

Below are questions from the July Webinar that were not answered due to the limited time.

Question: Is there a plan to integrate individual physicians, clinicians, dentists, etc. who may still rely on papers? How about get existing patient information on paper or in a non-standard systems into an EHR system?

Noam Arzt: We have no plans. The goal is to get as many physicians using CCHIT-certified EHR systems as possible (and that is the national goal as well!) and to get those systems to have interfaces to the HIE. For Vermont's Chronic Care Initiative (Blueprint), physicians who do not have EHR systems can use the DocSite web portal to view data, but it is only relevant to that project.

Jim Younkin: We have discussed a patient portal that would allow patients to upload their own documents to the exchange for a fee. Clinicians viewing this information would know those documents were provided by the patient, similar to what happens when a patient brings their info to a new doctor. This capability was included in a recent grant application. If funded we would begin development sometime next year. We could provide a similar tool for clinicians to enter scanned documents, but unless we're approached by clinicians willing to pay for such a service we do not plan to provide this capability.

Question: What were the most key Standards that these HIE's adopted? Are the standards mature enough at this point - I know they are evolving rapidly?

Noam Arzt: Core HL7 and IHE standards that HITSP constructs are based on are critical. For clinical documents, that's C32 (CCD) and related constructs. For message-based interfaces, it depends on the subject matter. You might check out the standards chapter of the Vermont Health Information Technology Plan at

<http://www.vitl.net/interior.php/pid/7>

Jim Younkin: Standard are mature enough to begin. I agree with Noam, use HITSP constructs based on HL7 and IHE, particularly HITSP C32 for exchanging Continuity of Care Documents.