

INFORMATION SYSTEMS ADVISORY COMMITTEE
Scottsdale, Arizona
May 18-19, 2004

Committee Members Participating

Darren Buchanan, Environmental Health, IHS
Pat Cox, IHS, Oklahoma Area
Floyd Dennis, IHS, Nashville Area
Rich Hall, Tribal, Alaska
Keith Longie, Chief Information Officer, IHS
Clark Marquart, IHS, Portland Area
Wesley Old Coyote, IHS, Navajo Area
Reece Sherrill, Tribal, Choctaw Nation, Oklahoma
Gary Wabaunsee (Alternate for Wesley Cox),
Tribal, Kickapoo Tribe, Oklahoma
Chuck Walt, Tribal, FonDuLac Reservation,
Minnesota
Ron Wood, IHS, Navajo Area

Committee Members Absent

Mark Carroll
Jay Grimm, National Indian Health Board
Carolyn Johnson, IHS, Warm Springs, OR
Don Kashevaroff, Tribal, Alaska
D.J. Lott, Urban, Great Falls, MT
Jaloo Zelonis, IHS, Billings Area

Additional Participants

Pam Conley, Division of Information Resources (DIR)/IHS
Denise Exendine, Urban Health Programs, IHS
Tom Fisher, Information Technology Support Center (ITSC)/DIR/IHS
Howard Hays, DIR/IHS
Rob McKinney, ITSC/DIR/IHS
Bruce Parker, ITSC/DIR/IHS
Jody Secarak, Statistician, Phoenix Area
Christy A. Tayrien, DIR/IHS
Rachael Tracy, DIR/IHS

Minutes/Agenda Items

The meeting began at 8:30a.m. A quorum was present. No previous meeting minutes were reviewed. Agenda items approved for action/discussion and presenters are listed below:

1. ISAC Membership Nominations/Recommendations to IHS Director
2. Annual Election of Co-Chairs
3. Electronic Health Record Status, Progress, and Future
4. CIO Report and Budget Update
5. Status of September 2003 ISAC Recommendations to IHS Director
6. "One HHS" IT Consolidation Status
7. IT Infrastructure and Agency Reorganization Status
8. Patient Accounts Management System (PAMS)
9. Medical Informatics
10. Five-Year Information Security Strategic Plan
11. HIPAA Security

12. IT Workforce Planning Project
13. HIPAA Compliance – Transactions Status and Activities
14. HIPAA End User Perspective - IT and the Business Office
15. Urban Programs IT Infrastructure Issues/Activities
16. Telemedicine Activities in the Navajo and Alaska Areas
17. Need for a Standard Inter-facility Health Summary Application
18. Telecommunications Initiatives - Activities and Status (VBNS, HHSNET, e-mail, Active Directory, Video-Conferencing, etc)
19. Information Systems Coordinator Charter-Request for Approval
20. Capital Planning and Investment Control Process Redesign
21. ISAC Discussion and Recommendations
22. ISAC Meeting Schedule and any Unfinished Business

Welcome and Introductions

Presenter: Richard Hall, ISAC Co-Chair

The meeting began with a welcome by Co-Chair Rich Hall and introductions of meeting attendees including ISAC members or their alternates, IHS staff, and guests.

ISAC Membership Nominations/Recommendations to IHS Director

Presenter: Rich Hall, ISAC Co-Chair

Issue: Rich identified the following members with terms expiring: Chuck Walt, Reece Sherrill, Rich Hall, and Carolyn Johnson. All individuals consented to being re-nominated for another 2-year ISAC term. Rich discussed Mike Danielson's resignation from the ISAC earlier this year due to accepting another position, however, it turns out Mike will be staying in his position at the Billings Area Office. Mike had indicated prior to the meeting that he would be willing to serve another term on the ISAC if nominated.

Discussion: Clark Marquart asked why the ISAC has 2-year terms, and if the intent of the terms was to bring "new blood" into the group. Keith Longie further discussed the need for revising the charter to remove the 2-year term since the group has been in place for a few years now. Chuck Walt pointed out the positive aspects of having a term, but not necessarily 2-years since the group only meets twice a year.

Action: The ISAC voted by consensus to recommend that Dr. Grim, Director, IHS, reappoint Chuck Walt, Reece Sherrill, and Rich Hall as Tribal representatives and Carolyn Johnson and Mike Danielson as IHS representatives. The ISAC Co-Chairs will write a recommendation memo to Dr. Grim and the accompanying reappointment letters.

Election of Co-Chairs

Presenter: Rich Hall, ISAC Co-Chair

Issue: In accordance with the ISAC Charter, Rich Hall asked for nominations for the two ISAC Co-Chairs since this was the first ISAC meeting of 2004.

Discussion: Nominations included Mike Danielson for the IHS Co-Chair and Reece Sherrill and Rich Hall for the Tribal Co-Chair.

Action: The ISAC voted to elect Reece Sherrill as the ISAC Tribal Co-Chair and Mike Danielson as the IHS Co-Chair. Rich Hall turned the meeting facilitation over to Reece Sherrill as the new Co-Chair.

