

**INFORMATION SYSTEMS ADVISORY COMMITTEE
MEETING
Rockville, Maryland
September 22-24, 2003**

Committee Members Participating:

Mike Danielson, Co-Chair, IHS, Billings Area
Rich Hall, Co-Chair, Tribal, Alaska Area
Ron Wood, IHS, Navajo Area
Carolyn Johnson, IHS, Portland Area
Jaloo Zelonis, IHS, Billings Area
Bernie Long, IHS, Aberdeen Area
Mark Carroll, Tribal, Navajo Area
Reece Sherrill, Tribal, Oklahoma Area
Keith Longie, CIO, IHS
Chuck Walt, Tribal, Bemidji Area
Wesley Cox, Tribal, Oklahoma Area
Pat Cox, IHS, Oklahoma Area
Floyd Dennis, IHS, Nashville Area
Don Kashevaroff, Co-Chair, Tribal, Alaska Area

Committee Members Absent:

Jay Grimm, NIHB
D.J. Lott, Urban, NCUI
Cris Kinney, Environmental Health, IHS
Clark Marquart, IHS, Portland Area

Additional Participants:

Richard Church, CIO Office, IHS
Jim Garvie, CIO Office, IHS
Gene Robinson, CIO Office, IHS
George Huggins, ITSC, IHS
Christy Tayrien, CIO Office, IHS

Agenda Items

1. Welcome and Introductions
2. DIR/ITSC Progress Reports
3. IT Consolidation Initiatives in Support of HHS & IHS Restructuring
4. IT Budget Update/Funding Issues
5. Review ISAC IT Strategic Plan & Prioritize Objectives
6. Identification of Priority IT issues & Designation of Individual ISAC Leaders to Oversee Issues
7. Finalize ISAC Recommendations to the Director, IHS
8. Development of Information Technology Conference Plans
9. Development of National IT Customer Survey Process
10. ISAC Roundtable Discussion with Dr. Charles W. Grim, Director, IHS
11. Department of Health and Human Services Consolidation Initiatives Discussion with Melissa Chapman, HHS CIO
12. Electronic Health Record

13. Telemedicine
14. United Financial Management System (UFMS) and Integrated Financial Administrative System (IFAS) Implementation
15. Department of Veterans Administration Future Information Technology Plans & Opportunities for IHS Collaboration & Sharing
16. HIPAA Compliance Activities & Status
17. Revisions to ISAC Recommendations to IHS Director
18. ISAC Meeting Schedule for 2004

Welcome and Introductions

Mike Danielson and Richard Hall, ISAC Co-Chairs

The meeting began at approximately 8:14AM. Mike Danielson and Rich Hall, Information Systems Advisory Committee (ISAC) Co-Chairs, opened the meeting with a welcome and asked each of the persons in attendance to introduce themselves. They then gave the floor to Keith Longie, who recently became the Indian Health Service (IHS) Chief Information Officer (CIO).

DIR Progress Report

Keith Longie and Richard Church, IHS

Keith discussed his transition to the IHS CIO position, and briefly talked about information technology (IT) issues of interest to the ISAC. This included additional funding coming into IHS for the Diabetes Program, of which the Director, IHS has set aside \$2.6 to \$5 million of the diabetes program appropriation for IT; the Director, IHS' support of the IHS Electronic Health Record (EHR) project; ongoing projects at the Information Technology Support Center (ITSC) including the Data Warehouse Project, Oryx, and the Executive Information System (EISS).

Keith spoke of his new found appreciation of the Department of Health and Human Services (HHS) since assuming his new position as IHS CIO. Keith acknowledged that they take an interest in and want to help the IHS. The IHS makes them look good with our numbers, and we are doing pretty well overall on the items they measure. He said Melissa Chapman, CIO, HHS, is very interested in what the IHS is doing. Dr. Richard Church added that Melissa Chapman was able to see firsthand our clinics during her visit to the Albuquerque Area IHS, and she had a greater appreciation of what IHS does. Dr. Church talked about the Office of Management and Budget (OMB) wanting the HHS to take more of an oversight role over their Operating Divisions (OPDIVS), and how the HHS is trying to balance it out.

