HEALTH INFORMATION TECHNOLOGY AND STATES
A PROJECT REPORT FROM NCSL’S HEALTH INFORMATION TECHNOLOGY CHAMPIONS

William T. Pound
Executive Director

7700 East First Place
Denver, Colorado 80230
(303) 364-7700

444 North Capitol Street, N.W., Suite 515
Washington, D.C. 20001
(202) 624-5400

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The National Conference of State Legislatures is the bipartisan organization that serves the legislators and staffs of the states, commonwealths and territories.

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NCSL has three objectives:

- To improve the quality and effectiveness of state legislatures.
- To promote policy innovation and communication among state legislatures.
- To ensure state legislatures a strong, cohesive voice in the federal system.

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The National Conference of State Legislatures launched Project HITCh (Health Information Technology Champions) at its 2006 Legislative Summit to establish and develop state legislative policy expertise on health information technology. The project brings together a highly respected public-private group of state legislative leaders and private sector partners. HITCh is made possible through the generous support of these members of the NCSL Foundation, who are active in shaping the project and carrying out its goals.

HITCh serves as the foundation for all of NCSL’s activities around health information technology (IT). During the past two and a half years HITCh has engaged key state policymakers and has contributed to the great rise in interest and activity around health IT at the state level. This report is based on the findings of the work undertaken by Project HITCh.

The project holds meetings and webinars throughout the year focusing on topics chosen by HITCh members and partners. NCSL project staff for HITCh responds to legislative information requests, tracks legislation, facilitates exchanges among states, creates issue briefs and prepares items for publication in State Health Notes and State Legislatures magazine.

To learn more about HITCh visit the project website at http://www.ncsl.org/programs/health/forum/hitch/

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NCSL thanks the following NCSL Foundation Partners for their support of Project HITCh:
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• MAXIMUS
• Quest Diagnostics
Information technology has revolutionized the U.S. economy, but the health sector lags behind. Health information technology (IT) as a part of broader system reform offers the chance to help reduce costs and improve quality in health care. With rapidly rising health care costs—which make up one-fourth of most state budgets—health IT’s promise of increased effectiveness and efficiency has drawn significant policy interest and action at the state and federal levels. Often as a part of broader health reform efforts, many states have begun to push the health sector forward into the digital age.

Quality Improvements

The ultimate goal of health IT is to bring together vital pieces of patient data scattered across providers. Having this data at the point of care, wherever it may be, facilitates high-quality care and avoids duplicate tests and procedures.

This flow of information is integral to efforts to improve the quality and safety of health care. However, policy concerns arise about what data enter the system, how data are compiled and aggregated, and what systems need to be in place so that information can be safely exchanged.

If implemented properly health IT will also facilitate efforts to reform health care payments systems to reward quality rather than paying for services. Health IT systems can decrease the burden on providers from reporting requirements that will likely be a part of payment reform.

**Key Terms**

Health Information Technology (IT) refers to the use of technology to electronically collect, store, retrieve and transfer clinical, administrative and financial health information. Health IT is a ‘marriage’ between the clinical health care activities and computer science for the benefit of patients and those who provide health care services.

Electronic Health Record (EHR) organizes a patient’s information from various sources and, over time. The record is centered around a patient rather than around treatment.

Health Information Exchange (HIE) refers to the electronic movement of health care information among organizations in a system that assures that the information is understood in the same way wherever it goes. HIE is also used as a catch-all phrase for all health information exchanges, including regional health information organizations (RHIO) and others.
Cost Savings?

The RAND Corporation has estimated that implementing clinical and administrative health IT systems will save the health system $162 billion annually, and the Center for Information Technology Leadership has estimated savings of $78 billion per year after a 10-year implementation period. The estimated savings result from administrative efficiencies and lower costs in filing and processing claims, improved care, better prescription safety, fewer redundant tests and treatments due to better documentation, better use of preventive services, and chronic disease management.

However, these savings won’t be achieved simply by having all providers adopt health IT systems. Health IT is really an enabler for a number of broader reforms in health care that can help bend the cost curve. The ability of the health system to conduct comparative effectiveness research and quality reporting will be greatly improved by health IT. This improved information will help facilitate many of the proposed payment reforms that to reward the delivery of high quality care.

Based on the findings from Project HITCh, this report lays out the key challenges and policy solutions that states are pursuing to advance health IT and broader system reform. A summary of key initiatives undertaken by HITCh this past year is included in Appendix A.
KEY CHALLENGES

An electronic health record in every pot alone will not magically bring about changes to the health care sector. Key technical and policy challenges must be overcome before the larger system reforms made possible through health IT can be achieved. During the course of Project HITCH, three key challenges to state health IT initiatives have been identified:

• **Privacy and Security:** Consumers fear their sensitive health data might be breached as more information is held in an electronic format—though paper records are, perhaps, even more susceptible to breaches. Providers want access to patients’ full medical records and are concerned about liability for misuse of data.

• **Interoperability:** Making different technology systems able to work together, both within and across providers—interoperability—is a vital to realizing the promise of health IT.

• **Misaligned Financial Incentives:** Insurers and other payors can save money through electronic health records, but providers usually have to pay for the systems and staff retraining.

**Privacy and Security**

As the health care sector transitions from a paper-based system to a digital system, there are new privacy and security challenges. All health care stakeholders are affected by these changes.

Patients fear they might lose their job or health insurance if their sensitive health information related to dire or stigmatized diseases becomes known. Health IT advocates make the point that these systems, if properly designed, can actually provide better security than paper records. Electronic records can provide audit logs enabling a patient to see who has accessed their data. In a paper system, patients have no way of knowing who has viewed their data or made copies of it.

A host of overlapping state and federal laws combined with business practices lead to conflicting practices and legal uncertainty among providers. This lack of legal clarity causes many providers to be reluctant to exchange health data with one another fearing liability for violations. Initiatives at the state and federal level are working to address this issue.

Providers, understandably, want access to all relevant patient information at the time of treatment. They are concerned about liability if they treat a patient based on incorrect or missing data obtained from a health information exchange. Providers also are concerned about the cost of implementing privacy rules and their effect on practice workflows.
Less dramatic but more pervasive concerns about how health IT can be misused include intrusive marketing to both consumers and providers and shifts in power in provider-plan negotiations.

