS-03).
- Quality Transparency- IHS will provide a list of its current quality measures and methodologies
- Certification Criteria- IHS will conduct an analysis of certification criteria as they apply to RPMS to identify gaps and resources necessary to address gaps

Federal Health Architecture - by 3/31/07

- Interoperable Standards - The IHS will conduct a review of the HITSP Interoperability Specifications version 1.2 delivered to the American Health Information Community (AHIC).
- Quality Transparency - The IHS will provide a list of its current quality measures and methodologies based upon our current Clinical Reporting Software application.
- Certification Criteria - The IHS will conduct an analysis of certification criteria as they apply to RPMS to identify gaps and resources necessary to address the gaps.

AHIC

- **Recommendation 3.1:** HHS, through the Agency for Healthcare Research Quality (AHRQ), and in collaboration with the IHS, Centers for Medicare/Medicaid Services (CMS), the Department of Veterans Affairs, and the Office of Personnel Management, should develop an evaluation framework that can assist in the systematic assessment of PHR offerings to federal employees and beneficiaries, by December 28, 2007. Evaluation criteria may include the effect of Personal Health Record (PHR) services on health outcomes, level of consumer engagement in their health care, economic impact, data security, and other measures.
- ACCEPTED 1/23/07
- **Recommendation 3.4:** HHS, through the Centers for Medicare & Medicaid Services and the IHS, should develop plans to offer portable PHRs with privacy protections to their beneficiaries, and report back to the Community about their plans as available. The plans should take into account the results of the studies and best practices from 2.1 and 3.2, as they become available.
- AHIC- Tabled 1/23/07

Latest Twist

- VA and DOD to develop inpatient Health Information Technology (HIT) solution
- Focus on requirements phase

- IHS can participate, however we have no funding. The VA and DoD have funding. The inpatient HIT solution will not replace the RPMS.
- Unclear if solution will be Government Off The Shelf (GOTS)/Commercial Off The Shelf (COTS)/etc
- Unclear who will pay for IHS to buy, deploy and support the system. Bill Lance asked if anyone has asked Secretary Leavitt for his support or presented our requirements. Dr. Cullen said it has been presented to the Assistant Secretary for Budget, Technology and Finance, but not to the Secretary. Bill said this is a golden opportunity for us with the AHIC being named. He stressed the need for Dr. Grim to have a meeting with the Secretary to advance this. Reece added maybe it's time for the IHS to start letting people know we don't have the resources, we are reaching the point of implosion.

Update on ISAC Priorities

EHR

- Currently deployed at 77 sites
- Version 1.1 currently in SQA. We are a year behind. Supposed to be out of Software Quality Assurance by the end of February. Pat Cox asked when it will be available. Dr. Cullen said possibly by the end of May.
- EDR was approved by the ITIRB 2/07. Dr. Clark asked what the approval meant. Dr. Cullen said it now goes to Dr. Grim. Clark asked how many EDR sites, he recalled they asked for 10 pilot sites. Christy said they are projecting 55 sites over the next five years. Dr. Cullen said their plan is still for 10 pilot sites this year. Clark said Portland Area will be looking at the VA EDR. He is still worried about interfaces and running two separate EHRs. Dental will have to run both the RPMS and the EDR. The ISAC discussed not being able to sole source this investment. George Huggins said this procurement will have to go through GSA. We are making a good case for the source the Dental Program recommended, but the GSA will still compete the procurement. The Co-Chairs requested OIT send all EDR ITIRB documents out to the ISAC (see Action Item Section).

Billing/ Revenue Generation

- 3PB, AR
- PAMS- current status

Data Quality/Accuracy

- Impact of EHR
- Impact of PCC+
- No formal initiative

Training

- 4 trainings/Area/year
- Additional training at Alb/ Phoenix
- Package training support through contractors

Telemedicine

- Ongoing
- Mark Carroll

Master Person Index (MPI)

- Currently in the budget document
- Work with Alaska on using their state option
- Meeting with AZ next week to look at their state option
- Final line– money in the budget

Decision Support

- EISS- impact of UFMS
- iCARE- Clinical Support

Infrastructure/Architecture

- Enterprise Architecture
- WAN/LAN

Cost Accounting

- Quality cost accounting

Security

- C&A

IHS Security Update

Robert McKinney, Director, Division of Information Security, OIT
IHS Chief Information Security Officer

Rob followed-up on action items identified at the October 2006 ISAC meeting. Highlights follow:

- Security will be addressed before ANY Development, Modernization, or Enhancement.
- WAN and LAN security will increase. Rob briefly discussed WebSense software and the Network Operations Support Center IHS is using to protect the networks. Rob talked about constant threats HHS-wide. Solutions continue to come down like PointSec. The IHS is requiring Point Sec, an encryption software tool, to be installed on all IHS lap tops. This is a new requirement and is due in part to the VA laptops that have been recently stolen with personally identifiable information on them. Dr. Cullen referenced the VA Director's ominous letter to staff that inferred they will probably be fired if it happens again. Reece said the VA in Muskogee, Oklahoma recently lost 1,800 patient files including Choctaw Health Systems Authority patients. The files contained social security numbers and insurance information.
- Rob said we will be looking at total encryption on not only laptops but desktops and servers in the future. Rob said the OMB is looking at security for all information and we anticipate requirements for paper to come down soon.

- Certification and Accreditation information went out at the All Feds Meeting held November 15-16, 2006. An IHS Committee headed by Ms. Doni Wilder, Portland Area Director, is being formed to look at the IHS budget and policy. Dr. Cullen stressed the importance of the new Committee's work. They will be looking at all Tribal shares, not just IT. It will cover much more. She said from an OIT perspective, we need a Tribal representative on the Committee. Reece Sherrill voiced his concern that Tribes be given an opportunity to participate on these decisions if they affect Tribal shares.

In closing, Pat Cox said this is a great improvement. The ISAC actions have resulted in these accomplishments. Reece said Rob has provided much help to his Tribe and is appreciated.

IHS Information Technology FY07 and FY08 Budget Updates

George T. Huggins, Director, Division of Information Resources Management

Presentation Slides can be found at: [IHS IT FY07 and 08 Budget Updates](#)

George said in the past the development of IHS spending plans being an exercise where you just added a percentage to the previous year's plan. This is not the case anymore. We are required to develop performance-based spending plans with a zero based budget as a starting point. He reviewed the cycle for budget development. Usually at the end of the summer is when we begin developing the spending plan. It is an ever changing document and we are on Version 33 of the OIT plan. The spending plan is very detailed and ranges in costs from \$8 million contracts to just \$50 software buys. The priorities listed on the OIT spending plan are as follows:

- 0 - mandate
- 1 - operational
- 2 to 4 – importance granularities

Reece would like to see the ISAC priorities tied to the OIT spending plan and Dr. Cullen and George agreed this could be done. Dr. Cullen talked about how projects are removed from plans. We put the Master Person Index in the spending plan, but it can be picked off easily when we don't get fully funded. Dr. Cullen then discussed items requiring approval by the ITIRB needing an investment sponsor. The ISAC discussed ways to get a sponsor for these projects and Pat Cox suggested the CIO Office sponsor some of them but Dr. Cullen said the OIT has no funds to bring forward with them. Dr. Cullen gave the example of the MPI, an ISAC priority that has no sponsor.

Floyd Thompson discussed unfunded mandates not having to go through the ITIRB since we are required to support and fund them. The group discussed an IT line item as a solution to some of these unmet costs. Dr. Marquart added he would like to see the OIT write the pros and cons of on IT line item. Dr. Cullen said she asked Jeff Lovern, HHS, about this issue and he said "you don't want an IT line item." Floyd said he would like to find out if we can even pursue a line item. He said we need to be communicating what these unfunded mandates are doing to our programs; their effect and what we are not able to do as a result. Pat said he is again asking for costs of unfunded mandates and Bill recommended an annual list of these costs. Dr. Cullen she

will make this an action item (see Action Items Section). Related to unfunded mandates, Dr. Cullen discussed the HSPD-12 initiative coming in \$3 million under the original estimate. She said we have no say on the HHS Enterprise IT Funding and these items come off the top of the IHS budget. Pat said he would like to see the analysis OIT will be preparing include the amount of funds taken off the top of our budget, unfunded mandates, and our approved projects.

Clinicians' Information Management Technical Advisory Committee (CIMTAC)

Kathy Ray, CNM, CAC, FATA, CIMTAC Chair

Presentation Slides can be found at: [CIMTAC Presentation 2-22-07](#)

Ms. Ray introduced herself as the CIMTAC Chair to the ISAC. The following summarizes her presentation.

History of CIMTAC

- Formed by a group of providers
- Consisted of physicians and nurses
- Charter developed, but never approved, i.e., not an officially recognized PSG (Professional Specialty Group)
- Has been – will continue to be very active
- In change process at present – growth and function

A Typical CIMTAC Meeting

- Updates on RPMS Packages – what's changing (IMM, GPRA/CRS, etc.)
- New/upcoming packages (iCare)
- Proposals (ER Dashboard and Clinical Queue)
- Presentations (CIO)
- Review of enhancement requests
- Discussion (whether there is time or not!)

