

NH HIEPI Comment Tracker - Includes comments from Stakeholder Representative, Core Team members, and Steering Committee members							
#	Plan Section	Plan Page	Plan Paragraph	Stakeholder Comment	Response to stakeholder comment based upon discussions with workgroups and core team	Clarification (as needed)	Action taken in version 5? (Y/NA/Defer)
65		3		table of contents: add appendix C	Acknowledged - Make Correction		Y
	TOC	3		Do the sections have to match the FOA?		Plan sections are aligned with updated headings from ONC found at <a href="http://statehieresources.org/wp-content/uploads/2010/07/PIN-Comparison-Table-for-HTML_7-6_1419.htm">http://statehieresources.org/wp-content/uploads/2010/07/PIN-Comparison-Table-for-HTML_7-6_1419.htm</a>	Y
156					Stakeholder question requires answer		
157	TOC	3	5.1	Included twice	Acknowledged - Make Correction		Y
244	SP-1	3	3	Clarification/ wording is ambiguous: "the high degree of hospital ownership in the state" . Specify hospital ownership of physicians' practices.	Acknowledged - Recommend revision/addition		Y
38		4	Bullet Points	Perhaps this is inferred in the lengthy document but it is important to tie back the Goals and Approach to these items. Note the focus on consumer benefits: improvement of care, cost reduction, reduced duplication, etc. New Hampshire must achieve this for the benefit of consumers (customers). Customers and employers are hampered by escalating costs, reduced benefits, lack of access - all with root cause of inefficiency and ineffectiveness within medical processes.	Acknowledged - Recommend revision/addition		Y
111	Intro	4	4	Description of 6 workgroups including public health. Not sure that is factually correct as there were 5 workgroups - public health at least started out differently. Not sure it is a distinction with a difference, but it might be worth using a more careful description. As we all know, HIE public health use is not currently authorized under state law and some stakeholders are sensitive to that.	Acknowledged - Recommend revision/addition		Y
158	Intro	4	3	CMS Incentive Program for Meaningful Use delivered through the Centers for Medicare and Medicaid Services (CMS) provides sizable incentives - It's really the ARRA HITECH Incentives Program administered by CMS	Acknowledged - Recommend partial revision/addition	Language aligned - Since program is widely referred to as "Meaningful Use" or "MU" these terms are used as well.	Y
159	Intro	4	4	Health Information Exchange Planning and Implementation (HIEPI) <b>Planning</b> project.	Acknowledged - Make Correction		Y
300	Intro	4	3	There is no 'meaningful use program'. Something like this should replace the first three sentences of the paragraph "The program also brings near term value to New Hampshire's hospitals and those providers eligible under the Center for Medicare and Medicaid Services (CMS) incentive program for adoption and meaningful use of certified EHR systems established by ARRA. The requirements of the incentive program include the exchange of key clinical information that will be exchanged through the HIE: e-prescribing, lab results delivery, and care summary exchange."	Acknowledged - Recommend partial revision/addition	Language aligned - Since program is widely referred to as "Meaningful Use" or "MU" these terms are used as well.	Y
301	Intro	4	5	Should mention DHHS engaged UNH for this	Acknowledged - Make Correction		Y
131	SP-1	5	4	could some clarification be added on the Gap section regarding Outside of hospital networks? It reads as if ambulatory physicians outside of existing hospital networks do not have opportunity of HIE plan, when some actually do from such entities as CHAN.	Acknowledged - Recommend revision/addition		Y
160	Intro	5		Insert Executive summary before Strategic Plan.	Acknowledged - Recommend revision/addition		Y
245	SP-1	5	last	it states that eRX on the clinician side has "lagged behind" very high eRX on pharmacy side, yet on pages 13, 14 and 57 you state that 96% of providers on EHRs are capable of using eRx. Suggest that there be a clarification made on page 5 that the "lagging" is not due to EHR availability.	Acknowledged - Recommend revision/addition		Y
303	Strategic plan	5		There is no introduction to the strategic plan that lays out what the plan is. Jumping into the Scan first off is jarring.	Acknowledged - Recommend no change	There is an introduction on p. 4	NA
304	SP-1	5	1	In Intro to strategic plan should mention FQHCs as a strong point.	Acknowledged - Recommend revision/addition		Y
306	SP-1	5	3	Is there a reason for why ePrescribing has lagged (technology, policy, ??)?	Acknowledged - Recommend revision/addition	Text added to explain reasoning	Y
32		6	2 above Fig 1	Would mention 10 Community Mental Health Centers in addition to the HCCN and hospitals.	Acknowledged - Recommend revision/addition		Y
89	SP-1	6	last	The location of critical access hospitals is not depicted clearly in figure 2. Either create a different color "tail" to identify the critical access hospitals in the figure or eliminate the phrase "As depicted in the map below."	Acknowledged - Recommend no change	Agree that this detail would be nice to have but the graphic is borrowed with permission from NHHA and will be used as is.	NA
132	SP-1	6	1	Could you include community health centers as one of the entities for which there is some document exchange with the hospital?	Acknowledged - Recommend revision/addition		Y
305	Enviro Scan	6	3	Not sure if this is useful to include since not a factor in Incentive program anymore.	Acknowledged - Recommend no change	Recommend keeping information - it does inform the strategy recommendations	NA
307	Enviro Scan	6	5	Call them community health centers or rural health centers, not just health centers. Not sure why AHEC mentioned here.	Acknowledged - Recommend revision/addition		Y