**Interoperability**

Ensuring health IT systems are interoperable—the ability of differing electronic systems to work together—is a central challenge to HIE. Interoperability is both a technical and policy challenge. On the technical side, uniform data standards are essential to achieving interoperability between health IT systems. National efforts are underway to address the technical challenges through the Healthcare Information Technology Standards Panel, which is establishing standards, and the Certification Commission for Healthcare Information Technology, which is certifying products. The policy challenge arises from payers’ and providers’ concerns about sharing data with other organizations they have traditionally seen as theirs alone. Many organizations believe that sharing patient data could hurt their competitiveness.

**Misaligned Financial Incentives**

A significant factor in the snail-paced adoption rate of health IT arises from the misalignment of costs and benefits across health care stakeholders. There is a growing recognition that we must determine how to balance costs and benefits among these groups. This may require helping to subsidize providers for their initial acquisition and implementation costs if that is what is needed to achieve the goals of industry-wide efficiency, quality-of-care improvements, and better performance outcomes.

The proportion of providers who currently use electronic health records remains low, with estimates varying among surveys. One widely cited survey estimates only 4 percent of physicians have a fully functional EHR and an additional 13 percent have a basic EHR. (In the study, basic systems lacked certain physician order-entry capabilities and clinical-decisions support that were available in fully functional systems.) Providers face significant costs for the purchase of health IT systems, and often productivity and revenue go down during the transition to an EHR. Small practices, rural providers and community health centers in particular find it much harder to finance a new system.

Initiatives like the new Medicare e-prescribing incentive program are essential to realigning the value equation so that insurers, employers and government share the savings from health IT systems with providers who have to purchase and implement new health IT systems. Many states see an essential role in allocating the costs and benefits of health IT systems across the various health IT stakeholders to ensure widespread adoption. In particular, states see a role in assisting small practices, rural providers and community health centers in the adoption of health IT systems.
Health Information Technology and States: A Project Report

National Conference of State Legislatures

States influence health IT, as they do health care more generally, in a number of ways—as purchasers, regulators, providers and planners, and through supporting infrastructure, innovation and workforce development. Traditionally they have regulated providers and shared insurance regulation with the federal government. Health IT policy is another area where the state and federal policy roles meet; a discussion of the federal role is included on page 21 of the report. States vary in the extent to which they tend to pick regulatory or market-oriented approaches to influence their health systems, and these policy preferences carry through in their choices related to health IT policy.

State legislatures have taken significant steps in recent years to address the policy challenges slowing the adoption and use of health IT systems. From January 2007 through August 2008, more than 370 bills with provisions relating to health IT were introduced in state legislatures. The National Conference of State Legislatures found that 132 bills with health IT content were enacted in 44 states and the District of Columbia. This represents a more than threefold increase compared to 2005 and 2006, during which 36 bills were enacted, according to the eHealth Initiative.

State initiatives generally fall into five major policy trends:
- Planning
- Protecting Privacy in the Digital Age
- Financing
- Promoting the Exchange of Health Information
- Drive Adoption and Use

The future outlook for health IT is hard to divine. In recent years the issue has attracted significant state policy interest. Dollars to fund health IT projects will become scarcer as states deal with the current economic crisis. States, which already have closed $40 billion in fiscal year 2009 budget gaps, face at least an additional $97 billion they must close over the next 18 to 24 months, according a recent report from the National Conference of State Legislatures. Fifteen states are forecasting fiscal year 2010 budget gaps of more than 10 percent of the state’s general fund. However, the squeeze on state budgets will likely increase interest in achieving cost savings in health care. Medicaid expenditures alone accounted for 21.2 percent of total state expenditures in fiscal year 2007, and thus could increase interest and state actions on health IT. States will have to assess the effects of health IT investments on their efforts to address these immediate budget challenges.
Planning

Convening stakeholders has been essential to the success of various state efforts to increase the adoption of EHRs and to facilitate health information exchange among providers. Many states have taken a strong role in these planning efforts by creating study commissions that bring together various public and private health care stakeholders in a neutral venue. Convening stakeholders in this type of setting helps to build an action plan, helps create buy-in for the plan and builds trust among participants who are used to competing. Building such trust-based relationships is essential for organizations to reach the agreements necessary to exchange patient data with one another.

Legislation to convene study commissions typically defines membership and sets tasks that include inventorying existing projects, detailing future needs and resources; recommending necessary state policy changes to facilitate health IT; and developing a statewide roadmap to create an interoperable, statewide health IT system that includes a sustainable business model and addresses privacy and security.

Colorado Senate Bill 196, for example, demonstrates common components of such legislation.

Establishes membership of commission

"25-1-1401. Health information technology advisory committee - members - duties - cash fund. (1) The Committee shall consist of at least eighteen members who have expertise in the area of health information technology, appointed by the Governor within thirty days after the effective date of this section, who shall include representative of interested groups, including:
(a) The academic community;
(b) The insurance industry;
(c) The pharmaceutical industry;
(d) Employer groups;
(e) The Attorney General’s Office;
(f) The Governor’s office;
(g) Medical practitioners, which may include representative of the medical industry, doctors, nursing homes and nurses;
(h) Medicare and Medicaid;
(i) The health information technology industry;
(j) Information technology associations;
(k) Home health providers;
(l) Mental health providers;
(m) Consumers;
(n) At least two members of the Colorado regional health information organization;
(o) At least one representative from each House of the Colorado General Assembly; and
(p) An association representing all types of hospitals throughout Colorado, including private and government-operated, metropolitan and rural, investor-owned and not-for-profit”

Define commission charge

“(3) (a) On or before January 1, 2009 the committee shall develop a long-range plan for health care information technology, including the use of electronic medical records, computerized clinical
support systems, computerized physician order entry, regional data sharing interchanges for health care information, data privacy and security measures, interoperable health information technology, and other methods incorporating information technology in pursuit of greater cost-effectiveness, improve efficiency, reduced redundancy, and better patient outcomes in health care and a decrease in price disparities in insurance coverage for residents of this state. In developing the long-range plan, the committee shall study the effect of health information technology on price disparities in delivery of health care services for residents of this state. As part of the process of making recommendations for interoperability, health information exchange, and health information technology, the committee shall consider uniform national standards, as they are developed or recognized by the United States Department of Health and Human Services, the American National Standards institute, the Health Information Technology Standards Panel, and other national standard-setting organizations."

The preparation of a roadmap in addition to bringing all stakeholders behind a single plan has been essential in some states to keeping continued political support behind health IT efforts after the initial planning process has been completed. Examples of roadmaps from Arizona and Vermont follow.