Electronic Health Record (EHR) Presentation

Presenter: Howard Hays, EHR Program Director

Issue: *Click on Control and this Link to see Presentation Slides:* [EHR Presentation](#)

Discussion: Dr. Hays asked how many of the ISAC were familiar with the EHR project, and had at least seen a presentation or demo on it. All persons present indicated that they were to some extent familiar with the project. Dr. Hays began by giving an overview of the EHR itself. He stated that the EHR will be a medical record in electronic format versus paper. He cited the e-Government Act as probably the highest level initiative within the Federal government today that is pressuring the government to move to an EHR. He pointed out the most important reason to go to an EHR is patient safety. There are no handwriting issues, no question on written orders, and it reduces the risk of tort claims. In the private industry, medical malpractice insurance gives discounts for electronic medical records versus paper ones. He cited cost as a barrier to using a commercial EHR and gave the example of Kaiser Permanente who spent approximately \$1.7 billion to buy their commercial EHR software. This product is geared for the private sector, and does not meet our need/functionality.

Dr. Hays then discussed how the Resource and Patient Management System (RPMS) was originally based on VA software applications, that the IHS has developed its own applications on top of theirs, and highlighted shared development efforts between the IHS and the VA.

He touched on the vendor, Clinical Informatics. Dr. Doug Martin out of Indianapolis, a former VA developer/programmer, owns this company. The Graphical User Interface (GUI) framework for the IHS EHR uses their product, VueCentric. Conversion costs for EHR are extremely low using VueCentric.

As to facility preparation, Dr. Hays wants our facilities to take a systematic and intense role in preparing to use the EHR. There is a need for a financial and leadership commitment. While the EHR is clinically driven, the local IT infrastructure needs to be examined. We need to ask how robust our network and hardware are and what capacity do we have to deal with failures at points of service.

Reece Sherrill asked what the recommended standard was going to be; would sites need to use tablets or Citrix? Wes Old Coyote, a participant on the national EHR Program Team, and Dr. Hays indicated it would be up to the individual site. Dr. Hays preferred the tablet, and didn't think Citrix could handle the volume of data that would be coming through it. Wes said that the Citrix was good for certain aspects of the EHR, but not at the point of service.

Dr. Hays discussed Clinical Application Coordinator (CAC) training and said that it takes at least 3-4 weeks to get this completed. It is a very important and time-consuming part of site preparation. The Patient Information Management System (PIMS) software application installation must occur prior to actually running EHR. Sites need to install it and let the staff used to using it awhile before moving on to the next step. Pharmacy file preparation is very extensive and requires a complete cleanout of old files. There is a lot of work up front to get a site's pharmacy files up-to-date. Again, need to let staff have time to get familiar with this process before proceeding to the next step. Between training and going live, there is some downtime. The local community needs to be aware of this. They may have up to 30% impact on productivity when EHR begins because of the learning curve. We will be doing a follow-up on the metrics about 6 months into use of EHR (evaluation).

Wes said he is recommending that sites identify an "IT Super-User" to assist them. Dr. Hays agreed that this is a good recommendation. The CAC is also a critical position for EHR. Sites may want to consider sharing the CAC at smaller sites. In addition, smaller Areas may want to consider implementing an Area CAC position (i.e., paid by the Area) to provide the CAC functions instead of establishing local CAC positions. Sites may want to have a clinical super-user in addition to the IT super-user. Fifty percent of the VA CACs are nurses. The IHS doesn't have to use nurses, there are others in the facility that may do well such as medical records or laboratory staff. Individual sites will just have to see where the skills are at the facility.

Pat Cox asked how a site gets on the list for EHR implementation. Dr. Hays talked about the Director, IHS asking each Area to designate 2 sites creating a list of the first 24 sites that are to be deployed. Of these, we will have 8 sites running EHR this fiscal year, 12 by the end of the calendar year, and the rest of the 24 by the end of 2005. Keith discussed how sites are anxious to get an EHR in place, and there are some going outside to purchase their own. While he can't tell them no, he highly encourages them to stay with the IHS EHR product.

Ron Wood asked whether sites need to suspend using PCC+. Dr. Hays said no, to continue with PCC+.

Rich Hall asked how we ensure that sites that have been designated by the IHS Director are going to be getting EHR by the end of the year. He has sites in Alaska that are considering going out there and buying a commercial product because they don't know the status of sites.

Reece Sherrill asked if the software was available now for these things Dr. Hays discussed, such as PIMS, Pharmacy, etc. He said that Choctaw had bought something from Clinical Informatics that was supposedly the latest version of Pharmacy V5. Howard stated that the EHR was still in testing, that V5 had not been released yet. Wes Old Coyote said they must have gotten a hybrid

of the software. Reece said that as long as he has been on the ISAC, he's heard the promise that EHR is coming. His sites would have bought a commercial product otherwise, and are still waiting, 3 years later for the EHR. Dr. Hays, Pat Cox, and Keith encouraged him to go ahead and begin the background work on site preparation, which takes several months. Dr. Hays told him he probably needed to contact David Taylor, ITSC, for more information on preparation.

Keith discussed the money for the EHR. He talked about carry-over funds being used on this project, and the proposal he would be presenting to the group later in the day to use some of the Diabetes funds on the EHR. These funds would not cover it totally, but would help considerably. He discussed the longer-term requirements, support requirement will be 24/7, and the IHS needs to decide how to acquire this. Alternatives include using contractors, hiring additional Federal staff, or a combination of both. Also the training requirement needs to be looked at. Network support will change to 24/7 versus our present 8-5 support; we have a lot of change ahead and he is looking to the ISAC for advice and guidance on how we can accomplish these things. We need to prioritize the changes we need to make. The IHS tends to prioritize by consensus. We may possibly want to establish EHR Professional Specialty Group.