Keith asked that the ISAC keep in mind the IHS received a rating of 89 on the OMB Program Assessment Rating Tool (PART) last year which was a phenomenal score, and was the highest score at that point in time anyone in the HHS had ever received. We have a PART measure for 20 sites to be running the IHS-EHR by the end of Fiscal Year (FY) 2004. The IHS' Urban GPRA got a very low PART score. Dr. Grim's Annual Performance Contract (previously called a performance rating) with the Secretary is affected by these types of measures, and IT plays an important role in each.

Dr. Church went on to discuss the budget and the work that goes into identifying and studying IT within the IHS budget. He pointed out that the IHS does not have a specific IT budget. IT is imbedded for the most part in the Hospitals and Clinics portion of the IHS budget at our facilities and programs.

Mike Danielson then went over the meeting's agenda items and discussed the possibility of having a business office presentation if there is time on Wednesday.

ITSC Progress Report

George Huggins, Software Engineering Team, ITSC, IHS

Presentation Hyperlink: [ITSC Update for ISAC 09-2003.ppt](#)

George began the ITSC progress report by reviewing the current organizational structure of the ITSC and staffing pattern. He identified positions filled and unfilled, and distinguished between Federal versus contract employee.

He gave a summary of the Self-Determination Services (SDS) provided by the ITSC including the functions they perform and how they calculate tribal shares for DIR budgeted items. George discussed the ITSC SDS website and how it can be used to assist tribes in deciding if they want to take the share for particular IT functions or not.

Rich Hall asked that the ITSC put a calendar together for the negotiations, and also discussed the problems tribes encounter with IHS when requesting services on whether the tribe left their tribal share for the PSFA or not. The IHS doesn't know which of the dollars were taken or not. This opened a discussion about how IHS needs to be able to identify them.

George talked about Enterprise Architecture and how it has evolved into more than just IT. The Enterprise Architecture takes into account staffing and other resources related to IT.

He briefed the group on current telecommunications activities including consolidation efforts.

IT Consolidation Initiatives in Support of HHS & IHS Restructuring

Keith Longie and Richard Church, IHS

Document Hyperlink: [HHS IT Consolidation Memo from Kerry Weems, 06-03-03](#)

Keith reported that the IHS recently announced the buyout and that IHS will be losing approximately 300 + employees through it. Of these positions, IHS will be losing approximately 47 IT staff at Service Units/Areas/Headquarters. Although we are losing positions that we will be unable to fill, functional activity must still occur. Existing IHS and contractor staff will have to pick up the additional workload.

Dr. Church discussed the IT Consolidation Initiative. In general, the HHS is concerned with decreasing redundancy throughout its OPDIVs. The IHS is considered a large OPDIV, and will not have to necessarily consolidate everything to the degree that the small OPDIVs are being

combined. The consolidation is being approached on an enterprise basis. The IHS will consolidate their IT metrics internally, rather than with the HHS as a whole. As to the administrative systems, the IHS has never had its own financial or Human Resource (HR) software/administrative systems, so we will be participating with the HHS on the consolidation efforts for UFMS and HR software/administrative systems.

The HHS has instructed all OPDIVs to convert all of their IT contracts to performance-based contracts and to utilize HHS enterprise contracts. In IHS, the DataCom IT services contract is one that is being converted to a performance-based contract.

Telecommunications contracts are being consolidated within the OPDIVs under HHS contracts and this one is coming down the road very quickly. Everyone is to adopt the same strategy within the HHS. E-mail is another consolidated project, the HHS plans to get everyone on the same system, i.e., one mega-server. The Active Directory migration comes in here. The HHS wants to be the big tree with IHS as a branch under it in the Active Directory forest, IHS wants to be its own tree. Geography, size of agency, self-determination, and single points of failure are reasons for this. The IHS needs enough local independence to ensure services are being provided. The IHS is the only OPDIV providing direct patient services and there is justification for keeping servers out there to ensure that facilities are able to be operational. Another area of consolidation is security. Common tools are going to be used, for example, virus and firewall software, etc.

IT Budget Update/Funding Issues

Keith Longie, Jim Garvie, and Richard Church, IHS

Jim Garvie began the presentation by talking with the group about the IHS IT budget. Of the total IHS IT budget, approximately \$20 million goes toward the RPMS. Ten million dollars go toward other things such as administrative requirements and staffing. Approximately 20% goes to tribal shares. In FY 2004, we expect to receive an additional \$2 million from the Agency for Healthcare Research and Quality (AHRQ) specifically for the development of the IHS-EHR. These monies will be coming through an agreement and will not be up for tribal shares. According to Dr. Grim's memo on the diabetes funding increase, we will be getting 5.2 million of the diabetes money for data improvement. Half of these funds will be for IHS Headquarters, the remaining half will go to the Areas. These funds are not open for tribal shares, either, according to Dr. Grim's memo. They are specifically budgeted to perform data improvement.