Arizona Health-e Connection Roadmap

Vermont Health Information Technology Plan
Protecting Privacy in the Digital Age

The potential of health IT that makes it so compelling also presents new risks for misuse. State policymakers will need to address this, reaching beyond the basic privacy and security issues to include concerns over what data enter the system (and who has access), how data are compiled and aggregated, the accuracy of data and the availability of technical systems at all times. Health IT’s promise will not be realized until there is a high level of public confidence in the integrity of these systems. States have a key role to play in ensuring this public trust develops.

States are actively working to address the key issues around privacy and security. Lawmakers are taking differing paths as they attempt to capture the benefits of mobile health data and temper the associated risks.

Structuring Patient Consent
States face fundamental questions on the issue of patient consent. Under what circumstances should patient consent be required? How should consent be structured (opt-in, opt-out)? Will patients have to choose between including all their information for exchange or none? Or will patients be able to choose specific information to share? Will providers be able to access patient data in an emergency? As states set policy on consent, a number of competing issues must be balanced, including: patients’ desire to control data, providers’ concerns about having access to all relevant information for treatment, and implementation costs for providers and health information exchanges.

For states that are considering how to structure patient consent for HIE, the following report will prove useful. Although some of the analysis is focused specifically on Arizona statutes the broader analysis of consent options is applicable across the states.

Consumer Consent for Health Information Exchange: An Exploration of Options for Arizona’s HIEs

Comprehensive Reform
Table 1 provides a side-by-side analysis of key policy decisions from two states that recently enacted comprehensive health information exchange privacy legislation.
<table>
<thead>
<tr>
<th>Bill</th>
<th>2007 HB 1078</th>
<th>2008 HB 7409</th>
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<tbody>
<tr>
<td>Status</td>
<td>Enacted 5/25/07</td>
<td>Enacted 7/10/2008</td>
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<tr>
<td>Summary</td>
<td>Allows creation of record locator services (RLS). An RLS is an electronic index of patient identifying information that directs providers to the location of patient health records held by providers and group purchasers.</td>
<td>Establishes a statewide health information exchange (HIE) under state authority. Designates the Rhode Island Quality Institute as the governance body or regional health information organization (RHIO) for the HIE.</td>
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<tr>
<td>Putting Patient Data into the System</td>
<td>An RLS can be created without patient consent. Patients have the right to opt-out of the RLS in total or can exclude specific provider contacts from the system.</td>
<td>Patients must opt in for their data to be included in the HIE.</td>
</tr>
<tr>
<td>Consent for Access</td>
<td>Consent is required to search an RLS for the location of a patient’s records except in an emergency. To facilitate the real-time exchange of data, one provider can electronically represent patient consent to another. To do so, a provider must have a signed and dated patient consent form authorizing the release. In addition, the provider releasing the record shall document: 1) the provider requesting the health records; 2) the identity of the patient; 3) the health records requested; and 4) the date the health records were requested.</td>
<td>Patients who opt in can choose which providers have access to their data. If a patient opts in, their authorization is not required for release to: • public health authorities for specified functions; • health care providers for diagnosis or treatment in an emergency; and • the RHIO for operation and administrative oversight of the HIE.</td>
</tr>
<tr>
<td>Audit Log</td>
<td>RLS must maintain an audit log of providers who access a patient’s information. The log must contain at least the following: 1) the identity of the provider accessing the information; 2) the identity of the patient whose information was accessed by the provider; and 3) the date the information was accessed.</td>
<td>Patients have the following rights: (a) to obtain a copy of their health care information from the HIE; (b) to obtain a copy of the disclosure report pertaining to their health care information; (c) to be notified of a breach of the HIE security system; (d) to terminate participation in the HIE; and (e) to request to amend their information through the provider participant.</td>
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Table 1. Comparison of Privacy Provisions from Minnesota and Rhode Island

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<th><strong>Minnesota</strong></th>
<th><strong>Rhode Island</strong></th>
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<tr>
<td><strong>Provider Liability</strong></td>
<td>(b) When requesting health records using consent, or a representation of holding a consent, a provider warrants that the request: 1) contains no information known to the provider to be false; 2) accurately states the patient’s desire to have health records disclosed or that there is specific authorization in law; and 3) does not exceed any limits imposed by the patient in the consent.</td>
<td>Provides immunity to health care providers who rely in good faith upon information provided through the HIE in the treatment of a patient.</td>
</tr>
<tr>
<td><strong>Penalties</strong></td>
<td>An RLS is liable for inappropriate disclosures of information.</td>
<td>The bill establishes civil and criminal penalties for violations of the statute. Attorneys’ fees may be awarded by the court to the successful party in any action under this chapter.</td>
</tr>
<tr>
<td></td>
<td>Anyone who inappropriately discloses a patient’s data is liable for compensatory damages caused by an unauthorized release, plus costs and reasonable attorneys’ fees.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Providers who violate the statute can face disciplinary action by the appropriate licensing board or agency.</td>
<td></td>
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</table>

**Source:** National Conference of State Legislatures, 2008.

**Modify Existing Statutes**

Some states have taken a piecemeal approach to facilitating HIE. For example, Wisconsin after doing a thorough analysis of their privacy legislation identified a few key points that were inhibiting the exchange of patient data. Rather than creating new regulations or laws the state decided to make small modifications to current law to address the identified issues. A short summary of the changes Wisconsin enacted in SB 487, 2008:

To facilitate exchange of health information the bill adds diagnostic test results and symptoms to the list of elements that can be exchanged without written consent from a patient; allows for the sharing of data with any health care provider involved in the patient’s care (previously, data could be shared only with providers in a related health care entity); and eliminates more stringent state requirements to document all disclosures of health information.

The bill expanded the circumstances under which a health care provider can release a portion of a patient’s records to specified parties.

**Make HIPAA the Rule**

Nevada specifies that the Health Insurance Portability and Accountability Act (HIPAA) preempts any more stringent state laws related to the electronic exchange of health information by covered entities. The bill allows patients to not participate in electronic transmission of individually identifiable health information, with an exception for Medicaid and SCHIP patients and when required by HIPAA or state law.
Nevada SB 536 Section 11. “If a covered entity transmits electronically individually identifiable health information in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which govern the electronic transmission of such information, the covered entity is, for purposes of the electronic transmission, exempt from any state law that contains more stringent requirements or provisions concerning the privacy or confidentiality of individually identifiable health information.”

