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Okay. Thank, very much. I am Denise Dougherty, the senior advisor at the Agency for Healthcare Research and Quality. Today, we have some very exciting presentations from some highly experienced and active people in HIT, improving quality and health care. First, we will have [a presentation on] improving children's health from Cheryl Austein-Casnoff. She is the Associate Administrator for Health Information Technology, Health Resources and Services Administration, U.S. Department of Health and Human Services. Then, we will have a presentation on foster care Health Passport, a program in Texas presented by Yvonne Sanchez. I will be moderating the Q&A session and doing the closing remarks.

Just before we begin, please note that all of the participants were muted as they joined the webinar. If you choose to be off mute, comment to the raise-hand option. Please send your question to all panelists through the chat. At the end there will be a Q&A period. Please e-mail Nicole nknops@rti.org if you [would] like a copy of today's presentation slides. We are in the process of posting all of the slides to the website. That is <http://healthit.ahrq.gov/medicaid-schip>. Thank you. I am just getting the hand that I need to do the page down. Sorry.

The next thing, if you would like more information about these webinars and what is happening with the date for CHIP program, you can subscribe to the AHRQ CHIP listserv. Those of you on the webinar can click on this page to subscribe to the listserv or follow the instructions below: send an e-mail message *subscribe* and in the body of the message, type *sub Medicaid-ship* with your full name. You can e-mail Nicole to get a copy of these slides if you do not want to take the time to do it now.

I would like to introduce Cheryl Austein-Casnoff, who is Associate Administrator for Health Information Technology, Health Resources and Services Administration, U.S. Department of Health and Human Services. She has a great history of working on HIT and children's issues, during which she improved the health care for children. Cheryl was previously the Director of the State Children's Health Insurance Program (SCHIP) at the Centers for Medicare and Medicaid Services (CMS), [which provided] insurance for low-income children. She was also responsible for designing and implementing SCHIP in 1997. Prior to coming to CMS, Cheryl was the Director for Public Health Policy in the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and a budget analyst in the Office of the Assistant Secretary for Management and Budget. She also served as a member of the President's Task Force for Health Care Reform. She was selected as a senior legislative fellow for health policy and served in the Office of Senator Dave Durenberger. Cheryl received her master's of Public Health in Health Services Administration from Yale Medical School, Department of Epidemiology and Public Health, and her bachelor of arts in Biological Sciences from Northwestern University. Cheryl, would you like to begin?

Thank you, Denise and hello, everybody. I will talk about how HIT can promote the health and well-being of children. As you know, HIT, like we like to say, is hot and everyone is talking about it. Very few people are talking about it for children and with all of your expertise in children and the challenges you face, hopefully, you will appreciate the kind of things we will talk about today. Children are not little adults when it comes to HIT. We know there are some complicated issues and not all electronic records have been built with children in mind. I think the HITECH Act for the first time recognizes the role of the pediatricians with the payment issues. Hopefully, through the kind of efforts we are doing today, children are becoming part of the HIT agenda. I am on speaker. Is that okay? Can everybody hear? I will move through this pretty quickly.

Basically, I will talk about why HIT is important to children and the programs that serve them, and Medicaid and CHIP are the top of that list. We know there are some unique challenges when it comes to HIT with children. I want to talk about concrete tools we are using to promote the adoption of HIT for programs that serve children and also for families. That is an important part of this: when you talk about children with special health care needs who have the parents walk around with file boxes full of records and you talk to families like that about HIT. [It is] disappointing and exciting about how this [HIT] can empower those families. We will also talk about adolescents; that has been such a huge challenge in adolescent health care. If you think about any adolescent that is not HIT-savvy—I do not know if there are any more—there are some great opportunities to reach out to adolescents. I did a presentation about oral health, and [I have] included the slides today is because many of you are familiar with the tragic case we had in Maryland where children died because they were not able to get dental care. The whole relationship between pediatric, primary care and oral health care for children is so, so important. Again, HIT is a wonderful tool to help facilitate that.