Dr. Church stated that in general, the IHS IT budget is open for tribal shares, there is no residual. Approximately half of the IT budget is set aside for tribal shares pending negotiations, what's left that doesn't go out in tribal shares doesn't really come back until much later in the year.

Review ISAC IT Strategic Plan & Prioritize Objectives

Mike Danielson and Richard Hall, ISAC Co-Chairs

Presentation Hyperlinks: [*ISAC FY 2004 IT Priorities*](#)
 [*IHS IRM Plan 2003-2008*](#)
 [*Draft ISAC Workplan*](#)
 [*ISAC Strategic Planning Goals Draft.pdf*](#)

Rich Hall distributed the FY 2003 ISAC Priorities, the IHS IRM Plan for 2003-2008, and a draft ISAC Workplan to the ISAC members. He asked the ISAC what products they wanted to come out of this meeting. Mike said the Strategic Plan was an outcome of a meeting several years ago. The IHS IRM Plan takes the ISAC priorities and incorporates them into the plan and sets objectives to go along with the priorities. The ISAC needs to recognize that it really does have a leadership role in IT, as evidenced by this IRM Plan. There was some discussion of how the current list was decided upon, and what direction the ISAC would like to take with it now. Don Kashevaroff pointed out that with previous chairs, the way the priorities were set has changed each time, they were established internally by the ISAC, and later sent out nationally to tribes and national Indian organizations for ranking and additions.

Identification of Priority IT issues & Designation of Individual ISAC Leaders to Oversee Issues

Mike Danielson and Richard Hall, ISAC Co-Chairs

Presentation Hyperlink: [*ISAC FY 2004 Priorities*](#)
 [*ISAC FY 2004 Priorities and Assignments*](#)

Discussion began on types of priorities the ISAC needs to be looking at. The ISAC decided to “Brainstorm” and came up with the following categories and subcategories:

Infrastructure Related Issues

- Cache Conversion
- Telecommunications
- Robust architecture
- Security
- Interoperability

Organizational

- Staffing
- Training
- Partnerships
- Data quality

Products

- EHR
- Billing
- Cost accounting
- EISS
- Telemedicine
- Clinical references
- Administrative Systems (Asset Management, Personnel, Financial Management UFMS/IFAS, etc)
- Unified complete patient record
- Data Warehouse/Analysis System
- Paperless Office

Discussion on what route to take, i.e., whether to stick with the old priorities and embellish them, or to take the new list and make some goals with the products prioritized, ensued. The ISAC took a vote and decided to keep the old list and embellish it. There was more discussion on categorizing items on the list. The group ended up with adding 2 new items, Administrative, and Unified Patient Record, to the old priorities list and the Co-Chairs asked each member to prioritize their first 10 choices. The ISAC then made assignments of each priority item to the individual ISAC members to lead the tasks (assignments made by volunteering). The new ranking list for Fiscal Year 2004 and ISAC assignments follow:

1	EHR	Carolyn Johnson, Jaloo Zelonis, Mark Carroll, Mike Danielson, Reece Sherrill
2	BILLING	Bernie Long, Don Kashevaroff
3	DECISION SUPPORT	Ron Wood, Bernie Long
4	DATA QUALITY	Jaloo Zelonis
5	TRAINING	Pat Cox, Wesley Cox
6	TELEMEDICINE	Rich Hall, Mark Carroll, Reece Sherrill, Clark Marquart, Wesley Cox
7	INFRASTRUCTURE	Floyd Dennis, Chuck Walt
8	SECURITY	No Volunteers
9	COST ACCOUNTING	No Volunteers
10	ADMINISTRATIVE SYSTEMS	Mike Danielson, Ron Wood

Finalize ISAC Recommendations to the Director, IHS

Mike Danielson and Richard Hall, ISAC Co-Chairs

Document Hyperlink: [ISAC Recommendations to IHS Director Signed 09-24-03](#)

The ISAC reviewed the previous recommendations made at the March meeting and decided to go ahead and submit them, with an introductory statement that these issues were identified by the ITSC and the ISAC supports and recommends the actions listed. Rich Hall, Co-Chair, revised the introductory statement and document title and both Co-Chairs signed the document on September 24, 2003, and the CIO submitted the document to the Director, IHS.