Address Varying Interpretations of State and Federal Privacy Laws
To address differing interpretations and application of federal and state privacy laws, the Oklahoma Legislature ordered the State Board of Health to create a standard authorization form for exchange of health information. Providers who use the form and follow the board’s instructions are immunized from liability under state privacy laws that may arise from the exchange of health information. Use of the form is not required. (Oklahoma SB 1420)

Data Breach Notification
California AB 1298 expands the state’s data breach notification law to include unencrypted medical information and health insurance information. The bill also expands the definition of provider of health care under the state’s Confidentiality of Medical Information Act to cover third-party vendors of personal health records such as Google and Microsoft. HIPAA and most state health privacy laws do not cover personal health records maintained by third-party vendors.

E-prescribing
A few states prohibit e-prescribing systems from influencing provider prescribing practices. New Hampshire passed the most comprehensive of these bills, which included the following language to prohibit use of prescription information by certain parties:

New Hampshire HB 134 “(e) No person who has access to electronic prescription information solely by transmitting or facilitating the transmission of prescriptions between the licensed prescriber generating the prescription and the pharmacy receiving the prescription, or any intermediary, shall retain the prescription or any information it contains for longer than is mandated by federal or state law, after which time the prescription information shall be destroyed. No such person shall sell, use, or otherwise make available the prescription information for any purpose other than transmission of prescriptions, prescription refills, and clinical information displayed to the prescriber or pharmacist.”
Financing

States view health IT as a means to an end, not the end itself. The real goal is the improvement of health care quality and bending the curve of the ever rising cost of health care. Many states see a role in financing health IT initiatives and in allocating the costs and benefits of these systems among various health care stakeholders to ensure widespread adoption and utilization. States are also helping to finance the establishment and operation of the infrastructure necessary for health information exchange.

Significant EHR adoption rate differentials exist between large and small practices; the smaller the practice the less likely it is to have an EHR (see Figure 1). To help address this disparity between states have been targeting their funds at groups—such as community health centers, small practices and rural providers—that have been reluctant or unable to adopt health IT. Public health is another area that state lawmakers acknowledge will need significant funding to bring it up to the 21st century. Legislators want to ensure they do not replace private sector funds that hospitals and large practices would use for adoption of IT.

States have been experimenting with various financing methods.

Health IT Funds

A number of states have special funds dedicated to increasing the adoption and utilization of health IT tools. The funds usually pool publicly appropriated dollars with contributions or required payments from the private sector. Money from the fund usually is tied to requirements for its use, such as the purchase of interoperable systems. Money in the fund generally must be appropriated by the legislature.

Vermont offers an interesting example of this trend. To fill fund coffers, the legislature created a dedicated revenue source with a quarterly 0.199 percent fee on all health care claims of health insurers in the state. Under the bill, “health insurer” includes third-party administrators for self-insured employers. Ensuring everyone paid the fee was a key policy issues as no single insurer was willing to foot the bill for physicians to adopt health IT tools when other insurers would benefit without bearing any of the upfront investment costs.
The state expects the fee to raise $32 million over the next seven years. The money will be used to increase independent small practitioners’ adoption of EHRs; support physician practices as they implement health IT tools; and support Vermont Information Technology Leaders’ construction and operation of a statewide health information exchange network.

Dedicated Funding Streams
Creating a dedicated funding stream is one option for funding health IT initiatives. Vermont, with its fee on all health care claims is one of the only states to have created a dedicated funding stream. States have considered using dues, bonds, insurer assessments and user fees to fund health IT activities.

Creating Funding Streams through Public Programs
Some state public programs—such as state employee health plans and Medicaid—provide funding streams by paying to participate in health information exchange organizations and by increasing or supplementing reimbursement rates for providers who use electronic health records.

In Michigan the state employee health plan and Medicaid are both paying a per member per month fee to the health information exchange in the capital area to have their participants’ data exchanged. Providing funding through public programs also helps establish the legitimacy of a health information exchange and can increase the willingness of other health care stakeholders to participate.

In New York, providers who meet certain standards set by the Department of Health can receive supplemental payments for increased costs to use electronic health records. To receive payment, the provider must have an operational electronic health record system and a certain percentage of patients who are on Medicaid or uninsured.

Appropriations
Most health IT funding provisions are one-time appropriations for a specific project included in general appropriations laws or departmental funding measures. These projects include purchase of health IT tools such as electronic record systems and development and operation of health information exchange infrastructure.

Grants and Loans
States provide targeted funding through grants and loans to groups—such as community health centers, small practices and rural providers—that otherwise might not be able to afford health IT systems. Some states set requirements—such as purchase of interoperable systems or matching funds from the recipient—for a grantee to receive funding.

- Revolving loan funds. Minnesota HB 1078 requires all providers to have an interoperable electronic health records system by 2015. The bill establishes a revolving loan fund to help eligible borrowers install or support an interoperable health record system. Eligible borrowers include community clinics, rural hospitals and physician clinics.
• **Grants.** The District of Columbia offers grants to help community health centers develop electronic health record systems.

D.C. B 2. “(B) Of the remainder of the grant, $2.2 million in fiscal year 2007 and $2.8 in fiscal year 2009, shall be used to develop an electronic health record system for community health centers to promote higher quality of care, improved coordination of services among providers, and more accurate reporting of health statistics to the Department of Health; provided, that of the $2.2 million allocated for fiscal year 2007, $200,000 shall be used to support information technology needs for District of Columbia public and charter school nurse suites.”

**Other**

States are experimenting with a wide range of other financing strategies including tax credits for providers to adopt IT tools, pay-for-performance and pay-for-participation initiatives.
Promoting the Exchange of Health Information

As the largest health care purchaser in the state, a state's choices can influence the development of health information exchange in the private sector. Much as the Internet developed because of investment by the Department of Defense, a state's investments in health information exchange for its own programs can create the backbone of a system for other data users.

States are working to advance health information exchange by promoting interoperable health IT tools and by establishing and sustaining health information exchange organizations and infrastructure. Interoperability, combined with state initiatives to create health information exchange organizations is essential to states' efforts to achieve quality improvements and reduce duplicative tests. Trends identified include the following.

Interoperability
Interoperability allows different systems to share information in an understandable format. Uniform data standards are essential to achieving this capability among health IT systems. At the national level, the Healthcare Information Technology Standards Panel is establishing standards, and the Certification Commission for Healthcare Information Technology certifying products.

State approaches to encourage interoperability vary. Some states adopted these standards by reference, while others designated a state agency or outside group to establish standards. To encourage use of the standards, states can require agencies to purchase only standards-based systems. States also can require specific functions for health IT systems sold within their borders.