Action: The ISAC is making the following EHR recommendations to the IHS Director:

- A. The ISAC recommends the IHS-EHR Program establish deadlines on release dates of required software applications and publish these dates and status on the IHS EHR website no later than June 30, 2004.
- B. The ISAC recommends the EHR Program publish a checklist of requirements that must be met prior to EHR implementation on its website. The checklist should include the Clinical Application Coordinator (CAC) and IT Super-User positions; Resource and Patient Management System (RPMS) software applications and corresponding versions to support EHR installation including the Patient Information Management System and the Pharmacy application; minimum training requirements; etc. The ISAC also recommends that the EHR program publish and regularly update the status of current site implementation on its website.
- C. The ISAC supports the development of CAC positions at the Area and larger Service Unit levels.
- D. The ISAC recommends the IHS establish an EHR Training Program for clinical providers, CACs, site managers, etc.
- E. The ISAC recommends the IHS identify alternatives to IHS resources for EHR deployment.
- F. The ISAC further recommends a plan to provide help desk support on a 24 hour, 6 day per week basis.

CIO Report and Budget Update

Presenter: Keith Longie, IHS CIO

Issue: *Click on Control and these Links to see Presentation Slides:*

[ITSC-CIO Newsletter April 2004](#)

[Director's Performance Contract 2004-2005](#)

[DIR Project Briefing May 2004](#)

Discussion: Keith Longie, IHS CIO, provided the ISAC with the April 2004 IHS Information Technology report (unofficial “newsletter”), and shared the types of reports contained within, asking the ISAC for feedback on it and also about the possibility for an ISAC column to be posted in the next issue. He stressed sharing this type of information with Tribes so they are aware of the IT activities within the IHS.

Keith then distributed the Director, IHS’ annual performance contract for 2004-2005. He pointed out that it hasn’t been signed yet and is still subject to change. He reviewed the Director’s performance objectives that are IT-related with the ISAC. Program objective #4 is the EHR, and states that 20 sites will have the EHR by the fourth quarter of 2005. Keith then went over the next few performance objectives and discussed how they are peripherally, if not directly, related to IT requirements and rely on them to be successful. Examples of this are: performance objective #15, related to the Patient Accounts Management System (PAMS) project; management objective #5 is related to DIR manpower planning; #7 and #8 are on the e-Gov and grants/GATES Management System; #10 applies to the industry standard model for Third Party Billing and PAMS.

On Management Objective #11, “One HHS”, the IHS is implementing the United Financial Management System (UFMS) along with the rest of the Operating Divisions (OPDIV) in HHS. The UFMS will completely replace our current financial and administrative systems. He touched on “One HHSNET” and security in the “One HHS” initiative and said these will be discussed in more detail later in the ISAC meeting. Keith said that the vendor HHS recently selected to consolidate all HHS OPDIV e-mail is Unisys out of Virginia. The current design is for all messages to go through Virginia and out to the recipient. For example, if a person is sending a message to the individual next door, the message will still have to go to Virginia and back.

Keith then distributed the Current DIR Project Briefing May 2004 (see handout link above). He gave an overview of the IHS IT budget. We lose 40 percent of the IT budget at the beginning of the year and don’t know what we’ll get back until the end of the year after Tribes identify what they are buying back.

He said \$2 million was coming into IHS from the Agency for Healthcare Quality (AHRQ) for the EHR project. The AHRQ will require an evaluation at the end of the year. We are using the funds for deployment of the EHR initially.

Keith identified \$5.2 million coming from the Diabetes project, but DIR has not received it yet. He will be meeting with Kelly Acton and Dr. Grim to discuss what the intent of the funding is for and to make sure that everyone agrees to it. He wants to ensure Area needs are being met

with the diabetes funds. Keith has a plan with \$2.2 million being made available to Areas to address their local needs.

He thanked Don Kashevaroff, ISAC member, for his advocacy for IHS' budget. Don has requested \$187 million for the IHS IT budget, with a total of \$9 billion for IHS overall into his advocacy efforts and testimony, and Keith said this is appreciated.

Wes Old Coyote asked about the 40 percent of the IT budget being taken out off the top in Tribal shares, and how it affects a Tribe that has taken its share but wants the EHR. Keith said this was a new area he hadn't been faced with before, and used a conversation with Reece and Mickey Piercey as an example. They were more than enthusiastic about getting the EHR, but had taken their shares. Mr. Piercey verbally said that he would buyback his shares. The ISAC continued to discuss what is required for EHR and Reece recommended that the IHS make it known to Tribes that they need to either leave their share or agree to buy it back if they want the EHR. Chuck Walt talked about the efforts of his Tribe locally to purchase equivalent products that IHS provides and pointed out that the IHS needs a product out there that is up and running and can be used before they consider putting their share back.

Action: None

"One HHS" IT Consolidation Status

Presenter: Keith Longie, IHS CIO

Issue: *Click on Control and this Link to see Presentation Slides:*
[HHS CIO Organizational Structure](#)

Discussion: Keith provided the ISAC with the HHS CIO organizational slides and stated that the HHS would like to see OPDIV CIO organizations correspond to the one they have designed for the Department. The first chart showed all the functions and activities that are important to us on the CIO level. The problem with the chart is that it doesn't show very much customer support. Our chart would be much different on terms of responsiveness. The second chart puts those functions and activities into organizations within the HHS. The third chart depicts the alignment of the Department with the OPDIVs by corresponding organizational component. Keith provided the ISAC with the HHS organizational chart to see how they are organized. He briefly talked about the IT Investment Review Board (ITIRB) changes within HHS, and how the IHS needs to ensure that our Exhibit 300 scores stay at a high level.