Changes in CIMTAC

- Expanded Role/Expanded Membership
 - Recommending Body for Clinical RPMS and perhaps EHR
 - Membership expanding to include other PSG's (Lab, Pharmacy, others as they develop such as BH, Radiology)
 - HP/DP, Chronic Care, Tribal EpiCenter

Charter and Membership

- Revision to reflect “as we are”
- Define relationships with other groups
- Two email groups
 - CIMTAC Voting
 - CIMTAC – ALL (includes voting)

The Provider Perspective - - Needs/Problems/Themes

- Easy to use – minimal training needed
- Use should be intuitive

- Lack of access to packages in RPMS
- Standardization on Implementation of Packages – Lack of Support
- And always - \$\$\$

Impact of

- UFMS (time and dollars)
- Out-sourcing RPMS/EHR (cost, control)
- Security Issues (log in/out; compliance agreements – lab)

Top 15 Priorities by Stan Griffith dated 9/2000

- 1) PCC Encounter Form that Allows Immediate Billing
- 2) Electronic Interface between Contract Labs and PCC
- 3) Customizable PCC Encounter Forms
- 4) A. Multi-path Turn-Around PCC Encounter Form
B. Point of Care Data Entry
- 5) Electronic Signatures
- 6) Integrated Superbill/Health Summary/PCC Encounter Form
- 7) Electronic Signatures in Lab Package
- 8) Integrated Flow Charts/PCC Encounter Forms that prompt for specific standards of care
- 9) Scanned Textual Data Entry
- 10) Customizable Medication List – can be defined and maintained by individual providers
- 11) Knowledge Couplers
 - Drug Interaction knowledge in Pharmacy PKG
 - Medical references electronically available in clinic
 - IHS Patient Education Protocols electronically available
- 12) RPMS Applications Interoperability
- 13) OB/ER/Surgical Logs
- 14) GUI Interface for Direct Problem List Editing
- 15) Web-based Access for RPMS

RPMS – The Backbone

EHR - Ease of Use

- RPMS **MUST** be maintained
- Development must continue

Discussion:

Pat Cox said the purpose of CIMTAC is to give our active providers an opportunity to have a say in RPMS software development. Chuck Walt asked what CIMTAC does with the RPMS packages and Kathy said they are returned to their owners or program/project management officers. Kathy said they will be prioritizing the software packages, but have not decided quite how to do this yet. She said clinical Professional Specialty Groups (PSG) have been given a vote on the CIMTAC recently. The group discussed CIMTAC presenting to the ISAC years ago when they were first forming. The ISAC did not pursue or support the CIMTAC proposal presented to them. Floyd Thompson asked about the Lab package interfaces and Kathy referred him to Dave White, OIT, and Burt Tallant, Santa Fe Indian Hospital for more information. Clark

suggested filling the ISAC Clinical Councils vacancy from the CIMTAC in the event the Clinical Councils did not find a person to take this position.

IHS Capital Planning and Investment Control Process

Dr. Theresa Cullen, CIO, IHS

Presentation Slides can be found at: [IHS CPIC Process 2-22-07](#)

Dr. Cullen reviewed the Capital Planning and Investment Control (CPIC) mandates. The OMB translated the intent of GPRA, Clinger-Cohen, and FASA into specific requirements for Executive Agencies. These requirements, in the form of plans and ultimately the budget submission, must be highly integrated to ensure investments and strategies are properly planned and adequately funded. **BOTTOM LINE:** Failure to fully justify a capital investment by demonstrating specifically how the investment will support the Agency's mission, strategic goals, and objectives is likely to result in decreased or denied funding.

Three CPIC phases:

- Select Phase
 - Screen investments
 - Rank investments
 - Choose investments
- Control Phase
 - Monitor progress
 - Take corrective action
- Evaluate Phase
 - Make adjustments
 - Apply lessons learned

Governance Structure:

- Director, IHS
- ITIRB
- Technical Review Board
- CPIC Team
- Investment Manager

Governance Roles:

- Investment Manager
 - Develops a sound and robust business case that links performance with strategic business goals
 - Ensures project is meeting target performance goals, projected schedule, and cost
- CPIC Team-meets quarterly
 - Reviews all new business cases for completeness
 - Reviews quarterly EVM and escalates investments that are out of variance to the CIO or ITIRB
- Technical Review Board (TRB)-only in Select Phase
 - Evaluates and scores all new investments for technical soundness

- Identifies opportunities to leverage and reuse existing investments
- Board membership: Deputy CIO, Chief Security Officer, CTO, Enterprise Architect, Certified Project Managers, DIRM Director, and two Area Office CIOs
- CIO
 - Approves or disapproves investments < \$500,0000
- ITIRB
 - Approves or disapproves investments > \$500,0000
 - Ranks investments
 - Monitors investments that are not meeting projected goals
- HHS CIO CPIC Team
 - Evaluates and scores Exhibit 300 investments only

CPIC Calendar

Dr. Cullen reviewed the CPIC calendar and discussed the OIT working with ISAC and Area Information Systems Coordinators on developing strategic plans.