Require purchase of certified systems. Minnesota mandated interoperable electronic health records by 2015 for all hospital and health care providers. To meet the interoperability standards set by statute, providers must use an electronic health records system certified by the Certification Commission for Healthcare Information Technology or its successor. An exception is included in the legislation for specialists because the Certification Commission for Healthcare Information Technology doesn’t certify electronic health records for such practice settings. (Minnesota SB 3780)

Use state agency purchasing requirements. Virginia HB 2198 requires that electronic health records systems, or other tools that interact with electronic patient information purchased by state agencies, meet interoperability standards or be certified by a recognized certification body. The bill also requires state agencies that provide grants available to other entities for such systems ensure that the systems meet interoperability standards or be certified by a recognized certification body.

Create standards and require use to exchange data. Utah HB 47 authorizes the Department of Health to adopt standards for electronic health information exchange. Payers and providers must use the standards adopted by the department to electronically exchange health information between health care systems. Payers and providers are not required to use the standards if they electronically exchange health information within a health care system.
**Require certain functions.** Texas SB 204 requires that electronic medical record systems sold to Texas health care providers who administer immunizations be able to interface with the state immunization registry.

**Health Information Exchange Infrastructure**

Some states are taking an active role in shaping the health information exchange infrastructure. The biggest fault line here appears to be between small and large states. Many small states are establishing a single health information exchange that covers the whole state.

Many large states on the other hand are supporting the creation of multiple health information exchanges across the state. Michigan, for example, took a very active role in this process. The state government did an analysis of claims data and broke the state up into nine medical trading areas. Then through a competitive process the state selected a single entity in each of the nine medical trading areas to operate the area's health information exchange. The state is providing funding for planning and implementation but expects each health information exchange to establish a long-term sustainable business plan. The Michigan Health Information Network Resource Center was established to assist the health information exchanges and to cut down on duplicative efforts and facilitate the creation of consistent policies across the state.

**Health Information Exchange Oversight**

Many early health information exchange efforts began in the private sector, and state governments were asked to join. The current wave of health information exchanges, by contrast, are as likely to originate at the state level.

Some states are designating independent public-private entities to enable health information exchange and are delegating many standard-setting roles to consensus-based processes. Often these entities are created or blessed through statutes that confer formal status and authority, charge the health information exchange to promote health IT in both the private and public sectors, define governance to include state agencies, and determine that they may receive and disburse funds on behalf of statewide health IT initiatives. Beyond these broad elements, various models have been adopted, reflecting existing activity in the state. Statutes that create these entities typically are comprehensive measures that, among other things, include: start-up support for a designated group, a state governance role, ongoing funding, and unique state-level responsibilities.

In some states, government is at the center of the operation and control of the health information exchange. Health departments or newly created health IT advisory bodies have been put in charge of oversight in most cases. Some states are delegating rule-making to quasi-governmental state-level health information exchanges such as the Indiana Health Informatics Corporation.
Drive Adoption and Use

States are drawing on a wide range of policy levers to expand the adoption and use of health IT. These include mandates, incentives and leveraging state purchasing power. Trends identified across the states include the following.

Mandates
Minnesota and Massachusetts have enacted mandates for the use of health IT tools. A few other states considered such mandates but did not enact them.

*Mandate purchase.* Minnesota enacted two mandates for the purchase of health IT systems. The first requires hospitals and health care providers to have interoperable electronic health records systems by 2015. (Minnesota HB 1078) The second requires that, by 2011, all providers, group purchasers, prescribers and dispensers establish and maintain e-prescribing systems. (Minnesota SB 3780)

*Tie facility licensure to implementation of health IT systems.* Massachusetts tied implementation of computerized physician order entry and electronic health records to facility licensure standards for hospitals and community health centers. The Department of Public Health is charged with adopting regulations to require implementation of computerized physician order entry by Oct. 1, 2012, and of electronic health records by Oct. 1, 2015. The systems are to be certified by the Certification Commission for Healthcare Information Technology or its successor. (Massachusetts SB 2863)

*Certificate of Need process.* Certificate of needs (CON) regulate the upgrade, expansion and building of new hospitals. At least two states have provisions relating to interoperable health IT systems in their CON laws. Vermont for instance allows expedited review of CON applications for health IT projects that among other things are consistent with the state health IT plan. New York requires hospitals investing in new health IT systems enable them to connect with the state’s health information exchange.

Build Professional Capacity
Simply dropping an EHR into a provider’s practice doesn’t magically lead to quality improvements. Health providers have to undergo workflow retraining and truly integrate the tool into their practice. Providers who specialize in health information technology will be needed to realize the full benefits of these tools in many organizations. To this end states are working to integrate health IT into health professional’s curriculum, and some are explicitly working to build the health informatics workforce.

Minnesota provides funding to a university contingent in part that it “increase by at least 700, compared to fiscal year 2007, the number of students trained on the use of electronic medical record technology” (Minnesota HB 1063). Oregon calls for a quality institute to “(c) Develop the capacity of the workforce to capitalize on health information technology” (Oregon SB 329). The board of medicine in Massachusetts is required to add health IT competency as a standard of eligibility for physician licensure (Massachusetts SB 2863).
Incentives
Various states have put incentive programs into place. A few states are considering building on top of the recently enacted Medicare e-prescribing incentives.

Link medical school loan repayment to health IT competency. Massachusetts created a workforce loan repayment assistance program for graduates of medical or nursing schools who specialize in areas where practitioners are in short supply. Among other eligibility requirements for the program is demonstration of competency with certain health IT tools. (Massachusetts SB 2863)

Offer tax credits. Wisconsin SB 40 creates a tax credit for providers who purchase electronic medical records. Providers can claim up to 50 percent of the cost of the system, to a maximum of $10 million per year.

Leverage State Purchasing Power
States are leveraging their role as a purchaser and provider of care to drive adoption and use of health IT.

Medicaid, Most state Medicaid programs are actively pursuing e-health initiatives. According to the U.S. Department of Health and Human Services, Office of the Inspector General, nine state Medicaid programs have primarily claims-based EHRs, and 27 states are working on EHR initiatives.

Current Medicaid law provides for 90 percent federal financial participation for design, development or installation, and 75 percent federal financial participation for the operation of state mechanized claims processing and information retrieval systems—administrative data systems—approved by the secretary. States are seeking to apply these resources to clinical data collection and transformation of Medicaid infrastructure to allow for health information exchange with other organizations. Medicaid transformation grants are encouraging state innovations, which may include using health IT to improve such things as prescribing safety and quality.

A few select examples of Medicaid health IT initiatives are:

- **E-prescribing**
  At least five states have e-prescribing programs in Medicaid. Florida gave providers participating in a pilot program free stand-alone e-prescribing systems that run on handheld personal digital assistants (PDAs). Initially, Florida enrolled its 1,000 highest Medicaid prescribers in the program allowing them to view the Medicaid drug formulary, see recent patient medication history and receive drug interaction alerts. It later expanded the program to 3,000 Medicaid providers.