Action: None

IT Infrastructure and Agency Reorganization Status

Presenter: Keith Longie, IHS CIO

Issue: *Click on Control and this Link to see Presentation Slides:*
[VHA CIO Organizational Matrix](#)

Discussion: Keith said the IHS is moving forward with the Headquarters reorganization by August, and that the DIR will be going up one echelon level in the reorganization to an "Office" level component. He talked about restructuring the DIR and that he has established a management committee to work on the reorganization. Security is one item that we need to pay much more attention to and elevate within the DIR and our committee is addressing this. Our number one priority will be customer support. The next ISAC meeting should have an agenda item to look at what has been developed on our restructuring. He provided the ISAC with the VA's organizational chart showing the matrix of functions and how they cross organizational lines. The DIR is considering something similar in its restructuring efforts. Reece Sherrill asked what would be the approach if Bush is not re-elected, Keith said we still have room for improvement, whether he's in office or not. The IHS is getting a lot of positive attention, we now need to deliver.

Action: None

Status of September 2003 ISAC Recommendations

Presenter: Keith Longie, IHS CIO

Click on Control and this Link to see September 2003 ISAC Recommendations:
[ISAC Recommendations Sept 2003](#)

Issue: Keith reviewed the September ISAC Recommendations to the IHS Director and provided a status of each. The following list summarizes those status reports:

1. Accomplished.
2. Budget/Funding-still working on it.
3. Data Quality-moving forward but still needs some work.
4. FTS Billing-accomplished.
5. Program Effectiveness/Business Process Improvement-PAMS will address this. The measurement piece needs to be addressed.
6. IT Consolidation-addressed this earlier.
7. Strengthening Security-Robert McKinney, IHS Senior Information Systems Security Officer (ISSO), will address the status of this.
8. IT Workforce Planning-Rachael Tracy, DIR Management Analyst, will provide the status in her presentation.
9. Section 508 Compliance-Keith thinks we're okay on this one.
10. Capital Planning and Investment Control (CPIC) Thresholds-These are under review by the HHS now. They're working on revising the HHS CPIC policies and procedures.
11. Video Conferencing-Tom Fisher, ITSC, will provide the status on this tomorrow. He had 18 sites on a video conference last week. We are still having some problems, but it's better than it used to be.

Discussion: Keith asked the ISAC if they had any questions, and pointed out that the recommendations they make are part of what determines the work that DIR accomplishes

throughout the year. The ISAC recommendations are very important in determining the direction of IHS IT resources.

Reece had a question on the 20 sites for EHR that the ISAC had originally supported and wanted clarification on whether it has been cut to 8. Keith talked about the test sites, and the importance of getting a product out there that is usable and quality, versus just putting something out there so we can meet a 20-site requirement. Pam Conley, EHR Program/DIR, said they were posting the EHR implementation schedule and the list of requirements sites have to comply with prior to running EHR on the EHR website. Rich Hall recommended that the IHS consider implementing PIMS and cleaning up pharmacy applications as a part of EHR implementation. He recommended IHS not wait for an end-product to say a site is starting EHR. Keith said he would have to discuss it with IHS Clinical and Area Directors and get their support.

Action: None

Patient Accounts Management System (PAMS)

Presenter: Sandra Lahi, ITSC, IHS

Issue: *Click on Control and this Link to see Presentation Slides:* [Patient Accounting Management System Presentation](#)

Discussion: Sandra stated that IHS needs to address line item (fee-for-service) billing with PAMS in the event the all-inclusive rate goes away. Rich Hall asked when Patient Registration Version 7.1 would be released. Sandra said Alpha testing will probably begin in June, with a release somewhere along August or September. It has to be released prior to October 1, since PAMS is scheduled for release then. Rich Hall then asked what the largest size tribal facility involved in PAMS now was. Sandra said it was Choctaw Nation of Oklahoma on outpatient (they had +200,000 outpatient visits last year) and Chickasaw Nation of Oklahoma for inpatient. Rich wanted to make sure it was being tested in a comparable size tribal location to Alaska. Chuck Walt stated that he would like to see a chart with encounter numbers such as outpatient/inpatient visits in relation to PAMS.

Action: None

Medical Informatics

Presenter: Keith Longie, IHS CIO

Issue: The Phoenix Indian Medical Center (PIMC) has come forward to the CIO with a proposal for a national informatics laboratory. The Phoenix Area would like to move forward with this concept.

Discussion: Keith began this presentation by discussing the steps beyond the EHR and PAMS. We need to start looking at Version 2 of the EHR. Keith pointed out that IHS used to have a very successful national informatics laboratory in Tucson years ago back when it was the Office

of Health Program Research and Development (OHPRD). There is an interest in recreating this functionality in some way. He discussed the Phoenix Area/PIMC Clinical Informatics Center (CIC) proposal. They want to look at health care quality, moving forward on an Area basis, and if we think it's a good idea, then onto a national basis.

Gary Wabaunsee said if the IHS was going to support the CIC concept he would like to see the location competed throughout IHS instead of just designating the PIMC. He said everyone would have an opportunity to be a potential site for the CIC. Rich Hall also discussed the history of the development center concept in IHS, pointing out we used to have 4 locations such as this in the past. Clark Marquart talked about the importance of the work that went through the OHPRD and gave his support for the Phoenix Area to be the site for this project due to the types of expertise available in this Area and at this Area only. He gave the example of the Lab Consultant they have in-house. However, he agreed that the other concerns as to competing it instead of having it in Phoenix were also legitimate. Keith discussed the core team that is available in the Phoenix Area, including Dr. Charlton Wilson, Dr. Terry Cullen, Dr. Galloway, and others who will be critical to the success of the project and the accomplishments they bring into the PIMC's proposal.