SELECT PHASE

Scoring Criteria

Step 1: Projects are scored against 10 criteria:

1. Mission Driven (PMA, HHS, IHS)
2. Alternatives Analysis
3. Life Cycle Costs Formulation
4. Acquisition Strategy
5. Risk Management
6. Performance Goals
7. Project Management
8. Performance Based Management System
9. Security & Privacy
10. Enterprise Architecture

Step 2: Projects are assigned an overall score of 1 to 5, based on the cumulative score for the 10 criteria. Acceptable business cases must score at least “31” overall and receive at least a “4” in the Security criteria.

Investment Approval

- CIO Approves or disapproves investments < \$500,000
- ITIRB
 - Approves or disapproves investments > \$500,000
 - Prioritizes investments

Minor Investments

- Criteria: Investment >\$25,000 < \$100,000
- Business Case Form: Short Business Case
- Decision Maker: CIO

- CIO- Approves or disapproves investment
- Technical Review Board- Scores business case
- CPIC Team- Reviews business case for errors
- Investment Manager- Submits business case

Moderate Investments

- Criteria: Investment >\$100,000 < \$500,000
- Business Case Form: Long Business Case
- Decision Maker: CIO
 - CIO- Approves or disapproves investment
- Technical Review Board- Scores business case
- CPIC Team- Reviews business case for errors
- Investment Manager- Submits business case

Large Investments

- Criteria: Investment >\$500,000 < \$3,000,000
- Business Case Form: Long Business Case
- Decision Maker: IHS ITIRB
 - ITIRB- Approves or disapproves investment
- Technical Review Board- Scores business case
- CPIC Team- Reviews business case for errors
- Investment Manager- Submits business case

Major Investments That Require IHS Review Only

- Criteria: Investment > \$3,000,000
- Business Case Form: Long Business Case
- Decision Maker: IHS ITIRB
 - ITIRB- Approves or disapproves investment
- Technical Review Board- Scores business case
- CPIC Team- Reviews business case for errors
- Investment Manager- Submits business case

Major Investments That Require OMB Review

- Criteria: Investment with life cycle Costs > \$3,000,000
- Business Case Form: Exhibit 300
- Decision Maker: HHS ITIRB
- OMB- Approves or disapproves investment
- HHS CPIC Team- Scores Exhibit 300
- IHS ITIRB- Approves or disapproves investment for Department review
- Technical Review Board- Scores business case
- CPIC Team- Reviews business case for errors
- Investment Manager- Submits business case

CONTROL PHASE

Control Phase Procedures

- Minor Investments -- Monitored annually by CPIC Team
- Moderate Investments -- Monitored and reviewed quarterly by CIO
- Large and Major Investments -- Monitored and reviewed quarterly by ITIRB

Minor Investments

- Criteria: investment life cycle costs >\$25,000 < \$100,000
- Investment manager submits updated project status and actual performance goals to CPIC Team
- Investment meets schedule, costs, and performance goals – Yes - Continue with investment
- Investment meets schedule, costs, and performance goals – No - CIO will decide if funding should be continued

Moderate Investments

- Criteria: investment life cycle costs >\$100,000 < \$500,000
- Investment manager submits EVM to CPIC Team
- Investment meets EVM tolerance level – Yes - Continue with investment
- Investment meets EVM tolerance level – No - CIO will decide if funding should be continued

Large Investments

- Criteria: investment life cycle costs >\$500,000 < \$3,000,000
- Investment manager submits EVM to CPIC Team
- Investment meets EVM tolerance level – Yes - Continue with investment
- Investment meets EVM tolerance level – No - ITIRB will decide if funding should be continued

Major Investments That Require IHS Internal Review

- Criteria: investment life cycle costs > \$3,000,000
- Investment manager submits EVM to CPIC Team
- Investment meets EVM tolerance level – Yes - Continue with investment
- Investment meets EVM tolerance level – No - ITIRB will decide if funding should be continued

Major Investments That Require Department Review

Criteria: investment life cycle costs > \$3,000,000

Investment manager submits EVM to CPIC Team

Investment meets EVM tolerance level – Yes - Continue with investment

Investment meets EVM tolerance level – No - ITIRB will decide if funding should be continued

- Investment is reviewed by HHS ITIRB

EVALUATE PHASE

Moderate, Large, and Major Investments

Investment manager will perform investment assessment and identify lessons learned

Next Steps

- Identify desk manager for each incoming investment; desk manager will work with investment manager to develop business case.
- Develop ITRIB schedule allowing 1 week for TRB review and 1.5 weeks for ITIRB review.