So, I start with the slides. In a lot of ways if children are more advanced than most of us are. We have to stop thinking about the 20th century and need to think about the 21st century child. These kids are connected to the technology and we need to make sure that technology can connect these kids to the myriad of programs that are available to serve them. If you think about the power that can come from sharing information across systems and while, today, I am discussing health care, this is not just about health care. This is about social services because there was a terrible tragedy in DC where a mother and four daughters [were] found dead in her house; the follow-up is that the District found that 20 different programs were providing services to one or more of those girls but never connected the dots. When you begin to see the power of connecting information, we really can make a difference in children's lives.

Why is HIT important for children? It can have a substantial impact on quality and efficiency of healthcare. EHRs can provide families with the data about their children's health and help those families track their children's health and development. And, also, as we begin to talk about adolescents, it empowers them as well. There are personal health records that enhance the partnership between the family and health care providers, promoting self-care, enhancing family decision making regarding the health of the

children and adolescents. There is key information when it comes from children being away from home or during disasters.

Again, you talk to families [who] walk around with records in the event that there is an emergency when the child is away from home. My very first week of work was the week after Katrina, and we remember that people all over the country were trying to help them normalize their lives. The problem was they had no immunization records or records about the school health activities and, as a result, the children were facing great barriers after all of the tragedy they faced in terms of being able to enroll and get acclimated into the school. Now, children with special health care needs, as I keep bringing up, certainly receive services in multiple, multiple sectors. We need to make sure that that all information is being shared. This provides the opportunity, even for things like teenage mothers who might have a premature baby, making sure that the social service system that is following them is in touch with the health care system.

After my presentation you will hear about very exciting thing going on in Texas in terms of foster care. Certainly having Medicaid programs, since we know such a large portion of children born in this country are either covered by Medicaid or CHIP, making sure that Medicaid and CHIP become major players in this; and the CHIP reauthorization began to recognize this. Like I said, there are challenges. I will reference, quite often, the pediatric supplement that Denise was instrumental in producing. Unfortunately, if you are not a member, you cannot get it, but as I understand it, there are copies released since then and, perhaps Denise can help with that if people need it later on.

We know there are special challenges around HIT and children. They include lab testing and vital signs and growth parameters. These are not necessarily things that you'd find in an adult record. There was a great deal of frustration among pediatricians because the record systems that did not necessarily have the kind of tools they needed to do basic pediatrics. There is also an issue around drug usage and growth charts and things like that. Many of you have [heard about] the tragedy [involving] Dennis Quaid where his newborn infants were given adult doses of heparin. The potential to improve the care through HIT, particularly child dosage, is critical and the systems have to be designed to accommodate that. I speak personally: my brother is a general [practice] pediatrician who does not have electronic records.

I am very sensitive to this issue. Mostly, I represent community help centers. Pediatricians are very similar. They do not have the economic margin to invest in HIT. Pediatrics, in general, has lagged behind other specialties. We know there have been barriers, primarily caused by the lack of appropriate products. We know that small practices tend to be later in adopting electronic records and track records and those pediatrics are small practices. They have not had the kind of functionality. Data in 2005 [showed] that about 14% of general pediatricians were using EHRs--pediatrics certainly lags behind. One of the good pieces of news was that the Certification Commission (that until recently was the gold standard for electronic records) did recognize that there was a need for child health products and have developed that and have a special Child Health Working Group. It was not actually recognized in the HITECH Recovery Act. It is not

clear what the form will be for certification and whether CCHIT will be that certification body.