Chuck Walt asked if they wanted to consider the proposal as a Center of Excellence. Keith said that Charlton is the Director of the Phoenix Area's Center of Excellence already, and Chuck's recommendation fits with the proposal.

Keith asked for the group's support of the concept of the CIC, and that they consider their support and recommendation of the proposal when the ISAC makes its recommendations.

Action: The ISAC is making the following recommendation to the IHS Director: "The ISAC strongly supports the establishment of an information technology Center of Excellence for training and advanced projects including, but not limited to, telehealth, EHR, medical informatics, clinical quality, and multi-facility integration."

IHS 5-year Information Security Strategic Plan

Robert McKinney, Senior ISSO, ITSC, IHS

Click on Control and this Link to see Presentation Slides: [IHS 5-Year Information Security Strategic Plan Proposal](#)

Issue: The IHS Senior Information Systems Security Officer (ISSO) presented the ISAC with a proposed Information Security 5-Year Strategic Plan. Highlights of the plan included a requirement to conduct an initial Risk Assessment and subsequent Certification and Assessment (C&A) of the General Support System at each IHS facility. The Risk Assessments are the initial steps of complying with HIPAA security. They have to be completed by the IHS in 2005, with subsequent reassessments every 3 years. The IHS Senior ISSO is proposing to enter a contract with the General Services Administration (GSA) to complete the initial risk assessments. This would allow the IHS to have access to multiple GSA vendors; it is not feasible to just use one vendor given the time frame we have to work with and the hundreds of sites that require

completion of individual risk assessments in 2005. Total cost of the proposed GSA contract to do the risk assessments is \$15,000,000.

Discussion: Rob discussed the IHS Major Applications (MA) including the RPMS, the National Patient Information Reporting System, and Telecommunications Management, and that they require national Certification and Accreditation (C&A). Each IHS site will be responsible for a C&A of their General Support System (GSS).

Floyd Dennis asked about the new requirement for the GSS to be conducted for each facility and asked whether instructions on how to conduct facility GSS have been distributed to the ISSOs. Rob said no, that he would discuss it in his presentation tomorrow.

Rich Hall pointed out that security requirements are particularly confusing, and made the recommendation that IHS designate whether its security requirements are required or just recommended for Tribes. He consistently has to ask whether they apply to Tribes.

Chuck Walt asked whether resources would be available for Tribes who don't necessarily follow the IHS security plan, to ensure that they are able to meet the security requirements on their own. Rob said he was working with Bruce Parker, Self-Determination Services Leader, ITSC, and has developed 3 tiers of security support for Tribes who are considering taking their Tribal shares.

The ISAC discussed the Area ISSO position in the plan and how the IHS proposes to address it. They talked about the possibilities of either regionalizing ISSOs for Areas that may not need a full time ISSO, contracting out the ISSO function, funding for ISSOs, how some Areas have come up with their own funding mechanisms like at Navajo where the Service Units fund the ISSO out of Medicare/Medicaid funds versus their Hospital and Clinics line-item in their budgets.

Reece Sherrill asked if Rob needed a recommendation from the ISAC. Keith Longie added to Reece's question saying he would break it down into levels of assistance needed at HQ and at the Areas, and the resources available to meet these needs, in particular the Areas. He tied it back into Rachael's workforce planning project, and Rob's staffing source options in his presentation.

Action: While the ISAC supports the IHS security initiative as presented by the IHS ISSO, the ISAC recommends the IHS further research alternative models to meet security requirements, emphasizing cost restraints and utilizing training of existing staff to accomplish the assessments.

Wednesday, May 19, 2004

The meeting began at approximately 8:30AM.

Health Information Portability and Accountability Act (HIPAA) Security

Robert McKinney, Senior ISSO, ITSC, IHS

Issue: *Click on Control and this Link to see Presentation Slides:* [HIPAA Security Presentation](#)

Discussion: Rob McKinney stated that the Risk Assessment is the initial step of complying with HIPAA security. Risk assessments are required for e-authentication, and must be completed before the C&A. He is looking at entering a contract with the General Services Administration (GSA) to get the risk assessments complete. As to contracting methodology, he said we can either do a time and materials contract or a firm, fixed price contract. He said that IHS needs approximately \$15 million to conduct the risk assessments through a contract. Rob stated it wasn't feasible to try and go with just one vendor directly, given the time frame we have to work with. The Risk Assessments need to be completed in 2005. One vendor cannot complete the hundreds of reviews the IHS has to complete. That is why Rob is proposing to use the GSA.

The ISAC discussed the funding issue and what exactly was required to conduct a Risk Assessment and a C&A. Rob told them to conduct a C&A for a hospital, it will take approximately 5-6 months to complete. If it's a smaller facility, they can get by with just a Risk Assessment and parts of a C&A. We're at the stage where we need to tell GSA something to secure the vendor. Keith asked how much seed money GSA needs to get this going. Rob said he wasn't sure. The total requirement is \$15 million, but he has not been able to pin them down on what they need up front.

Wes Old Coyote alternately proposed using existing ISSO staff from the Areas to conduct the reviews. Rob and the group discussed a training program to train IHS staff on conducting Risk Assessments and C&As.

Rob stated that this area is so new it hasn't been in Tribal share negotiations yet.

Rob said that SecureInfo RMS offers software and training for Risk Assessments and he recommends that IHS go with the SecureInfo proposal.