Development of Information Technology Conference Plans

Mike Danielson and Richard Hall, ISAC Co-Chairs

Mike discussed the VA tech conference and the training modules available there and conveyed that he was very impressed with the structure of the conference. He tossed the idea on the table for the IHS to possibly join the VA's tech conference and have training sessions at their conference. This would allow the IHS to participate in VA and IHS training at one location. The group discussed the merits of asking the VA representatives who would be presenting the next day if it would be possible to join their conference. There was discussion on the IHS maintaining its own conference separate from the VA. Decision was made to add an IT technology conference recommendation to the Recommendations document and present it to Dr. Grim the next day.

Tuesday, September 23, 2003

The ISAC meeting began at approximately 8:15AM

IT Customer Survey

The group discussed the IT customer survey that they will be developing. Ron Wood and Rich Hall volunteered to draft a customer survey later today and bring it back to the group.

ISAC Workplan

*Presentation Hyperlink: [Draft ISAC Workplan](#)
[ISAC Charter](#)*

The ISAC then reviewed the draft ISAC Workplan and discussed items that they felt would require action items by the Committee. Dr. Church provided some insight as to how the IRM strategic plan is developed and the timelines for submission to HHS. The plan is due in March. The IRM Annual Operational Plan has not been developed this year due to management changes. Don asked the ISAC to review the current charter's 9 items under its charge and decide whether they are still applicable today. The following ISAC members volunteered to review and edit the Workplan: Bernie Long, Reece Sherrill, Mike Danielson, and Rich Hall.

ISAC Roundtable Discussion with Dr. Charles W. Grim, Director, IHS

Charles W. Grim, D.D.S., M.H.S.A., Director, IHS

Dr. Grim, Director, IHS, began his presentation at approximately 9:30am. Michel Lincoln, Deputy Director, IHS, attended the ISAC meeting with him. The ISAC members introduced themselves to Dr. Grim, identified the types of appointments they have, and where they are from. Dr. Grim began by stating that he fully supports the ISAC. He spoke about his confirmation speech and that he was a proponent of the Agency's infrastructure and IT needs.

Funding Issues

- He touched on the new diabetes program funding, discussions with the appropriations committees, and his decision to keep 5.2 million at the national level for data annually for the next 5 years. Dr. Grim said that he has taken a lot of heat over this, but felt it was very much needed because of the previous experience with distributing the funds over individual programs. Individual programs did not receive enough data collection funds to do any data collection with it.
- He stated that he has taken a million dollars out of the alcohol and substance abuse money to go to IT as well.
- He put 3 or 4 million into IT last year.
- He has a strong commitment and belief that IT needs additional funding in order to develop the program. Dr. Grim spoke about the AHRQ agreement for the joint venture for the EHR. He estimates that he's already put \$36 million additional funds into IT over the past year.

IT Priorities

Dr. Grim stated that what he needs from the ISAC is guidance on what the highest priorities are for IT. He would like for IHS to make noticeable improvements to the users over the next 4 years as he is actively searching for more money and identifying funds for IT. He's talking to Congress about the need for additional funding for UFMS requirements. He looks to the tribes for guidance as well. Mike Danielson, Co-Chair, thanked Dr. Grim for his support for IT. He shared the draft ISAC Recommendations (finalized the day before) with Dr. Grim, the new FY 2004 Priorities, and the group held a roundtable discussion with him on various IT issues.

Melissa Chapman arrived at approximately 9:40am and joined the discussion with Dr. Grim. Topics discussed by both Dr. Grim and Ms. Chapman included the following:

United Financial Management System (UFMS)

Don Kashevaroff brought up tribal and IHS concerns with the UFMS including the following: costs; does not meet the needs of IHS users at the facility level; and does not address requirements for cost accounting nor does it have the capability to do so. He asked if Dr. Grim was conveying these issues to the Department. Dr. Grim stated that he has and is. He talked about advocating for the IFAS and other IHS software applications that are under development. Melissa Chapman talked about the Department supporting the IHS and its cost accounting requirements, the IFAS and how it integrates with UFMS in the fields that are needed (not necessarily all of them, but the values that are required).