I do not like to leave out PHRs—the real empowerment to children and the families. There are some very challenging aspects [of] PHRs. I just visited New York City that is very advanced and have personal health records and for all of their clients, but not allowing it for anyone under 18 because they are not sure when do parents see the personal health records and the child, when should the adolescent only see it. There are a lot of issues, and we will talk a little bit about the privacy issues. Sara Rosenbaum, who some of you might note from George Washington [University], is not real expert in this area and has written on couple of special pieces in the pediatric supplements. I will not go through these in great detail, but HIPAA, which is the driving force, considers minor children to have special protection, but it also expects that parents and guardians of the state acting in the role of parent might make decisions on behalf of the child. While sharing information might be in the best interest of the child, there are a lot of protections about sharing that information; this because sometimes they are rumors of protections and sometimes are fact. Certainly one of the biggest challenges to sharing information, and particularly [at] the state level, is a perception that this kind of sharing is not legal. There are times when minor children can see their own records. In general, HIPAA refers to state law with privacy. In general, the parents are presumed to have access to that information. We know that there are health agencies, schools, social service agencies, and other organizations, and how the impression can be shared with those groups or information from those groups can go into the record are all challenges. As I have [referenced] several times, there are challenges about adolescents and who will have access to those records? That will be different by state. We also certainly know that all records have to have multiple levels of security, and that the kinds of information and permission to get that information will be different by age and state. It is challenging and not logical for our health center to say to get this right and come back and deal with the child and adolescent issues. Then, we have foster care that you will hear about and different treatment and other issues too in terms of sexual information and other kind of mental health information. Some lessons from this is that [it] is complicated, but not something that should stand in the way from making sure that everybody has access to their [information] because this just gives us more about the emancipated adults. Another exciting aspect of health IT is that this is a way to simplify applications and sharing information.

I will go through a little bit and show some of the things that the states are doing and this is so, so important in the CHIP reauthorization. Oklahoma is doing some online enrolling. South Carolina is using data to outreach to uninsured children using emergency rooms. Florida is trying to link some of the information about insurance and food stamps. Since I have been involved with CHIP from Day 1, these are the challenges we have been talking about, but finally, with health IT, if they have a country told to do something. Another theme of CHIP, and something we have been working on for years, is HIT and quality, and how we use real-time data to make real-time identification of problems and make real-time changes to improve the quality. In Rhode Island, they have increased the

immunization rates, and in Wisconsin, they are trying to reduce the emergency room use and in Arkansas they are talking about EPSDC screening rates. In Hawaii, they are using HIT to provide feedback on EPSDC performance. Again, some of us have been doing this for a long time and, finally, I really view HIT as the first concrete tool we have in public health to achieve the kind of things we have been doing. In Indiana, they are doing a mental health tool. We have a health center in Virginia that is putting kiosks in every waiting room in a confidential area where the patient can take a self-screen [assessment] for depression, and before they sit down with a provider, the test has been done and if the information is put into the record and then can be shared between the providers and patients. CMS is making sure that that the patient uses their prescriptions, for example, with asthma, they fill the acute prescriptions or might skip one renewal. Now, all of that information can be in the record, and the provider and patient can see what is up for renewal and how often is being taken and be able to assess the effectiveness of the medication. I have talked about how HIT can be a powerful tool for children with special needs and, certainly, about foster care that you will hear about. [HIT can] reduce long-term residential placements, even help parents not have to take off from school, from work to help the child in school because some of this information is now electronically even available and help them manage their care. It really can empower the family. We have telemedicine as part of this and reach out to families that might not be able to get mental health assistance. Instead of the parent having to go to the school, take the child out of school and take the child to the primary care providers, much of this is being done through telehealth. It's just a very exciting opportunity, with HIT and disease management, in terms of helping the families understand what the challenges are and providing really good health promotion and disease prevention activities and helping with the coaching, weight management, things like that. Certainly, in terms of understanding the need for the program [to be] designed and redesigned as we move to health reform and CHIPRA, the expansion of HIT can help in understanding where we need to intervene and help us measure the impact of what we are doing. Certainly, all of you, I know, are doing some exciting things, and sharing that information across states is so important as a building block moving towards the future. There will be some very exciting years ahead of us, and [we] are very fortunate to have pistol with us because you are probably aware that CHIPRA recognize the first legislation how important HIT is in children. There are several provisions here that will help demonstrate the impact of electronic health records to improve pediatric health and chronic care conditions, as well as reducing health care costs. The second provision is what the record must show and the interoperable exchanges will be key. Since CHIPRA passed the Recovery Act, that will define meaningful use that many of you have heard about. Pediatricians are specifically named in the meaningful uses and ability for providers, for the first time to receive, not insignificant, financial incentives, to help them with adoption.