  According to the Florida Agency for Health Care Administration the program saves Medicaid $1.8 million to $2 million a month. This savings is based on an average 25 percent reduction in prescriptions per patient sent by prescribers using the system compared to prescribers who did not use the system.
- **Reimbursement**

  States can structure their Medicaid reimbursement payments to drive provider adoption and utilization of health IT. In New York providers who meet certain standards set by the Department of Health are eligible to receive supplemental payments for the increased cost of using electronic health records. To receive the payments, a provider must have an operating electronic health records system, and a set percentage of patients must be on Medicaid or uninsured.

  At least 26 Medicaid departments provide reimbursement for some services delivered via telemedicine. Medicaid must pay for patient transportation to providers so telemedicine can provide savings in transportation costs in some areas.

*Leverage the State Employee Health Plan.* A few states are using their state employee health plan to drive health IT adoption. Minnesota for example added a requirement in its state employee health plan contract that by 2009, all pharmacies serving the plan must accept e-prescriptions, and by 2011 all providers who treat state employees must e-prescribe. Those who fail to meet the deadlines will face removal from the plan network.

In California, CalPERS has directed its health plans to work with CalRHIO, a statewide health information exchange. This initiative will start by providing emergency departments that have a high volume of CalPERS members with electronic access to patient data. CalPERS is the largest purchaser of health care in the state and the third largest in the country.

According to the Commonwealth Fund eight states had personal health records available to their state employees in 2007.
Other State Groups

State Alliance for e-Health
The State Alliance for e-Health is working to identify, assess and, through consensus solutions, map ways to resolve state health IT issues that affect multiple states and pose challenges to interoperable electronic health information exchange. The State Alliance is made up of governors, legislators, attorneys general and insurance commissioners.

New Jersey Assemblyman Herb Conaway, Florida Representative Gayle Harrell, Massachusetts Senator Richard Moore and North Dakota Representative Ken Svedjan are members. They meet quarterly to make recommendations.

The State Alliance is supported by the National Governors Association and financed by the Office of the National Coordinator for Health IT. For more information go to: www.nga.org=center/ehealth

State-Level Health Information Exchange Consensus Project
This group is targeting its effort at state-level health information exchange initiatives (not necessarily lead by government). The project is working to identify and disseminate the characteristics and distinct roles and contributions of state-level health information exchanges. The project is identifying best practices in the areas of governance, structure, financing, operations and health information exchange policies.

For more information go to http://www.slhie.org/

Health Information Security and Privacy Collaborative
The project is a national collaboration created to address privacy and security policy questions affecting the exchange of health information within and among states. Over the various phases of the project most states were engaged in its work.

For more information go to: http://privacysecurity.rti.org/
Federal Activities

A number of efforts are under way to develop nationwide approaches to health information exchange. Many efforts seek to balance a need for uniformity, in order to allow interoperability, against concerns that the market and technology are still changing and premature standardization will dampen innovation.

In 2004, President Bush laid out his vision for most Americans to have access to EHRs by 2014. The Office of the National Coordinator for Health Information Technology (ONC) was established in the Department of Health and Human Services to coordinate the federal government’s efforts on this initiative. The American Health Information Community (AHIC) was an advisory board made up of the many interest groups in HIT. It provided recommendations to the secretary of HHS on how to make electronic health records interoperable and secure. The National eHealth Collaborative (NeHC), a public-private initiative housed outside of the federal government, was recently announced as the successor to AHIC.

The ONC supports four other health information technology projects designed to accelerate movement toward the 2014 goal. The Healthcare Information Technology Standards Panel (HITSP) is tasked with setting interoperability standards for health information technology. The Health Information Security and Privacy Collaboration (HISPC) has worked in 34 states to conduct state-level studies in order to develop security and privacy standards that will allow state laws to vary yet still enable interoperability. The Certification Commission for Healthcare Information Technology (CCHIT) is creating and applying certification criteria and establishing an inspection process for health IT. These projects provide some of the vital building blocks for the creation of a Nationwide Health Information Network (NHIN) to allow the exchange of health information among providers and patients across the nation.

While standard-setting and convening is coming from ONC, the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) have both funded grant programs to states and localities.

Congress recently enacted an e-prescribing incentives program for Medicare. The law will provide Medicare physicians who e-prescribe with incentive payments of 2 percent in fiscal years 2009 and 2010, 1 percent in 2011 and 2012 and 0.5 percent in 2013. In addition, Medicare physicians who do not e-prescribe will see their payments reduced by 1 percent in 2012, 1.5 percent in 2013 and 2 percent in subsequent years. Other payors often follow the lead of Medicare on reimbursement issues so this program has the potential to spur many imitators.

During the campaign, President Obama was a strong advocate of health IT and called for $50 billion to increase its use. The Obama administration has signaled it will make an aggressive push for health IT. States will likely have a key role in some of these initiatives.
CONCLUSION

During the past two years, state policymakers have actively been engaging the policy issues surrounding health IT. A plethora of approaches to address privacy concerns, correct misaligned financial incentives and allow for data exchange among providers have been employed at the state level. As always, states, the federal government and other health care stakeholders have much to learn from these initiatives. Project HITCh has played a key role in cataloging and disseminating these efforts.

In the coming years, states will continue to push forward on health IT efforts as they seek to reform health care. Many states see health IT as a key enabler to bending the cost curve and providing high-quality care.
APPENDIX A. SUMMARY OF PROJECT HITCh PHASE II ACTIVITIES

Project HITCh Meetings

Five meetings of Project HITCh were held during Phase II. The meetings provided a chance for partners and legislators to learn from experts in the field and network with one another. Sessions are planned by the partners and the legislative leaders of HITCh. A short description of each session is below. For more information on the sessions or to download the presentations, please go to http://www.ncsl.org/programs/health/forum/hitch/Past_HITCh_meetings.htm.

HITCh at Fall Forum (Atlanta, Ga., Dec. 12, 2008)
This session focused on how rural areas can leverage health IT to address some of the unique challenges faced by their residents. The session featured Dale Alverson, University of New Mexico; Speranza Avram, Speranza Avram and Associates; and Neal Neuberger, Institute for e-Health Policy.

