

**TESTIMONY BEFORE THE INTERIM
HUMAN SERVICES COMMITTEE
BEHAVIORAL HEALTH ELECTRONIC HEALTH RECORDS
AUGUST 28, 2014**

Mr. Chairman, members of the committee, I am Lynette Dickson, the Chair of the Health Information Technology Advisory Committee (HITAC). I am providing information regarding the usage of electronic health records in North Dakota, including the potential use of electronic health record systems to facilitate a behavioral health repository.

Use of Electronic Health Records in North Dakota

Attached is a summary of the status of electronic health record systems in North Dakota. Slide 1 provides an overview of primary care providers and critical access hospitals in North Dakota for those providers that are utilizing REACH services. REACH is a nonprofit federal Health Information Technology Regional Extension Center. They help providers in clinics, small hospitals, and other settings in North Dakota and Minnesota implement and effectively use electronic health records.

The summary indicates that about 45 to 50 percent of providers signed up for REACH services have met milestone 3. Milestone 3 indicates that a provider has signed a service level agreement with REACH, has a certified EHR with e-prescribing and quality reporting, and has met stage 1 meaningful use requirements.

Slide 2 is based on surveys completed by the Center for Rural Health for the HITAC and indicates the usage of live EHR's by various providers. As you can see, from 2008 to the 2015 prediction, there has been a major increase in EHR systems

utilization. This can be attributed to the providers' willingness to invest in EHR technologies and the health IT revolving loan program funded by the Legislature. As of today, we have approved loans to 25 providers totaling \$12.3 million dollars. These are loans payable with 1% interest over ten years.

Slide 3 and 4 are indications of maturity of EHR systems nationwide (slide 3) and in North Dakota (Slide 4) based upon HIMSS Analytics EMR Adoption Model. Stage 0 represents no system installed and stage 7 is a complete system, with each step in between representing more functionality. North Dakota has hospitals ranging from stage 0 to stage 6, with the majority of the large providers at stage 6. On the ambulatory provider side, we have several large providers at stage 6 and 7.

Finally, slide 5 shows the usage of e prescribing in our state based upon Surescripts data. In 2010, North Dakota ranked 47th in e-prescribing activity and in 2013, we ranked 15th. Additionally, in 2012, over 98% of physicians in North Dakota have embraced electronic prescription routing.

Use of an EHR System to Facilitate a Behavioral Health Repository

EHR systems can facilitate a behavioral health repository. A prime example is the North Dakota Immunization Information System (NDIIS). Providers enter information into their respective EHR system for each immunization provided at their facility. Once they have entered the data, the EHR system sends an HL7 (Health Language 7) transaction through the North Dakota Health Information Network (NDHIN) and populates the NDIIS registry. Additionally, the EHR system can query the NDIIS to determine if an immunization is due through its forecaster

module. After the query is complete, the EHR system displays the information created through the forecaster module.

The same can also be true for behavioral health provider EHR systems. However, I have a few words of caution, unless all behavioral health providers utilize the same instance (same databases) of an EHR system, having an EHR system does not create a repository. Separate EHR systems simply create silos of information. There has to be a method to consolidate the data from disparate behavioral health EHR systems. The NDHIN can be the interface between the EHR and the behavioral health repository.

Additionally, the EHR system must capture the information that is required in the repository. For example, name, date of birth, address, diagnosis, etc. are common fields in an EHR system; however, other things, such as work history, may not be. If the information is not collected, or not a mandatory field to be collected, the information may be incomplete or not useful in the repository. To ensure that the information is available, the data required in the repository will have to be compared to the data fields in each EHR system.

Finally, if the repository is not mandatory, the EHR system has to have a way to flag and not send the information to the repository. Currently, most EHR systems do not have this option. Thus, it is easier to complete these tasks if reporting is mandatory. If it is determined that reporting to the repository is optional, the easiest way to handle that is to send the information and have the individual opt out of displaying/sharing the information that is collected.

Your next agenda item includes testimony from Lisa Feldner, who is going to talk about the North Dakota Data Hub; this hub is a prime example of a process that could be put in place to capture the data that you are looking for in a data repository. When completed, this system could pull information from various sources to populate a behavioral health data repository that meets the needs of stakeholders.