Now, let me talk a little bit about what we are doing here to help promote how HIT can help children. We are building a toolkit, adjutancy on this page, part of AHRQ the National Research Center. We did this in a Q&A format. There is already a tool kit up there of there that is specifically for primary-care providers on what is it, how do I do it? Now, we are building one specifically around kids. I will show you the general questions that we are going to be asking, and after the call, if any of you want to get in touch with

me, if you have any tools, specifically, that we [can add] to this, and if you have suggestions for other modules, we are working closely with foundations to help support that. So the first one is an introduction to children's health IT. [What] is nice about this model issue [is that you] do not have to read a 500-page document; if you read and go to the document, you want to get to the resources. The second one is developing the pediatric from the electronic medical record. The third one is building a medical home for children and how health IT can help support that. The next one is being supported by the award foundation, cross-sector coordination because we know that Head Start and foster care and homeless programs and code programs are only able to talk to each other in schools. This is how health IT can begin to do that. There are a few places. We are showcasing the Texas program as part of this. The fifth is enrollment and retention. This is being supported by the California endowment. Family members. We are working very closely with family voices that represent children with special health care needs to make sure this is a powerful tool for there needs. Quality is something near and dear to AHRQ's heart, and developing any tools there are, specifically, around kids and health IT and quality and other topics. We are hoping we can continue to build these. If you have any ideas or resources, this is all about tools to share with your colleagues. This is not about reading long documents because this is about getting in there and getting what you need. If you have any tools, please send them to Sophie Miller. We really want to make sure we utilize as much as there is out there and make [this information] available to your peers.

The last thing I want to talk about is oral health. While pediatrics are lagging behind, oral health is lagging even further behind. One of the exciting things about health centers is its one of the few facilities where oral health and primary care sit in the same facility. In those cases, we actually see interoperability across primary care and for oral health, particularly for children, that is so valuable in making sure that the dentist is aware of whatever medical conditions there are, and the primary care physician knows that the child is going to the dentist and actually knows that some of the follow-up is there as well. This all comes from, many of you know, Bert Edelstein. This is a powerful tool for informing parents, empowered all of the programs that asked about a child's oral health. They would have access to the record through the WIC and programs like that. Effectively, it sets up referrals, and part of what you see it in CHIPRA comes from the tragedy of Maryland, where the child was not able to find a pediatric dentist. I think there is increased attention. HIT is certainly going to help support that. We need to make sure that offices are linked and certain living to primary care, and it will improve, ultimately, the care that was delivered to the child. Electronic dental records have been slow, even slower than pediatric records. There is some increased interest because the two can say that dentists are very technology loving, in general. They will have less fear, hopefully, once the products are available. So, this is more about having to make sure that the medical homes are linked to the dental homes and promotes communication among all of the programs affecting children. And, definitely, improve the quality of pediatric dental care and definitely improve performance tracking and tracking that is linked to primary care and the oral health providers together is because these are some of the recommendations that came out of the [proposal to] extend the HIT to include pediatric health and make sure it is focused on children and even propose a pediatric-specific

demonstration and, definitely, working with the other programs that serve children. If so, this is my contact information. I look forward to conversations today. If you have any questions, do not hesitate to send me an e-mail. I will turn it back over to Denise. Thank you.

Thank you, Cheryl. We will have time for questions later. Right now, I would like to introduce Yvonne Sanchez, who is currently a Senior Health Policy Analyst with the Medicaid and CHIP Division of the Texas Health and Human Services Commission, where she is the project lead for the Foster Care Health Passport. She has 27 years of progressive experience in health and information technology (IT) management positions in local, state, and federal government. Prior to her last 3 years working in Texas state government, Ms. Sanchez worked for 14 years with the U.S. Government Accountability Office as an Assistant Director, leading program reviews of health IT issues. She has a Bachelor's of Science from the University of California at Davis and a Master's in Public Administration from Harvard University.

Are you ready to go?

I am. Thank you, Denise. Thank you.

You're welcome.

I think I am ready.