HITCh at Legislative Summit (New Orleans, La., July 24, 2008)
HITCh put on two sessions at NCSL's 2008 Legislative Summit. The first was an Issue Forum (the term used to identify NCSL's large concurrent sessions) that focused on the implications for states of the entrance of tech-savvy players such as Microsoft and Google to health care. The session featured Matthew Holt, The Health Care Blog, and Brian Russon, Microsoft Corporation.

The second session brought together experts from three of the leading health IT projects focused on state efforts. The session featured Julia Costich, University Kentucky; Lynn Dierker, FORE/AHIMA; and Alan Levine, secretary, Louisiana Department of Health and Hospitals.

HITCh at Health Chairs (Washington, D.C., June 18, 2008)
Project HITCh sponsored the welcome reception and dinner for the 2008 Health Chairs Meeting. Senator Richard Moore gave an overview of the important work of Project HITCh and the Project Partners introduced themselves.

HITCh at Spring Forum (Washington, D.C., April 24, 2008)
The session focused on state and federal leadership around health information technology. Representatives from Minnesota described the state's 2015 EHR mandate. The National Coordinator for Health IT gave HITCh members an update on federal efforts to advance e-health. The session featured Dr. Robert Kolodner, national coordinator, Office of the National Coordinator for Health IT; Representative Paul Thissen; and James Golden, director, Minnesota Department of Health.

HITCh at the 2008 HIMSS Annual Conference (Orland, Fla., Feb. 26, 2008)
This session focused on the role states can play in helping to advance health IT. A Florida official described their financing efforts and e-prescribing pilot program in Medicaid. State lawmakers heard what they can do to address consumer concerns about data breaches. The session featured Christopher B. Sullivan, Florida Agency for Health Care Administration; Senator Bob Hagedorn; and Lory Wood, Good Health Network Inc.
Legislative Tracking

NCSL does extensive tracking of health IT legislation. In 2008, NCSL redesigned its legislative tracking portal into a searchable database that has increased the usefulness and accessibility of the data to end users. Legislation can be searched based on various categories including; topic, status and a keyword search of NCSL prepared bill summaries. This new resource has met with wide praise from users. NCSL updates the legislative database monthly. It includes enacted legislation from 2007 and 2008 and introduced legislation from 2008. 

Publications

Health Information Technology 2007 and 2008 State Legislation
This report, focused on enacted state health IT legislation from 2007 and 2008, identifies and analyzes five major policy trends—planning, targeted financing initiatives, privacy law updates, promoting health information exchange, and advancing adoption and use—in the enacted legislation. Appendices compare legislation from three states and summarize the enacted legislation in all states.

State Legislatures Article
State Legislatures magazine is NCSL’s premier publication and is sent to every legislator and legislative staff in the country. NCSL produced an article focused on state efforts to advance the use and adoption of health information technology tools with an emphasis on the policy directions taken in Minnesota and Texas. The article included a sidebar on the work of Project HITCH. In addition, an interview with Newt Gingrich, the former speaker of the U.S. House of Representatives and founder of the Center for Health Transformation, on health IT was included in the magazine. Both of these pieces elicited significant interest from NCSL members.

LegisBrief
NCSL created a very well received LegisBrief on e-prescribing. A large number of information requests from legislators were generated from it.

State Health Notes Articles
State Health Notes is NCSL’s premier health publication and provides an excellent forum to introduce a general legislative audience to the work of Project HITCh. A listing of health IT articles is below.

- Vermont Shows Providers the Money for Expanding HIT (Oct. 28, 2008)
Although health IT has been shown to provide cost savings to the health care system as a whole, providers are often left out, leaving them reluctant to adopt. Vermont hopes a new fund will help encourage their transition.

- Personal Health Data on the Net: States Address Privacy Concerns (June 9, 2008)
Through the lens of Google Health this article looks at how states are responding to privacy issues raised by personal health records.
• **E-Prescribing: Missives from the Front** (Feb. 4, 2008)
  Looks at states’ efforts to increase the use of e-prescribing.

• **Broadband to Boost Access, Quality in Rural Areas** (Jan. 22, 2008)
  Organizations in 42 states and three territories will get $417 million in federal grants. The money will enable clinics, universities and others to connect to broadband Internet access.

### NCSL Staff Presentations

NCSL staff made presentations to various groups over the year based on materials produced under Project HITCh. Staff members presented at the meetings of two HITCh Partners.

- National Committee on Vital and Health Statistics: **States in Action: Improving Health Through Information Technology** (Kory Mertz: Sept. 16, 2008)

- eHealth Initiative Policy Working Group: State Legislatures and Health Information Technology (Kory Mertz: Aug. 12, 2008)


- Blue Cross and Blue Shield Association 2008 Spring Health IT Workshop: States in Action: E-prescribing and Broader E-health Initiatives (Kory Mertz: June 12, 2008)

- HIMSS CALR Roundtable Training: State Legislatures and Health Information Technology (Kory Mertz: June 10, 2008)

- State Alliance for e-Health: **State Roles in Financing Health Information Technology** (Donna Folkemer: Feb. 22, 2008)
APPENDIX B. HITCh PARTNERS

**AARP**

[http://www.aarp.org/health/](http://www.aarp.org/health/)

AARP is a nonprofit, nonpartisan membership organization for people age 50 and over. AARP is dedicated to enhancing quality of life for all as we age. We lead positive social change and deliver value to members through information, advocacy and service.

Personal computers, mobile communication, DVD players – new technologies are changing the ways people conduct virtually every aspect of their lives. With an aging population creating new challenges and opportunities for societies, many leaders in business, government and non-profits are beginning to focus on how these same life-changing technologies can play a role in transforming and improving the aging experience.

Active in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP celebrates the attitude that age is just a number and life is what you make it.

**Blue Cross and Blue Shield Association**


The Blue Cross and Blue Shield Association is a national federation of 39 independent, community-based, and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for more than 102 million individuals - one-in-three Americans. BCBSA is committed to advancing interoperable health information technology to improve the safety, quality, and affordability of healthcare nationwide. Working with providers, the government, and consumers, Blue Plans across the country are spearheading innovations in health information technology. A growing number offer electronic patient health records based primarily on claims information -- prescriptions filled, hospital admissions, doctor visits, and more -- that help consumers and providers make better informed healthcare decisions. Many Blue Plans are collaborating with other stakeholders in their communities to develop state and regional health information exchanges. Blue Cross and Blue Shield companies have also been among the first to establish successful electronic prescribing and medication management programs. E-prescribing saves time for physicians and patients while helping prevent harmful drug events and lapses in necessary care. BCBSA supports continued collaboration by all public and private stakeholders to develop standards that will drive further innovation and adoption of interoperable health information technology.