Discussion:

Wendie Murray asked where the ISAC fits in the governance structure. Dr. Cullen said ISAC is advisory to the ITIRB. Drs. Marquart and Cullen recommended displaying a dotted line in future CPIC Process documents illustrating a line from the ITIRB box to the ISAC. Bill Lance asked if the over \$500,000 threshold was just for IHS Headquarters or all IHS. Dr. Cullen said it applies IHS-wide.

Wendie pointed out the regional budget consultation meetings must be held by March 15. We need to ensure ISAC meets and has information available to share at these meetings. Terry discussed having the ISAC priorities going back to the budget consultation team.

The ISAC reviewed the ITIRB scoring form criteria and recommended adding ISAC on item 1 – Mission Driven. (see Action Items Section). Dr. Cullen said the OIT will provide the ISAC with the ITIRB scoring forms (see Action Items Section).

Dr. Cullen discussed the OMB reviews of major investments and said they do not tell agencies that they can or cannot go through with the investment, they only “endorse.”

She said in the Control Phase, the IHS has not yet had the IHS ITIRB conducting these. As the Board progresses, this will be an activity for them to perform. John Redding, OIT Consultant, said the OIT is developing guides for each aspect of the CPIC process, i.e., alternatives analysis, risk management, EVM, etc.

IHS Investments 2007

Carl Gervais, CPIC Manager

Presentation Slides can be found at: [IHS Investments 2007](#)

Investments and Program Sponsors

Carl Gervais identified the following 2007 IHS IT investments and Sponsors/Program Managers:

RPMS

- Dr. Peter
- Dr. Hays

IOAT

- Phyllis Eddy
- Adriane Burton

NPIRS

- Dr. Church
- Dr. Griffith

RPMS 2007 Milestones

- Electronic Health Record
 - EHR Phase 1.1 & Vista Imaging
- Electronic Dental Record
- Integrated Behavioral Health
- Clinical Reporting System
 - CRS 2005 v.5 & UDS
- Clinical Decision Applications
 - Case Mgmt, Pediatrics, Obstetrics, Women's Health v.3
- Other Clinical Applications
 - Reference Laboratory
- Patient Administration Applications
 - Patient Registration v7.1p2 & PAMS v.3
- Administrative & Infrastructure
 - CSV, RPMS/3M Interface, Telemedicine, Patient Merge v1.0

IOAT 2007 Milestones

- FY2007 Projects for Infrastructure, Office Automation and Telecommunications (IOAT)
 - UFMS Phase II Network Upgrades Phase II
 - Network Upgrades Phase II
 - HHS Enterprise Email
 - IPv6 Data Gathering Phase II
 - IPv6 Inventory Backbone Phase II

NPIRS 2007 Milestones

- Migrate the entire Legacy NPIRS and IHPES environments to their new NPIRS/NDW system
- Improve NDW efficiency and reliability
- Improve unduplication of encounter data
- Archive Legacy NPIRS
- Develop method for archiving less-used NDW data
- Begin planning to add new data elements and types; data from new sources
- Complete alternatives analysis for managing hardware/software requirements
- Continue to meet production report requirements

Electronic Dental Record

- For the next 5 years
- COTS Package
- 55 sites
- \$11.9 million
- Priority under the EHR project

Discussion:

Reece Sherrill asked about the EDR being separate from the EHR on the list Carl presented. At the ITIRB meeting, the Board was told the EDR is a part of the EHR. Dr. Cullen asked John Redding, OIT Consultant, if this will make a difference. He said the 300 can be modified to show the EDR under the EHR, it wasn't a problem (see Action Item Section).

Reece was concerned whether the Dental Business Case specified a particular COTS product and Dr. Cullen assured the ISAC that it would not.

Bill Lance requested names/points of contact for each of the RPMS packages. Pat Cox said we need to look to the IHS Helpdesk first instead of going directly to the development staff.

Dr. Marquart said the ISAC is concerned with the Helpdesk and asked if Dr. Cullen needed the ISAC to assist. Dr. Cullen said we have 3 external persons coming into IHS to conduct an evaluation of our Helpdesk and should have a report by May.