My role here is [to] present an example of an electronic health record for children, specifically to get our case, foster care, and give background in terms of how we started the project or where we started the project, an overview of the passport itself, and some lessons learned and benefits, as well as our current status. Some background. The idea for the Health Passport began in 2005, and the Texas legislature passed Senate Bill 6. It [is] for the development of a comprehensive Medical Service delivery model for [getting] the children in Texas in foster care. Some of the unique needs of the foster care kids [are] they have multiple placements changes, disjointed medical history because they are pulled from the home or around people, their medical information does not necessarily go with them, and a lack of coordinated access to medical and behavioral health. Part of it also mandates the development of an electronic health care system which became the Foster Health Care Passport. Develop [an] RFP, and the contract was given to Star Health. We are all under the umbrella. An overview of the Passport, like I said, it was initially begun in 2005, and the system became operational in April of 2008. That was when Star Health began operation. The system itself became available to the state staff, network health providers—the foster care. The system currently serves about 30,000 children statewide. It is a secure web-based health record. In our case, how we define electronic health record is an aggregated record [that] includes information from other sources. It provides access to authorized users according to their role. Providers are the only users who have a role that allows them to write to a child's record; all other users of the system only have use privileges. When the system went live, it was initially populated with 2 years of Medicaid and CHIP claims and pharmacy data. This accounted for about 60% of kids. Now, when a child is placed into foster care, there is an automatic

query that goes back and pulls the 2 years worth of history on that child. If they go out and back, there is another query. If [they] were still on Medicaid or if they were seen outside of foster care and taken back, that information comes back with them. The record is continuously building. The record also became available in electronic or printed forms to the child's legal guardian or to the child if [he or she is at] least 18 years of age or and [an] emancipated minor.

Features of the software display the demographic information, personal contact information, who their physicians are, case workers assigned to them, the foster parents, and any individual who plays a key [role] in that child's health care. It displays visits, medical visits for that child with the date of service, the diagnosis, [and] procedures performed. We can also pull in all medical medication claims [and] prescriptions that are filled. That comes from our pharmacy benefit. Immunizations. We can pull them [a] list of immunizations from our immunization registry and the date [when] lab tests have been performed. They have a contact, Qwest, that provide electronic lab results for any foster care children that have tests performed through their lab. We are working with our state health services to pull all of our lab results that are then in the state laboratory in Texas because they are all done by one lab. We are working to get this put into the system as well.

There are two components in the system that allow for a provider to write into the record, which is of vital signs and allergy. They have modules, and in field slides I have screens were you can see where providers can enter in vital signs, as well as entering in allergy [information]. The system does do a simple allergy and medication check. The system also allows us to collect information electronically. In Texas our program is the Texas Health Step. All of our forms are online. We also [scheduled] a good morning for dentists to perform dental services. And our behavioral health providers, they have an initial assessment form and monthly update form to complete. That is available online. Currently, as of April of this year to date, the average number of forms that are being completed per month is 1,300 that are entered online and about 1,058 are scanned in. We have a total of over 17,000 assessment forms already in the system. The data sources, our member's data regarding eligibility and the demographic, come from our Department of Eligibility broker. We get our claims data and encounter data from our claims administrator contract. We get other claims data, regarding vision and dental, from contractors [and] subcontractors to our managed care organization. Qwest provides lab results, and we add our own state lab to that and get immunization data from our immunization registry.

On this screen this is our portal to access the system. There [are] some materials. If people want more information, they can go to this site and pull up the training material. There are two screens. If you put in the identifying information for the child, it takes you to the sheet for the child. You get basic demographic information. You get any allergies that have been entered into the system, [this information] will be displayed, as well as any immunization [information]. This gives them [a] nice, quick glance of what is happening with the child. There is part of the overview model that is the recent activities screen, [which] gives a quick view of the last claims that are listed for that child, the

diagnosis, type of visit, and if you scroll over, you can get this information to find out more specifics about the provider [who] that child is seeing. You get medication [information]. On the left-hand side, you can see that there are other modules that give more detail in terms of what is available, the allergies [and] where you can see the medication claims. If you click on the date of service, it will expand the information that is available on the claim. This is where a provider can go in and enter on a form, the assessment information online, vital signs, display lab results, and disclaimers. Because it is not a complete record, we can tell providers and people who log on that this is incomplete based on claims, [so to] be careful in terms of the information in terms of how it is used. We have some statistics on patients in terms of who is using the system to date. In terms of staff, about 7,000—these are the child protective—service workers; behavioral health providers are those in red. They are fairly high users of the system. Foster parents and medical providers are averaging about 3,000 in terms of look ups. As you will note on this chart, we have to look at our dental and vision providers. You can see again, the DFPS staff are high the foster parents, although some of this information is a little bit misleading because there are a few, because up until recently, we had some of the case workers also. We fixed the problem, and most of that is now separate. We get a much cleaner count in terms of the usage by the foster parent; then the behavioral health providers and medical providers; dental providers are not really using the system much.