Action: While the ISAC supports the IHS security initiative as presented by the IHS ISSO, the ISAC recommends the IHS further research alternative models to meet security requirements, emphasizing cost restraints and utilizing training of existing staff to accomplish the assessments.

IT Workforce Planning Project

Rachael Tracy, Management Analyst, DIR, IHS

Issue: *Click on Control and this Link to see Presentation Slides:* [IT Workforce Planning Project](#)

Discussion: Rachel discussed the 10 IT specialist positions identified by the Office of Personnel Management (OPM). The DIR has identified 6 of the 10 IT specialty areas that IHS might need. Rich Hall and Wes Old Coyote recommended that we use all 10, and that an Area can tailor their specific position descriptions using portions of any/all of the 10 samples the DIR will provide. Floyd Dennis talked about the difficulty Nashville encountered in grouping parts of the 10 IT categories into one position description.

Rachel presented a plan to conduct a skill gap analysis after the position descriptions are completed. Bruce Parker shared an attempt to do something similar a couple of years ago when IHS converted all of its position descriptions classified as 334 to the 2210 series. He said the Union in Albuquerque stopped the analysis, they would not allow it. This is a potential roadblock we may face as we attempt another skill gap analysis.

Rachel discussed the CAC and Management Analyst positions within the IT organizational components in IHS as being outside the 2210 series. She added that the DIR would be looking at IT industry standards, and other Federal organizations such as the VA, the DoD, etc. We are looking at the end of July to see what positions we need, and having plans in place to begin the skill gap analysis.

Ron Wood recommended utilizing the HHS Baltimore Human Resources Office as much as possible to accomplish any or all of these tasks since IHS is paying them \$800,000 this year, regardless of whether they do any work for IHS or not.

Chuck Walt talked about the Bemidji Area's strategic plan with the IT component. Dr. Kathy Annette, Bemidji Area Director, recently put a contract in place to assist in identifying the Area's IT requirements. He recommended that Rachael request a copy of the strategic plan to see if there was any information she might be able to use in it.

Action: None

HIPAA Compliance-Transaction Status and Activities

Sandra Lahi, Business Process Development Leader, ITSC, IHS

Issue: *Click on Control and this Link to see Presentation Slides:* [HIPAA Transactions and Code Sets-I/T/U RPMS Current Status](#)

Discussion: Sandra pointed out that after July 1, 2004 if your forms are not HIPAA-compliant, you won't get paid for 30 days. Presently, there is no 30-day wait for payment.

She discussed the new National Provider Numbers that the Centers for Medicare and Medicaid Services (CMS) are implementing and that providers will have to sign up for these numbers by May 2005. All payers will have to use this number after that date. This new requirement is moving forward from the CMS Roundtable session last week.

The group discussed the possibility of identifying 3 vendors as a "clearinghouse" that sites could use to contract for their medical billing. Keith said the DIR has been working on putting contract vehicles in place for claims processing. The clearinghouse would consist of making these contracts/vendors available to IHS and Tribes to purchase claims processing services from. Areas and Tribes would be able to select a vendor that best meets their needs locally. Keith said the DIR and ISAC could not determine which contractor to use alone, this issue needs a IHS National Business Office Council (NBOC) recommendation. Ron Wood said Navajo had Bernie Yazzie and Wes Old Coyote look at several vendors a couple of years ago and they picked

Quovadx because they had the best alternative out there to meet their needs from a financial point of view. The Navajo Area has approximately 1 million patient visits per year and this will pay for itself in less than a year. Wes said Navajo picked Quovadx to use as their clearing house because they already have a contract vehicle in place with HHS through the National Institutes of Health. This HHS contract should open the door for the rest of IHS to use it, too.

Ron Wood asked the ISAC to decide whether to make a recommendation on the 3 vendors.

Action: The ISAC supports the concept of an IHS HIPAA Claims Processing Clearinghouse that identifies multiple vendors for the IHS and Tribes to purchase claims processing services from. The ISAC will provide this recommendation to the IHS Director and the NBOC.

HIPAA End User Perspective-IT and the Business Office

Roland Todacheenie, Navajo Area Business Office, IHS

Issue: Roland Todacheenie gave the group an update on implementing Quovadx for medical billing within the Navajo Area. They are looking to have it in use throughout the Area within the next 4 months. To date, it has been quite successful. As Ron Wood stated earlier, Quovadx had the best alternative out there to meet the Navajo Area's needs from a financial point of view. The Navajo Area has approximately 1 million patient visits per year and this will pay for itself in less than a year.

Action: None

Urban Programs IT Infrastructure Issues/Activities

Bruce Parker, Self-Determination Services Leader, ITSC, IHS, and Denise Exendine, Urban Health Programs, IHS

Issue: *Click on Control and this Link to see Presentation Slides:* [Urban Program IT Infrastructure Presentation](#)

Discussion: Denise provided an overview of the urban programs within IHS. She said that all Areas have urban coordinators, but they are performing this function as a collateral duty with the exception of the California Area. California is the only IHS Area that has a full-time urban coordinator position. She stated that the urban programs designated as Federally Qualified Health Centers (FQHC) have no Federal Torts Claim Act coverage, and they are required to serve all, not just Indians. Urban programs get approx 1% of the IHS Budget, however, according to the 2000 census, 60% of all Indians reside in urban areas.