Thank you for the opportunity to provide you with this information, if you have any questions, please do not hesitate to let me know.

REACH #'s

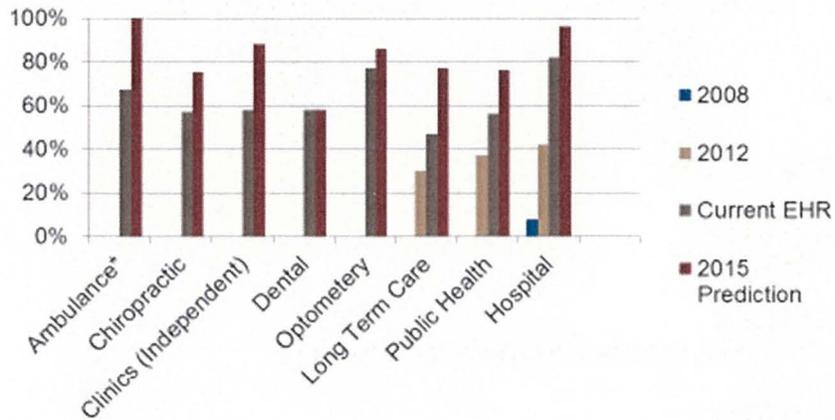
Milestone	Priority Primary Care Providers		Critical Access Hospitals	
	Goal	Actual	Goal	Actual
Milestone 1 (Service Level Agreement)	325	521	36	33
Milestone 2 Certified EHR, e-RX, Quality Reporting	325	425	36	29
Milestone 3 Stage 1 Meaningful Use	324	237	36	17

July 2014



Electronic Health Records

Reported Live EHRs as of February 2014



* Patient care record



Slide 3

Data from HIMSS Analytics – US Statistics

United States EMR Adoption Model **				
Stage	Cumulative Capabilities	2013 Q4	2014 Q1	2014 Q2
Stage 7	Complete EMR, CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP	2.9%	3.1%	3.2%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	12.5%	13.3%	15.0%
Stage 5	Closed loop medication administration	22.0%	24.2%	27.5%
Stage 4	CPOE, Clinical Decision Support (clinical protocols)	15.5%	15.7%	15.3%
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	30.3%	27.7%	25.4%
Stage 2	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging, HE capable	7.6%	7.2%	5.9%
Stage 1	Ancillaries - Lab, Rad, Pharmacy - All Installed	3.3%	3.2%	2.8%
Stage 0	All Three Ancillaries Not Installed	5.8%	5.6%	4.9%
Data from HIMSS Analytics® Database ©2012		N = 5458	N = 5449	N=5447
PLEASE NOTE: These graphics are an abbreviated version of the HIMSS Analytics EMR Adoption Model http://www.himssanalytics.org/emram/scoreTrends.aspx				



Slide 4

North Dakota Data –

Source – HIMSS Analytics
<http://www.himssanalytics.org/emram/scoreTrends.aspx>

	First Quarter 2014	Second Quarter 2014
• Mean	2.9468	3.0499
• Minimum	0.0100	0.0100
• Maximum	6.0710	6.0710
• Median	3.4540	3.4700
• # of Hospitals	45	45
• Ambulatory at State 7		
• Essentia Health		
• Hospitals at Stage 6		
• Altru Health Systems, Essentia, Sanford Health & Trinity Health		
• Ambulatory at Stage 6		
• Altru Health Systems		



E-Prescribing

Physicians Embraced Electronic Prescription Routing in 2012

Adoption of E-Prescribing >90% in Five States

STATE	PHYSICIAN ADOPTION: % E-PRESCRIBING
North Dakota	98%
Minnesota	95%
Massachusetts	94%
Iowa	94%
New Hampshire	92%

- ND Ranks 6th in 2013 E-Prescribing Activity (Surescripts Ranking)
 - 15th in 2012
 - 18th in 2011
 - 47th in 2010

2013 Primary Mode for Pharmacies to Receive Prescriptions

- E-Prescribing

2012 Primary Mode for Pharmacies to Receive Prescriptions

- Phone
- Fax