Lessons learned in terms of developing and growing out the system: what worked well for us, is initially communicating formally and informally with all of the stakeholders in the process. That included DFPS staff, Medicaid/CHIP, different IT/commission IT working with the contractors that have claims and with Superior Health Network. All of the internal stakeholders were involved early in the process, and [there was] a lot of support by executive management. They were very engaged, and we continuously updated them on the progress. That helps move things along. Another thing that moved along well was managing expectations throughout the process. Everybody wanted to add things to the system, and we kept saying this is a medical record and we are trying to display medical information and kept the scope to the original task. What also helped was that the system was being developed. Superior came in, and they displayed different screens so that people got an idea, made modifications on some, but did allow people to see what the system was going to look like when it became operational and what kind of information [they] would have access to. Managing expectation.

What can be improved? There were very few full-time staff dedicated to this. A number of us have other duties, as well. It was kind of tough. I think our next expansion would be to [ensure] the quality of the data coming from the Legacy system, especially eligibility. There were a lot of issues that had to be worked out regarding the eligibility data that was going through. Children were either not getting into the system or there were several entries of children in the system. More rigorous testing [will be conducted] to identify problems. In hindsight, if we would have done better testing, we would have uncovered issues earlier. That was not the case. Spending more time up front to determine what you're reporting requirements are because we had a transformation grant, there was not a lot of thought given to a lot of the different management needs. Once we started seeing the data available to us, it was easier. If we would have brought up front what kind of

data we needed and reporting we needed, it would have made it simpler than trying to scramble after the fact. Then, involving and external stakeholders early in the process [would have been good]. The system was already further along in the development process when we actually reached out to providers, and [we now] have [a] focus group. If we would have done that sooner, we would probably have been able to incorporate some of these suggestions. A lot of the discussion we had was very valuable, but [it] was too late to incorporate those changes into the system.

The expected benefits of the Health Passport [are] a reduction of duplication of services, monitoring of compliance in a number of areas, and enhanced preventive care for documentation. A case worker was able to avoid duplication of double services for a large family because she already made appointments and decided to check the Health Passport and found out they already have a dental visit [scheduled]. She canceled the appointment to avoid that visitation. A monitoring of compliance [example] is [that] a case worker was checking the Passport and noticed there was some noncompliance in terms of medication not being filled. She was able to go talk to the foster parent and get them [to] get the child back on the medication and following the treatment plans. Another expected benefit is data sharing amongst the providers. They have access now to the same information. They can intervene more quickly. One example is a child that had behavioral issues. They looked into the Passport and got the child's provider, physician, called that physician, and got the medical history on that child to properly treat the child and, therefore, prevented the breakdown. Also in a kinship placement for a child, the relative knew that the child was diabetic because that was all they knew. They did not know anything else because they could go into the Passport and find out about the child, the previous feedback, and get the medication dosage and get the child back on the medication much more quickly.

As I said, we did get Medicaid grants for the system and were awarded \$4 million to develop [it]. The grant paid for the initial development and the current enhancements we are working on, there are a few corrections. I talked about the separation of behavioral health. I am sorry, the DFPS staff, that is a fix that we were paying for. One of the things about the Passport is it cannot exchange data with anyone. We want to bring clinical data with our data providers that already have electronic medical records to help bring some continuity of care documents into the Health Passport to establish that exchange of data. As I mentioned earlier, we are working with our state laboratory to develop a data interface to bring in all of the laboratory results, newborn screening, and lead testing. We can bring all of those lab results into the system as well. We are evaluating the option. That is it. If you want additional information or have questions, this is my contact information.