GPRAs Indicators

Dr. Grim talked about his discussions with HHS and OMB officials and their movement away from process-driven GPRAs indicators to efficiency/outcome indicators. Dr. Grim has made it clear to them that we will still have a requirement for process driven indicators due to the complicated nature of our business -- we don't have simple measures. He does not think it is possible for these efficiency-type indicators in a health care or hospital setting.

In closing, Dr. Grim would like to see the amount of funds associated with the priorities and recommendations made by the ISAC, and he would like to see some accountability for the resources he is putting into IT as a result. His example was the diabetes funds he has made available, and the fact that he is already taking heat for how we will be spending it.

Department of Health and Human Services Consolidation Initiatives

Melissa Chapman, Chief Information Officer, HHS

The ISAC Co-Chairs turned the presentation over to Melissa Chapman, HHS CIO, who began her discussion with the HHSNet Project. One of Secretary Thompson's priorities was to reduce the number of Internet connections across HHS. She touched on universal and Internet connectivity and the numerous connections that can be consolidated.

She briefly talked about the HHS E-mail consolidation project. She said that OPDIVs will be able to keep our e-mail addresses as we now know them. The new system will have the capability to map the old addresses to the new ones. The HHS had targeted turning on new e-mail at the end of the calendar year, but have security concerns that will delay it. The transition will begin from that day forward, you don't have to use it right away, but it will be available.

The HHS will be taking a proposal to the CIO Council at the end of year with a plan for how they might take \$20 million from their Congressional appropriation and \$20 million from the OPDIVS to pay for security, connectivity, e-mail, etc.

The HHS takes the position of staying out of programming and application support. They leave this with the individual OPDIVS, but will be focusing on the consolidation efforts mentioned above.

She discussed "Secure One," and identified Fred Cole, HHS is the Department official with more information in this area. The HHS would like to consider Secure One policy guidance as something that will be robust enough for any OPDIV to get a minimum set of guidance from. She would like to see the Department provide this level of security guidance for the dollars contributed to the project.

The Federal Health Architecture (FHA) was approved by the President's Management Council in January 2003. The HHS had to put a 300 together quickly for this information system. They took the rules and format to capture an architecture, but used what the OPDIVs have to capture the best breed for everyone to use. It is important to see OPDIV needs and priorities. Will be hearing a lot more on FHA.

The Workforce Assessment Survey is a tool for looking at IT needs across the Department. We don't have a lot of dollars, and would like to demonstrate the gap between the needs and the resources. The CCA has a requirement for agencies to complete a skills assessment.

The IT enterprise fund (Security and Innovation fund) provides \$20 to 23 million directly to HHS to be spent on technology and significant improvements in IT solutions. It is used for a variety of projects including PKI, etc. The HHS has collected matching funds from the OPDIVs, totaling \$20-23 million. These funds are spent on Department- wide initiatives.

There is a standardized desktop-metric set by the Secretary for purchasing personal computers and laptops. The HHS has set a range of standardized desktops. The Assistant Secretary for Administration and Management (ASAM) is charged for developing this HHS-wide procurement vehicle. If they are successful in negotiating this, all OPDIVs will be required to use this procurement vehicle. Ms. Chapman was not sure how this will affect Tribes.

Mike Danielson said that Tribes are encouraged to participate with IHS on these types of initiatives. He asked if they be able to participate on things like HHSNET. Ms. Chapman said HHS would like to preserve that option.

Don Kashevaroff discussed problems in Alaska and gave the example of not being able to video conference in because of the limitations on carriers in Alaska (only 1 or 2 in the State) and the prohibitive expense of going through the local carrier to achieve this function versus trying to use the HHS contractor. Don further discussed problems with having to using one server/router and having them shut down for security reasons. He pointed out different HIPAA requirements IHS and Tribes have than other OPDIVS because IHS and Tribes provide direct patient care. Security clearances will probably be higher for IHS due to this. Ms. Chapman discussed similar security clearances for pharmaceutical data at another OPDIV and the security solutions that are being examined.

Ms. Chapman then discussed the Enterprise Architecture and how it should flow something along the lines of the Business Process, Standards, Software, and Outcomes.