The ISAC appointed Chuck Walt as the ISAC Tribal Representative to the ITIRB as the newly developed ITIRB charter requires. (Note: the discussion on having Don Kashevaroff fill this position is not possible. Don is already filling the ISAC TSGAC representative position on the ITIRB.)

Resource and Patient Management System (RPMS) Update

Dr. Theresa Cullen, IHS CIO

Presentation Slides can be found at: [RPMS Update 2-22-07](#)

RPMS

- IHS Health Information Solution since 1984
- RPMS is an integrated Public Health information system
 - Composed of over 60 component applications
 - Patient and Population based clinical applications
 - Patient and Population based practice management applications
 - Financially-oriented administrative applications
- www.ihs.gov/CIO/RPMS

VistA and RPMS

- Common programming/database architecture (M/Cache)
- Applications shared by VHA and IHS
- Most developed for use in VHA and adapted for IHS

- Some developed for use in IHS and adapted for VHA
- RPMS focused around Visit data contained in Patient Care Component (PCC)
- IHS uses HRN instead of SSN

IHS is not VHA

- Cradle to grave care
 - Pediatrics
 - Prenatal and obstetrical care
- Smaller facilities, more rurally located
- Decentralized administration
- Tribal autonomy
- Community and population-based mission
- Very modest IT staffing & budget

RPMS Integrates Multiple Clinical Systems

RPMS Electronic Health Record

- Graphical User Interface to RPMS
 - User-friendly and intuitive access to RPMS database for clinicians and other staff
 - Componentized to allow incorporation of CPRS functionality as well as new capabilities developed within IHS
 - Proprietary “framework” for presentation of various GUI components

RPMS EHR Commonalities with CPRS

- Notifications
- Text Integration Utility – note author
- Reminders application
 - IHS-specific national reminders
- Consults application
 - RPMS has separate referred care application
- Order Entry, Lab, Radiology, Pharmacy
 - Numerous IHS customizations esp with medication management

IHS-Specific EHR Components

- Medication management interface
- Immunizations
- Patient Education
- Problem List
- Diagnosis entry and coding
- Superbills and CPT coding
- Numerous others

Additional Development

- Well Child Care
 - CDC Growth Charts

- Breastfeeding information
- Developmental screening
- Well Child Knowledgebase
- Prenatal Care
 - Data collection for first & subsequent prenatal visits
 - Data carries over to future pregnancies
 - Flowchart presentation where appropriate

RPMS Behavioral Health System

- First complete electronic record in IHS (1990s)
- Ability to document:
 - 1:1 patient encounters
 - Group encounters
 - Patient Education, Health Factors and screening (depression, EtOH, DV)
 - Treatment Plans and Treatment Plan reviews
 - Case Management Information
 - Incidences of Suicidal Behavior
- Integrated with RPMS medical information

RPMS Case Management Applications

- Registry-based systems with reminders, performance indicators, and population-based reporting
- Immunizations
- Diabetes Management System
- Asthma Management System
- Women's Health
- HIV Management System
- Integrated Case Management (iCare)

Integrated Case Management (iCare)

- Graphical interface for a fully integrated case management system
- Decision support and patient management for multiple chronic conditions
- Nationally defined preventive and disease-specific healthcare reminders
- Customizable patient panels
- Quick performance views using CRS/GPRA logic for any patient or group of patients
- Plan to incorporate current and future disease-specific register systems (DM, Asthma, HIV/STD, CVD, WH, etc.)

CRS (Clinical Reporting System)

- A component of RPMS
- An automated reporting system used for tracking over 300 clinical quality measures, including 22 GPRA measures
- Intended to eliminate the need for manual chart audits
- Available in both GUI and roll-and-scroll versions
- Awarded 2005 Nicholas E. Davies Award of Excellence
- Identical logic ensures comparable performance data across all facilities

- Updated annually to reflect changes in the logic descriptions and to add new measures
- Local facilities have the option of transmitting their data for most CRS reports to their Area Office for Area Aggregate Reports

CRS 2007 Clinical Measures

- 22 GPRA treatment and prevention measures
- 23 other key clinical performance measure topics. Examples:
 - Diabetes Comprehensive Care
 - Osteoporosis Screening
 - Comprehensive CVD-Related Assessment
- 22 HEDIS measure topics
- 26 Elder Care measure topics (patients 55+)
- 17 CMS (hospital) measures

RPMS and Related Websites

- RPMS: www.ihs.gov/cio/rpms
- EHR: www.ihs.gov/cio/ehr
- RPMS Clinical: www.ihs.gov/cio/ca
- CRS: www.ihs.gov/cio/crs
- GPRA: http://www.ihs.gov/cio/crs/crs_gpna_reporting.asp

Discussion:

Dr. Cullen discussed the Medsphere licensing issue. The IHS pays \$1 per year for the license but there is no guarantee we will have this price in later years. Right now this is working for us. She said in meeting with Dr. Grim, our long-term goal is to get to a non-proprietary software status.