**Electronic Data Systems Corporation (EDS) an HP Company**


EDS’ suite of services for Health Information Exchanges and Electronic Health Records (EHRs) helps optimize patient safety and efficiency across the healthcare continuum. It ensures that verifiable health information is accessible to enable decision-making at the point of care. The Care Network Solution offered by EDS, an HP company, meets each client’s unique needs while underpinning compelling health informatics and outcomes. Concerns about consumersafety, healthcareaffordability,changingdemographics,publicwellness and quality of care are driving healthcare transformation. Availability of and access to complete
medical histories is fundamental to appropriate clinical and economic decisions. Governments need better data for analysis to optimize care programs and administration. All depend on solid primary care relationships, aggressive public health interventions and timely access to accurate information.

EDS’ interoperable Care Network Solution helps close the healthcare information gap among clinicians, payers, administrators and consumers. It contributes to controlling the spiraling costs and risks inherent in paper-based, information-intensive approaches. This flexible, standards-based set of services combines relevant information about an individual’s health, treatment, medications and demographics from many wide-ranging data sources to promote collaborative care. And it offers the metrics necessary to model greater wellness outcomes and enhance public health, including assistance for rapid disaster response and bio-surveillance.

**Healthcare Information and Management Systems Society (HIMSS)**
http://www.himss.org/ASP/index.asp

The Healthcare Information and Management Systems Society (HIMSS) is the healthcare industry’s membership organization exclusively focused on providing global leadership for the optimal use of healthcare information technology (IT) and management systems for the betterment of health care. Founded in 1961 with offices in Chicago, Washington D.C., Brussels, and other locations across the United States and Europe. HIMSS represents more than 20,000 individual members and over 300 corporate members that collectively represent organizations employing millions of people. HIMSS frames and leads healthcare public policy and industry practices through its advocacy, educational and professional development initiatives designed to promote information and management systems’ contributions to ensuring quality patient care.

**Johnson & Johnson**
http://www.jnj.com/

Johnson & Johnson, through its operating companies, is the world’s most comprehensive and broadly based manufacturer of health care products, as well as a provider of related services, for the consumer, pharmaceutical, and medical devices and diagnostics markets. The more than 250 Johnson & Johnson operating companies employ approximately 119,000 men and women in 57 countries and sell products throughout the world. The fundamental objective of Johnson & Johnson is to provide scientifically sound, high quality products and services to help heal, cure disease and improve the quality of life. This is a goal that began with the Company’s founding in 1886.

**MAXIMUS**
http://www.maximus.com/corporate/pages/

The diverse services and products that MAXIMUS offers may be categorized into three groups: Government Program Management and Operations, Consulting, and Systems. Government Program Management and Operations focuses on having a measurable impact on the lives of the citizens we help government serve. The insights of MAXIMUS Consulting, and the technological innovations advanced through Systems, help government gain program efficiencies and pursue improvements that in turn benefit citizens.
MAXIMUS is proud that our 5,500 employees, located in more than 280 offices, devote their energies and careers to government service. Our focus on helping government distinguishes MAXIMUS from our competitors.

**Quest Diagnostics**

http://www.questdiagnostics.com/

Quest Diagnostics is the nation's leading provider of diagnostic testing, information and services with more than 35 laboratories and over 2,000 patient service centers across the United States. Each day Quest Diagnostics performs diagnostic testing on more than 500,000 patients – over 140 million service encounters annually. The majority of these order and result transactions are processed via secure electronic exchange, such as our MedPlus Care360 Physician portal, hub and bridge services to EMR vendors, or direct interfaces to customers' electronic health records or practice management systems. We are an active participant in HIT standards organizations and advanced connectivity projects across the country. With our industry-leading MedPlus applications and our national reach in the provider community, we are on the leading edge of interoperability and have a vital interest in HIT developments at the state and Federal level.
APPENDIX C. HITCh STEERING COMMITTEE

Co-Chairs
Senator Judy Lee, ND
Senator Richard Moore, MA

Staff Chair
Joe Flores, Legislative Fiscal Analyst, VA

Legislative Members
Senator Linda Berglin, MN
Representative Shay Schual-Berke, WA
Senator Joe Brannigan, ME
Senator Allen M. Christensen UT
Assemblyman Herbert Conaway, NJ
Representative Dianne DeLisi, TX
Senator Julie Denton, KY
House Minority Leader Craig DeRoche, MI
Senator Gary Dillon, IN
Delegate John Doyle, WV
Senator Robert Garagiola, MD
Assemblymember Susan Gerhardt, NV
Representative Josh Green, HI
Senator Kemp Hannon, NY
Senator Bob Hagedorn, CO
Representative Gayle Harrel, FL
Senator Margaret Rose Henry DE
Representative Jerry Iekel, WY
Senator David Ige, HI
Representative Earl Jones, NC
Representative Pam Maier, DE
Delegate Shane Pendergrass, MD
Representative Peggy Sayers, CT
Senator Jeffrey Schoenberg, IL
Senator Renee S. Unterman, GA
Representative Linda Upmeyer, IA

Staff Members
Mark Andrews, Policy Analyst, UT
Barbara Baker, Legislative Committee Analyst, KY
Marie Ganim, Senate Health Policy Director, RI
Stacey Hettiger, Policy Analyst, MI
Jim Hester, Director Vermont Health Care Reform Commission, VT
Wes Keller, Legislative Assistant, AK
David Knutson, Senior Research Analyst, WA
Sara McCarthy, Senate Office of Research, CA
Richard Sweet, Senior Staff Attorney, WI
Brian Tabor, House Democrat Policy Director, IN

NCSL Staff
Donna Folkemer
Kory Mertz
Joy Johnson Wilson
NOTES

1. The electronic health record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery system. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician’s workflow. The EHR has the ability to generate a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface—including evidence-based decision support, quality management and outcome reporting. HIMSS http://www.himss.org/ASP/topics_ehr.asp


During the past two years, state policymakers have actively been engaging the policy issues surrounding health IT. A plethora of approaches to address privacy concerns, correct misaligned financial incentives and allow for data exchange among providers have been employed at the state level. *Health Information Technology and States A Project Report from NCSL’s Health Information Technology Champions* identifies and analyzes key trends in state health IT policy.

The findings are based on work undertaken by NCSL’s Health Information Technology Champions Project. The project brings together a highly respected public-private group of state legislative leaders and private sector partners. During the past two and one-half years, HITCh has engaged key state policymakers and has contributed to the great rise in interest and activity around health IT at the state level.