Ron Wood asked about the Human Resources consolidation and the IT requirements. Ms. Chapman recommended that the IHS contact Rosemary Taylor right away as soon as the consolidation begins and stated that problems are anticipated in any consolidation at the beginning.

Ms. Chapman ended her presentation and the ISAC Co-Chairs and CIO thanked her for taking the time to attend the meeting.

Electronic Health Record

Mike Danielson, IHS & Mark Carroll, Tuba City Regional Health Corporation

Presentation Hyperlinks: [EHR Presentation-Danielson](#)

[EHR Presentation-Carroll](#)

The Chief Medical Officers were meeting in Portland, Oregon and conferenced into the presentation through a televideo link. Mike Danielson began the presentation by giving a brief history of the EHR. The EHR is a means of automating the documentation process for individual patient encounters at facilities. It has a universal signature capability. There will be substantial costs associated with the development and implementation of the EHR. The system will be required to be up and running 24 hours a day, 7 days a week at hospitals, and we are not at that level of support or use yet.

There will be negative provider productivity at the onset as they learn how to use the EHR. Hopefully there will be a positive impact to ancillary departments with the electronic transfer of information versus paper and the elimination of retrospective coding. However, we will still have a requirement for reviews of documentation. Charge capturing tools are built into the EHR. The IHS is a “leg up” on the VA in billing capabilities. The EHR has a note authoring capability. This is the most difficult part of the VA’s EHR. Hopefully this will be enhanced and further developed. The EHR has good analysis tools for things like lab tests ordered, other ancillary items ordered and their results.

Mike turned the presentation over to Dr. Mark Carroll, Tuba City Regional Health Corporation (TCRHC). Dr. Carroll talked about TCRHC going under a P.L. 93-638 contract last year. Discussed Leap Frog and their Computer Physician Order Entry (see slide). He talked about the EHR product as pretty much a “point and click” type one. The EHR clinical reminders tend to improve performance. Whether you are using them or not can be seen by others. He gave the example that a CEO can see if you are following the clinical reminders or not, and question why you may not be using them. People tend to use them because it seems that others are watching your personal work. These can be rolled up into a management report.

Dr. Carroll discussed the timeline for EHR rollout (see slide). They are anticipating having alpha sites deployed in second quarter of FY 2004, beta sites in the third quarter, and additional 10-15 sites in the fourth quarter. Reece Sherrill asked why they chose a staged rollout versus an across-the-board rollout. Dr. Carroll said it depends on the size of the organization, whether they are inpatient, outpatient, etc. The VA did staging and it was very wise due to the large size of their facilities. Efficiency is going to go down initially due to redundancies that will be occurring. He gave the example of a pharmacist that enters data electronically, but still has to review the paper chart and document in it.

Pat Cox asked when the electronic record will be considered the official patient record instead of the paper record. Dr. Carroll said this is a critical issue and it requires further examination.

Doctors will be getting an electronic tablet to use at TCRHC. Security is something that is being addressed with these, as well as the costs associated with putting in a wireless LAN to run these on.

Dr. Carroll discussed ambulatory care redesign required to support use of the EHR and how it encompasses everything, from scheduling to the actual patient encounter.

Mark had a slide on challenges, discussed LAN/WAN optimization, redundancies in network and hardware, and ongoing training and support.

Future Plans include Vista imaging and integrated health enterprise (IHE) development. This won't be in the front-end rollout, but Dr. Carroll would like to see it later on in the year. The VA has this capability but it will be very complicated to implement within the IHS. He discussed enhanced coding and billing support. There is software out there that has a "smart" capability that allows you to search and code by key word. The VA software does not have this functionality at present. The IHS historically under-codes. As to clinical decision support, again, we don't currently have "smart" links, but are looking toward this functionality. The "Unified patient record" is a long-term goal. Patient/service kiosk is another goal for not only general health information but individual patient information for users to be able to access on the kiosk.

Telemedicine

Mark Carroll, Tuba City Regional Health Corporation and Rich Hall, ISAC Co-Chair

Presentation Hyperlink: [*AFHCAN Telemedicine Project 09-23-03*](#)

Dr. Carroll gave a brief summary of telemedicine and tele-radiology activities in the IHS. He briefed the group on the telemedicine project strategic plan and recommendations made by their workgroup, etc. These have been prepared in consultation with the CMO Council. Dr. Carroll said that he would forward the Survey to the ISAC.