The discussion turned to common reporting requirements. Keith asked how the urban program got the requirement to do annual reports versus the 3 year IHS requirement. Denise said she thought it was legislatively mandated. She also pointed out that if you live in the urban program's designated area, you have to use the facility at least one time annually to be counted. Consequently IHS may be greatly underreporting the numbers of persons residing in urban areas. Denise said the urban program has no ability to query any data with the present IT structure

using the IHS uniform data set requirements. She said urban facilities balk at the use of the RPMS because of its inability to generate financial data. Clark asked about the use of RPMS at the IHS demonstration sites in Tulsa and Oklahoma City, but not at other urban sites. Denise said entries have to be entered into both their billing system and in the RPMS. These sites have to do parallel entries. Denise also pointed out that the Community Health Representative (CHR) information in the RPMS has no field for urban data. The CHR program software application is automatically defaulted to "tribal". The CHR software application needs to be modified to add an "urban" field so their information can be captured accurately. Keith asked what the determining factor for urban uniform data set requirements was. Denise said they have a workgroup, policy, and a legislative requirement for the report. Keith recommended looking at the common utilities for these reports between IHS and Urban programs.

Denise discussed the IHS Urban Program's OMB PART findings. The urban programs scored a 69, which was adequate. The OMB gave this score because they found no clear purpose for the program identified in their submission and stated that the IHS Urban centers were duplicative of community health centers.

Action: The IHS Urban Indian Health Program has uniform common reporting requirements and uniform data set requirements established legislatively. There is a need to examine common utilities for these requirements between the IHS and Urban programs. The ISAC recognizes the need for quality Urban Indian program data to ensure continuity of care and therefore recommends that IHS integrate urban information technology into the IHS IT infrastructure.

Telemedicine Activities in the Navajo Area

Wes Old Coyote, Navajo Area CIO, IHS

Discussion: Wes stated that the Navajo Area operates two networks within their Area; a Frame Relay Network through IHS and a secure Telehealth/Telemedicine network through the Tribe. Annual recurring costs for the telehealth network are \$1.3 million. They receive \$700,000 from USAC in annual circuit reimbursements to assist with funding this project. The Navajo Area collects over \$130 million in third party reimbursements annually with approximately one percent of Medicare/Medicaid collections utilized for the funding and support of the telehealth network. The Tucson, Phoenix, Albuquerque, and Navajo Areas are working on a joint venture for a southwest telehealth network. Wes said they and their partners have to get creative to get the most efficiency out of the telehealth network. All Navajo Service Units have some form of digital imaging modality. As to billing, the IHS parties involved have to send their readings to University of Arizona physicians in Tucson to interpret and as a result, they are collecting the reimbursements on them, not the IHS. Wes proposed that the IHS hire radiologists to do readings for regions of IHS so IHS can keep the reimbursements within the IHS. If the IHS would hire regional radiologists, significant funding would be available for Telehealth through reimbursements.

Action: None

Telemedicine Activities in the Alaska Area

Rich Hall, Alaska Area CIO, Tribal

Discussion: Rich said the Alaska Area also uses its USAC funds to pay for its telemedicine activities. They get 50% of the IHS USAC reimbursements, which allows them to pay for 90% of the project. They have regional health corporations that pay their individual portions to the Area. The Alaska Area is marketing its telehealth solution, from their software to consults. They are available for Tribes, IHS, and are currently doing international work with parts of Russia. The American Telehealth Association awarded the Alaska Area's AFHCAN project with an outstanding award at their meeting in April. The project has ended, and Alaska can now market these products to parties outside the Federal government like Tribes.

Action: None

Need for a Standard Inter-facility Health Summary Application

Wes Old Coyote, Navajo Area CIO, IHS, and Richard Hall, Alaska Area

Issue: The Navajo and Alaska Areas have developed applications capable of sharing inter-facility health summaries. These applications do automatic updates of each facility's information daily.

Discussion: The Navajo Area has developed a Multi-Facility Integration (MFI) application through Mitretek that was later updated by Dr. Mark Delaney. It is a web-based application using SQL and does automatic downloads of each facility's information daily. The Alaska Area has also developed an MFI application with similar functionality. Darren Buchanan suggested using a GIS type software in coordination with the health status indicators. Keith added that HHS asking the IHS to identify our GIS software standard and is forming a group to look at this issue.

Action: The ISAC recommends that the IHS evaluate the MFI applications developed by the Alaska and Navajo Areas for integration of health summary applications at multiple facilities for possible deployment throughout the IHS.

Telecommunications Initiatives - Activities and Status (VBNS, HHSNET, e-mail, Active Directory, Video-Conferencing, etc)

Tom Fisher, Telecommunications Management Team Leader, ITSC, IHS

Issue: *Click on Control and this Link to see Presentation Slides:* [Telecommunications Initiatives-Activities and Status](#)

Discussion: Tom Fisher provided the ISAC with a progress report on IHS telecommunications activities. Highlights follow:

- Active Directory Migration Project - The IHS is approximately half way through its Windows 2003/Active Directory/Exchange 2003 migration. Navajo Area, Headquarters East, Information Technology Support Center, Oklahoma and Albuquerque Area Offices,

Bemidji Area Office and all of its sites, and the Pawnee Service Unit have completed migrations. The Phoenix and California Areas are nearly complete. The Department of Health and Human Services (HHS) supplied IHS with a Bandwidth Calculator to analyze the amount of bandwidth being used/how much is available. All remaining Service Units are being scheduled. Target date for completion of IHS migrations is December 31, 2004. We look forward to collapsing the entire Exchange 5.5 environment by January 2005. The following is the next 3 month's migration schedule:

Tucson and Billings Area Offices	May 17 – June 4th
Aberdeen Area Office	June 7 – June 18th
California Rural Indian Health Board	June 21 – July 2nd
Nashville Area Office	June 21 – July 2nd
Portland Area Office	July 5 – July 23rd
Seattle/Dallas OEH	August 2 – 13th