She said 21% of the OIT staff has left this year and it has had quite an effect on OIT's workload. Seven persons left in the first quarter and 6 in the second due to the buy-out.

The group discussed sharing software applications between the IHS and VHA. They use the IHS Women's Health and Immunization packages. Mike Danielson added the IHS has significantly contributed to the development of the VHA's software applications.

Bill Lance asked if IHS will be developing a Superbill that interfaces with Chargemaster. Mike Danielson said yes.

Kathryn Lewis asked why IHS is so dependent on contractors and why we are not using our Federal staff more. Dr. Cullen reviewed the Government's push to use contractors to discourage hiring full-time Feds to perform work that will not last forever. Kathryn asked about the mentoring program. Pat Cox said this ended about 15 years ago when middle management went away. Mike Danielson talked about the Federal staff old-timers/dinosaurs going away and the need to develop staff to take their places.

Pat Cox asked what Dr. Cullen sees for the future of RPMS. She said she heard an HHS official refer to the RPMS as "just a homegrown system" but she believes it's a great system on the

cutting edge. Bill Lance said it is a good product but there are Tribes out there that say it doesn't have the functionality they require. He said the Chickasaw Nation and he believe in it.

As to the life of RPMS, Dr. Cullen said she can see it here for the next 5 years but doesn't know about 20 years from now. Pat Cox said he doesn't see it in 10 years. The ISAC talked about what direction we may be going. Reece Sherrill said Tribes are in this all the way and if we consider switching to something else they need to know early on. Kathy Ray said after all the work she has done promoting RPMS she could be our spokesperson. In her presentations she uses the comparison of the RPMS to the ugly blind date. Chuck Walt said she hit the nail on the head. If the EHR does not succeed, Tribes will be going to something else. New doctors want something more usable, more GUI like the EHR than the old roll and scroll.

UFMS and Business Office Status Report and Discussion

Sandra Lahi, Office of Resource Access and Partnerships

Presentation Slides can be found at: [Business Office-UFMS Update 2-22-07](#)

Objectives of UFMS and AR RPMS

- *Ultimate goal*
 - Design the "tunnel" to transmit information from each RPMS server at each Federal site to the IHS Integration Engine for submission to the UFMS Oracle for financial reporting system
 - Daily transmissions to update accounts with invoices/receipts/ adjustments
 - Accommodate cash reconciliation through the financial system
 - Aging account information by Budget Activity. Ie. Medicare, Medicaid, PI, Other

Workgroups specific to Business Office

- Accounts Receivable Workgroup
 - Defining the RPMS Interface data elements
- Conversion Workgroup
 - Insurance names = tax ID #s (unique id)
 - AR Balances reconciliation efforts
 - Programming efforts to address overstatement of accounts
- Feeder Systems Workgroup
 - Testing file transmission through OIT Integration Engine
- Leadership Coalition workgroup
- TASS – Training workgroup

Primary Team Members

- Jim Garvie, OIT Lead
 - 5 FTEs from OIT
- Don Hornback, Accounts Receivable Lead, Finance, Portland Area
- Sandra Lahi, Business Office Lead, ORAP
- Other Important Participants
 - Adrian Lujan, OIT, Indian Health Service
 - Poornachandra Aithal, UFMSAR Project Coordinator, Bearingpoint

- Cynthia Larsen, Business Office Coordinator, Billings Area
- Toni Johnson, Business Office Coordinator, California Area
- David Battese, Business Office IT Support, Portland Area
- Sharon Sorrell, Management Analyst, Phoenix Area
- Wanda Rebiejo, Management Analyst, ORAP

RPMS Interface Overview

UFMS and RPMS “Learning Process”

- Mapping the terminology...