Rich Hall discussed the Alaska Telemedicine Project and stated that it has proven to be quite successful. Presently 77 percent of the Alaska sites have the capability to connect to the project with 67 percent actually connected and participating. The project has significantly decreased travel requirements and their associated costs for the Area and its sites. However, they have found that the State Medicaid Program does not care/support the project or that the telemedicine project saves significant travel money for them directly.

United Financial Management System (UFMS) and Integrated Financial Administrative System (IFAS) Implementation

Tom Doherty, HHS and Sandra Winfrey, IHS

Presentation Hyperlinks: [*UFMS Overview.ppt*](#)

[*IFAS Overview.ppt*](#)

Department of Veterans Administration Future Information Technology Plans & Opportunities for IHS Collaboration & Sharing

Gary Christopherson and Robert Kolodner, DVA

Presentation Hyperlink: [*VistA-HealthVet-HealthPeople ISAC 09-23-03.ppt*](#)

[*VA Care Management ISAC 09-23-03.ppt*](#)

The VA, Centers for Medicare and Medicaid Services (CMS), and IHS are meeting this week to discuss the possibilities for development of a integrating a disease registry with the registration and care management modules of the HealthVet-Vista System. See presentation links for detailed information presented. Highlights of the presentation by the VA include the following:

- The VA is going from a national database to a local health data repository by the end of the phase-ins.
- They will be using whatever is standard in their commercial software packages (like billing, etc).
- The EHR will not duplicate information contained in commercial software packages in its software development.
- The VA is outsourcing its billing function. They are not developing an in-house software application to bill.
- They are using Oracle for their financial software.

Wednesday, September 24, 2003

HIPAA Compliance Activities & Status

Nick Provost, IHS

Presentation Hyperlink: [*HIPAA Presentation ISAC 09-24-03.pdf*](#)

Nick Provost gave the group a presentation on the status of HIPAA compliance activities currently underway within the IHS. He said that compliance with the HIPAA transaction rule was supposed to be made by October 2002, but the IHS got a one-year extension. Tribes were required to get their own extensions as IHS was not allowed to get the extension for them. The extension is almost up now. The CMS had said they were not going to accept non-compliant transactions, but yesterday, September 23, 2003, the CMS issued a contingency plan to accept non-compliant electronic transactions after the deadline.

The IHS has 7 of the 9 transactions ready to be tested. The guidance states that covered entities that make a "good faith" effort to comply with HIPAA transactions and code set standards may implement contingencies to maintain operations and cash flow. There is concern that by October 16 we will lose revenue. Nick said this is not true, we will be able to bill after this date.

The CHS form is a problem. The Washoe Tribe has requested that IHS do one for the CHS payment. The IHS CHS process does not fit with an electronic format. It is one where payment is made through a purchase order. We are not sure what the IHS response to this will be.

Revisions to ISAC Recommendations to IHS Director

Mike Danielson and Richard Hall, ISAC Co-Chairs

Document Hyperlink: [ISAC Recommendations to IHS Director Signed 09-24-03](#)

The ISAC discussed the VA EHR Project and what the ISAC can do to reaffirm the relationship and support of the VA's EHR project and the direction of the IHS one. The VA is not going to be up and running for 8 years. The IHS has projected having theirs operational this year. Also, the VA decision to outsource their billing activity is causing the IHS to reexamine its billing software as well. The group discussed the status of EHR in IHS. Keith questioned what is preventing the IHS from moving forward with its EHR project. He said the money is there. Mark Carroll talked about the contract with CIA requiring some action within the next two weeks, the VA going to version 20, the IHS is still working with 14 or 15, the IHS does not have a project plan right now, has not identified the 20 sites the OMB has asked to have EHR running by the end of FY 04, etc.

The ISAC talked about a development strategy and how the IHS can there. Keith talked about establishing a technical workgroup in the next 2 weeks, identifying the resources required, (the business case for the EHR), identifying the 20 sites, and having a meeting of the 20 sites. He discussed the need for an implementation strategy, identification of the resources required, the development of a publication strategy, marketing the EHR product, and the evaluation strategy.

The EHR discussion ended with the ISAC making the recommendation that the EHR be in beta testing by March (see recommendation document link above)

ISAC Meeting Schedule for 2004

Mike Danielson and Richard Hall, ISAC Co-Chairs

January 13-15 in Phoenix

April 6-8 in Rockville