Terrific. Thank you, very much, Yvonne. Right now, we will give you an opportunity to type your questions into the tab box. I do not see any questions yet. I might not be able to. This is Denise. If you wish to be off mute, to use the raise hand option to notify the host. So, Allison, we will do that first and then do the other announcements.

Yes. I am not seeing any questions coming in just yet. If you have questions, send them to all participants.

I have a question for Yvonne, that might be a strange question. Compared to the work you used to do, that would be for a government agency to review HIT activities, I suppose, of the federal government and now, you are actually down on the front line developing the systems, what are the differences and, what would you hope that other people would know—should know about creating the system that could help people like Cheryl and us at AHRQ think about how to support or how to provide incentives, how to provide technical assistance, those kind of things?

That is an interesting question. Well, I kind of dealt with, especially HHS, I got a lot of good exposure to how the federal government operated all of the different layers associated and who provides health care. It is a pretty expensive list, and when I got to the state level, although it served me well, I realize a lot of people do not know about the different programs and the different layers. The federal government has a 30-second explanation of where you are in the organization and what you do. It is different. There is so much that people do not realize how extensive they are.

Uh huh.

That helps put things in perspective to let people know what else is available.

Okay.

I also worked for L.A. County. That was a joke going from the county to the federal.

Did you have any questions for Yvonne, Cheryl, or vice versa.

Not at this point. Thank you.

We have a question from Randall that says, “Did you have legal restrictions on the use or sharing of data that had to be accommodated? If so, were you able to remove or had to [indiscernible] what could be contained in the Passports?”

It was not so much a legal restriction, but a concern from our end. In Texas, once the child enters foster care, can get access to the record. One of the changes we are still in the process of doing with the Passport. I mentioned the behavioral health providers can go in and do their initial and monthly assessment or the summary of that child health care treatment plan. Once a provider can get into the system, they can see it all. We are working to partition off the behavior of health formed. They will be able to see that they had treatment, but not view the form unless they are the provider or caseworker. The medical centers will no longer have access to that form. That was one. Right now, we have a lot of people asking for access to the system. We have different organizations and lawyers. I am not a foster care person, so I will mess this up. They all want access to the system. We have been resisting and are trying to figure out how we can give them that

and still maintain some privacy and control. That is something that we are grappling with right now. Once people find out it was available, a lot of people now want access to it. We are hesitant to give them that access this point. Did that answer the question?

Yes, it did. We have another question. Assuming that the dental providers rank a higher level of income with other physicians, what is the panel's thoughts with the adoption among these providers?

Well, I think that we all know there is a long history of dental providers not serving the populations that we talk about. So, I do not know if the problem is the lack of software, the lack of incentives, the lack of demand by patients? I think the dental providers that serve our populations often do not have the higher income levels. It is a combination of things. That is why I like to think about things from the focus of a population. If we think about a child and how all of these different providers can come together to better serve that child, then electronic dental records would be a key part of that. I think they have been behind in recognizing this adoption and the adoption side of it, the availability of products, they are not recognized all in the HITECH Act in terms of payment policy, I believe. So, I think there are barriers on both sides. I do not think there is an easy answer.

Are there any more questions? Allison, did you hear of any more?

No, I do not see any more in front of me. There was someone thanking Cheryl for response.

I had to put my phone on mute because my line was ringing. So, Cheryl, what do you think? This is Denise. How long do you think it will take, and Yvonne, too, to connect these different parts of the system? It is very impressive what Yvonne has been able to do with limited funding and a lot of the hard work to connect different providers in the health care system. We sometimes do not see themselves as connected to the health care system.