<u>RPMS</u>	=	<u>UFMS Oracle</u>
Bills	=	Invoices
Payments	=	Receipts
Adjustments	=	Adjustments
Clinic codes	=	Cost Centers
Type of Insurer	=	Budget Activity Code
ASUFAC #s	=	CAN #s/Location Codes

RPMS Modifications – Third Party Billing

- Bill number – Invoice Number
 - Attaching ASUFAC number for unique identification
- CAN # based on Clinic code
- Budget Activity codes: Medicare, Medicaid, Private Insurance, CHIPS Medicaid, CHIPS PI, Other Reimbursements
- Tax ID # field per Insurance company
- Cashiering functions
 - Maintain a log of billing activity per individual for audit purposes
 - Manager also reconciles Pharmacy POS transactions for site
- System to electronically create files and send to “OIT Hub” to be pushed out to Oracle *on a daily basis*

RPMS Modifications – Accounts Receivable

- Account number – Bill number
 - Attaching ASUFAC number for unique identification
- Batch to include IPAC or Schedule number entry
- Cashiering functions
 - Maintain a log of receipt/adjustment activity per individual for audit purposes
 - Manager also reconciles Pharmacy POS transactions for site
- Unallocated = Unapplied receipt
 - Modifications for Miscellaneous (HPSA payments, Incentives, FRP, etc)
- System to electronically create files and send to “OIT Hub” to be pushed out to Oracle

Preparation by Business Office

- Preparing for Data Conversion
 - Identifying Tax ID # for Insurance companies

- Cleanup of AR accounts prior to going live
- Reconciling Billing and AR data at the facility level at daily basis
 - Including Pharmacy POS transactions
- Scheduling data files creation and transmission processing times
- Timeliness of AR Batching
 - Linking to PNC Bank deposit/Schedule number
- Timeliness for AR Posting activities
- Training of Business office staff for cashiering functions, tax ID entries, posting procedures

RPMS Development – Action Items

- AUT Standard Table Files
 - CAN population activity per facility
 - Logic to automatically derive CAN from visit data by clinic, facility, Insurer type
- Third Party V2.5 Patch 12
 - Inclusion of Tax ID
 - Creation of Invoice Number to include ASUFAC identifier
 - CAN number to Clinic Code mapping
 - Cashiering/File creation
- Accounts Receivable V1.8 P2
- Pharmacy POS Patch 20

NEXT STEPS...

- Finalize RPMS Software Design Documents
 - Role of Management Analyst
 - Development, testing, deployment of AUT, 3P, AR and POS
- Deployment
 - Train staff on Third Party and Accounts Receivable staff on cashiering functions and reconciliation steps
 - Train field on obtaining Tax ID #s process and update to Oracle
 - Train staff on monitor error reports and correction
- Testing
 - Send files from each Area to OIT Hub to Oracle
 - Monitor error reports, data quality, timeliness of submissions, system issues

Discussion:

Floyd Thompson asked about data clean-up and what to do with data locations have never been able to take care of. Sandra said to get rid of the bills prior to October 1, 2005; they won't be able to bill for these anyway.

Kathy Ray said she is the GovTrip FATA and asked if IHS will be using GovTrip to enter personal data on personnel or will we be getting it from ARMS. Mike Danielson said from GovTrip and discussed tests IHS is conducting on feeder systems like GovTrip.

ISAC Action Items

1. The ISAC will send a letter to the IHS Clinical Councils requesting designation of their ISAC representative.
2. Dr. Marquart will discuss the ORYX/iCare issue with the CMOs the week of February 25 and follow up with the ISAC.
3. Christy Tayrien, OIT, will write a history of the IT budget and provide documents ISAC has used in previous years to advocate for IT funds.
4. Co-Chairs requested OIT send all EDR ITIRB documents out to the ISAC.
5. The OIT will develop a white paper with the pros and cons of an IT line item.
6. The OIT will prepare a report identifying costs of all unfunded IT mandates, funds taken off the top of the IHS budget, and include a list the IHS approved IT projects.
7. OIT will insert a dotted line into future CPIC Process documents illustrating a line from the ITIRB box to the ISAC
8. The OIT will add the ISAC on the ITIRB Scoring Criteria, Number 1. Mission Driven (PMA, HHS, IHS)
9. OIT will provide the ISAC with the ITIRB scoring forms.
10. OIT will modify the RPMS 300 to reflect the EDR under the EHR.
11. The ISAC appointed Chuck Walt as the ISAC Tribal Representative to the ITIRB as the newly developed ITIRB charter requires. (Note: the discussion on having Don Kashevaroff fill this position is not possible. Don is already filling the ISAC TSGAC representative position on the ITIRB.)
12. OIT will provide the ISAC with a copy of the report on the external review of the IHS Helpdesk when available (approximately May 2007).
13. ISAC meeting schedule for the rest of FY 2007 is set for May 23-24, 2007 in Washington, D.C. and August 8-9, 2007 in Anchorage, Alaska. Wendy Murray will assist with meeting logistics in Alaska.
14. Dr. Cullen will change the August ITIRB meeting date to August 2, 2007.

Meeting adjourned at 4:40PM.