- HHSNET Implementation Project - As part of the "One HHS" information technology consolidation metrics, the IHS and other HHS OPDIVs are combining their networks into one integrated network, the Very high performance Backbone Network Service (VBNS). The IHS has completed 100% of the orders for line installations for the IHS VBNS Network conversion and installed 95% of the associated equipment. All Area Offices have been converted. The IHS has completed all T1 connections to the VBNS from IHS health facilities (62 circuits). All Internet for the IHS was converted to the centralized 45 MBPS on May 25, 2004. The IHS frame relay circuit implementation schedule has been readjusted due to late shipment of T3 cards to our Albuquerque and Rockville locations. The IHS has minor issues with Local Telephone companies; some are too small to accommodate the work requested and rural issues.
- HHS Enterprise e-Mail Project – The HHS has awarded a contract to begin implementing a new Department-wide e-mail system.

Action: None

Information Systems Coordinator Charter-Request for Approval

Wesley Old Coyote, ISC Chair, IHS

Click on Control and this Link to see Handout: [ISC Charter-DRAFT](#)

Issue: The IHS ISCs are requesting that the IHS approve the formation of the ISC Committee and charter. This will provide them with an official forum to work together to guide the development of a co-owned and co-managed Indian health information infrastructure that meets the requirements of each respective Area and addresses the uniqueness particular to each.

Discussion: The ISC Committee as proposed would report to the IHS Chief Information Officer (CIO), and is in accordance with the Department of Health and Human Services IT consolidation

metrics memorandum dated June 3, 2003 which states in part the following, "All IT infrastructure organizations and staff within each large OPDIV must report to the OPDIV CIO." Keith said that he would have Christy Tayrien of his staff prepare the charter in final and work with the IHS Management Policy Support Staff on getting the charter formally approved and issued.

The ISAC voted to approve the ISCC Charter, leaving minor edits to the ISC Committee.

Action: The ISAC supports and approves the establishment of the Information Systems Coordinator (ISC) Committee and its Charter.

Capital Planning and Investment Control Process Redesign

Christy Tayrien, CIO Office, IHS

Click on Control and this Link to see Presentation Slides: [Capital Planning and Investment Control-Briefing](#)

Issue: The HHS CPIC Program Team's is reengineering the HHS CPIC policies and procedures.

Discussion: The HHS is implementing an Executive IT Steering Committee chaired by the HHS CIO and Co-Chaired by the Assistant Secretary for Budget, Technology, and Finance. Members will be Executive Officers or Senior Representatives of OPDIVs (i.e., IHS Director) and STAFFDIVs. The Executive IT Steering Committee's role will be to provide project oversight, funding decisions and Enterprise Architecture changes. The Steering Committee will recommend investments for the Secretary's Budget Council, provide large project oversight, ensure policy adherence, and identify areas for collaboration. There is one vote per OPDIV on this board; therefore, the OPDIV CIO and the OPDIV senior representative must come to an agreement on the vote.

Under the HHS Executive IT Steering Committee will be the HHS CIO Council. It is chaired by the HHS CIO and comprised of OPDIV CIOs, CIO Consultants, OCIO Senior Staff (as advisors). The HHS CIO Council will provide the Executive IT Steering Committee with project oversight and technical reviews. The HHS CIO Council has two distinct roles – to identify HHS IT Issues for CIOs to discuss; and to serve as the Technical Review Board that reviews investments and discusses issues raised from working groups.

Christy identified Gene Robinson, as the IHS' designated CPIC Coordinator and spoke about the Exhibit 300 preparation process the IHS goes through annually to prepare the Agency's IT investment portfolio. She discussed ProSight, the new HHS software application that IHS now uses to enter CPIC data and ProSight user training requirements the Agency is now participating in. She discussed the major systems the IHS reports on its Exhibit 300s including the RPMS, Telecommunications Infrastructure, the National Patient Information Reporting System (NPIRS), and the Integrated Financial Administrative System. The ISAC discussed changing the name of the NPIRS to Data Storage or something similar since the IHS is beginning to utilize the Data Warehouse, not just NPIRS. Christy talked about the Exhibit 300s getting less than desirable

scores and this being due, in part, to our not having conducted alternatives analyses. Rachael Tracy added that the IHS just awarded a contract this week to complete the alternatives analyses. Rich Hall discussed a similar project the Alaska Area was working on and had a proposal with 4 different alternatives they wanted to analyze. Rich said he would provide this information to the IHS CPIC Coordinator.

Action: None

ISAC Discussion and Recommendations

Reece Sherrill, ISAC Co-Chair

Issue: *Click on Control and this Link to see this Meeting's Recommendations:*
[ISAC Recommendations to Director May 2004](#)

Action: Recommendations will be written and signed by the Co-Chairs and sent to Dr. Charles Grim, Director, IHS, for his consideration.

ISAC Meeting Schedule and any Unfinished Business

Reece Sherrill, ISAC Co-Chair

- Meeting Schedule: The ISAC scheduled its next meeting for Friday, August 27th, at the Information Technology Conference for half a day in the morning.
- Agenda item for next ISAC meeting: The ISAC will review its charter for possible revisions and plan to spend approximately 2 hours on this task.
- Other: Rich Hall's staff thanked Keith for the NPIRS basic business rules. Reece Sherrill thanked the ISAC for electing him as Tribal Co-Chair.

Meeting Adjourned at approximately 5:15 P.M.