The challenges are, unfortunately, in every part of this. The pediatricians are very well adopters right now but we have state systems, for example, immunization registries or newborn screening programs that are not equipped to get the information into electronic records. It is kind of a "cart and horse" situation. You have all of the barriers that we talked about today about sharing information across the programs and challenges that are unique to mental health that are unique to reproductive health or adolescence class because the President has called for every American to have electronic records by 2011 and is a critical part of health reform. Congress spoke very aggressively with putting \$2 billion down to get this started and in addition, adding around \$17 million, estimated, to help create incentives for providers. I think part of what might move this, ultimately, is the demand of patients. You are starting to hear people say that I am going to that doctor because they have an electronic record and this other doctor does not have that. What does that say about that? Part of this will be the consumer base, as well. The most exciting opportunity is that Medicaid/CHIP agencies, if they start to speak out on this issue, will help move it along. In many states, they represent 50% of newborns. If each

could start with an electronic record in the hospital, they all have a birth record, immunizations and newborn genetic and hearing screenings, we have the beginnings of information for every child. I think it will take real partnership among all of the key players to make it happen.

Thank you. I think what Yvonne said about reducing duplication might be one of those things that help Medicaid/CHIP Directors to see that this has some implications for their budgets.

Just to echo Cheryl, for us it is the adoption rate. It is solo. The providers that do have it, the early adopters using these, they are motivated. I think because of the success we have had with the Health Passport, we have been able to reach out, even though we are all in the same enterprise, we have been reaching out to the state. Obviously, we work with our family protective services staff. We have been breaking through some of these barriers and getting people outraged. They have no problem working with or talking to us; we have to reach out to them so it has been very helpful from that standpoint. I think, also with the Recovery Act and incentive programs, we will break more down and get people to talk and ask questions. Beside the physician adoption, there is the learning curve, the state workers, educating them on the health IT.

Okay. Thank you.

Is there another question?

Yvonne. I assume she is typing. I can take you off so you can ask the question, if that would be easier. Melissa, you should be off of mute. If you want to ask your question, I also have it in front of me. Was the web tool developed to meet the HL7 Standards?

The web tool being the Health Passport?

Yes.

Not when it was originally developed. The lab is an HL7. The lab results come from Qwest or HL7 when we bring in the state lab results data that will be with standards, as well as the interoperability that we want in terms of bringing in the CCD's from the physicians' electronic medical record. Anything up to this point, we will be following. What was done initially, they are not following national standards.

Cheryl, would that be a problem in the future?

I am not a techie, unfortunately. We will have to have the system interoperable. Part of IT is creating I am calling plug-in solutions, systems that are not necessarily compatible, but plug in and would allow them to communicate with each other. They are in Texas right now looking some of their programs and how we can create and probability without changing the existing programs and languages.

We have had some sessions with the connect gateway on how we can do that. We are [at] a point. Hopefully, we will get passed the customize interfaces. Is this the kind of thing that the regional extension centers might help state programs with?

The regional centers are more geared towards individual practitioners. Certainly, this will be part of the effort, the overall effort, and there will also be grants for health information exchange.

Great. Well, if there are no more questions, maybe we can have the announcements and end the call early. Allison, is that okay?

Okay.

On the screen, there is a new community of practice, which is focusing on CHIP-only agencies. It is for health IT and health exchange leaders—stand-alone CHIP agencies. The meetings are taking place every month to month starting in August. The participants set the agenda and identify the priorities and topics for discussion. Here are some potential topics: designing and using health IT and quality improvement initiatives, exchanging health information [with] the public health agencies, CHIP provisions, and there are some demonstration projects that are required in the lot about promoting the use of HIT. It would be good to hear from people. If you are interested, Stephanie at skissam@rti.org. If you are not looking [at] a screen, raise your hand and we will send you that information to give it to others in your organization that are interested. There are a couple more, I think. Okay, yeah, the next is on the evaluation and immediately following the webinar an evaluation form will appear on your screen. Please, please send that back. It is important to get your feedback as we help improve future sessions to ensure that we provide the best possible assistance to you. If you do not have time to complete the evaluation immediately, please contact Nicole [at] nknops@rti.org. As always, thank you, very much for that. Please send your comments and recommendations to the project's e-mail address. Thank you, very much.

Thank you, again. I am going to post Nicole's e-mail address in the chat box and Stephanie's as well. That will come up there in just a second for anyone who was looking for a copy of the slide deck or for any questions or comments.

Great. Thank you, very much. Thank you for the support. It was great being part of this whole initiative. Thank you. Goodbye.

Thank you everyone.

[Event concluded]