23	SP-1	7		Figure 2 would be more helpful if it mapped large hospitals vs. critical access hospitals. As a minimum, specialty hospitals should be mentioned in the text if this map is used.	Acknowledged - Recommend no change	Agree that this detail would be nice to have but the graphic is borrowed with permission from NHHA and will be used as is.	NA
142		7	last - cont. to pg 9	the reference made "leaving just under 1500 clinicians.. Outside of the state's existing health exchange networks." - not clear about the reference "state's existing health exchange networks"??	Acknowledged - Recommend revision/addition	Clarify in text	Y
45	SP-1	8		Table 2 - Ambulatory practices vs ambulatory clinicians. In my opinion this is confusing and somewhat misleading; especially since the numbers appear to be contradictory. For example, 62% of practices do NOT have an EMR, yet the table shows that 57% of the clinicians DO have an EMR. This tells me that larger practices (i.e., with more clinicians) are automated but smaller practices are not. This isn't obvious and may need more explanation since it appears contradictory on the surface.	Acknowledged - Recommend partial revision/addition	Clarify in text	Y
308	Enviro Scan	8	4	Say 'Medicaid HIT Planning' not just Medicaid.	Acknowledged - Make Correction		Y
309	SP-1	8	2	Which HIT capabilities are you talking about here?	Acknowledged - Recommend no change	Defined within the paragraph	NA
112	SP-1	9	Table 3	The table describes current HIE transactions including several public health HIE transactions. We may want to insert a footnote explaining that to the extent public health transactions are being sent electronically the term HIE is a verb and not a noun.	Acknowledged - Recommend revision/addition	Change table heading	Y
310	SP-1	9	Table 3	What is meant by Quality Measures? We don't believe any are submitting to Medicaid. Perhaps change to just CMS as the Receiver?	Acknowledged - Recommend no change	This is a use case for the transmission of quality data to CMS and/or State Medicaid. This is a use case that we will want to look at in its current state and follow over time. Recommend that we keep Medicaid in the table as there is a good possibility that Medicaid will be included in these types of transactions in the future.	NA
312	SP-1	9	Table 3	Were any questions asked about Medicaid and other insurer's use of HIT for utilization management practices like prior authorization requests and replies? Is this something where HIE could play a role?	Stakeholder question requires answer	This capability was not assessed. The survey only looked at electronic eligibility checking and claims submission per ONC's PIN instructions. It is conceivable that the HIE could support administrative transactions such as prior authorizations given a change in NH law.	Y
316	SP-1	10	Table 4	Same comment about quality measures and Medicaid	Acknowledged - Recommend no change	This is a use case for the transmission of quality data to CMS and/or State Medicaid. This is a use case that we will want to look at in its current state and follow over time. Recommend that we keep Medicaid in the table as there is a good possibility that Medicaid will be included in these types of transactions in the future.	NA
246	SP-1	11	whole page	We aren't sure that the analysis of "greater need for community record" and "greater need for summary referrals from ambulatory physicians and clinics" is entirely appropriate at the individual hospital level - especially since only inpatient admissions is used for the data point. We believe that the graph is very misleading. It's probably sufficient to say that many handoffs occur between EDs, hospitals, and physicians and HIE would play a large role in supporting information sharing at critical junctures in patient care delivery. But, again, trying to tie individual hospital admissions data to the "spectrum" of HIE is not appropriate. Figure 3 should be removed.	Acknowledged - Recommend no change	Recommend not removing this information. This analysis gives evidence to show the diversity of information exchange needs among the hospital systems and points to the volume and types of handoffs. This information can inform our strategies with facts and is valuable.	NA
144		12	Last	This would be a good justification to add in the financial section - I.e. recognizing the large volume of transitions of care thus the value of HIE ...	Acknowledged - Recommend partial revision/addition	Use information to support value propositions where they appear.	Y
247	SP-1	12	whole page	same comments as above on page 11. In addition, it may be more appropriate to describe the types of exchange already occurring in hospitals, with physicians and other healthcare providers and how hand-off of information is already handled and how it could be enhanced. Figure 4 should be removed.	Acknowledged - Recommend partial revision/addition	Clarify in text - Recommend keeping exhibit as it provides valuable facts to inform strategies.	Y

248	SP-1	12	last	the figure of "260,000 transitions of care" is grossly underestimated since the report has only used inpatient discharges. We dare to say that figure is much higher when hand-offs between primary care, specialty care, LTC, home care and other healthcare providers are added. We suggest removing that 260,000 figure since it's misleading.	Acknowledged - Recommend revision/addition	New text - "Overall, this analysis reveals that hundreds of thousands of transitions of care occur annually among New Hampshire's hospitals, physicians, community health centers, clinics, home health services, skilled nursing facilities, and other providers or care settings."	Y
249	SP 1	12	3	Addition: While we do not have data on ambulatory-ambulatory handoffs, I believe there are significant numbers of these handoffs that would also benefit from exchange. Can we quantify these handoffs, or estimate/extrapolate based upon ambulatory visits in the all payer database?	Acknowledged - Defer to Future Discussion (After ONC submission)	Acknowledged in text that we do not have this data but will attempt this type of analysis post ONC submission using all claims database.	Defer
318	SP-1	12	3	Does any NH data on Medical error rates? Duplication of test rates? I think research nationally says this is a problem, but is there any data showing rates in NH? ONC might want to see something like this as a performance metric	Acknowledged - Defer to Future Discussion (After ONC submission)	Agree that this would be interesting to include. Recommend inclusion in future research efforts.	Defer
320	SP-1	12	3	How about adding reduction in readmission rates?	Acknowledged - Recommend revision/addition		Y
322	SP-1	13	1	Might want to explain who Surescripts is and why they are the source for data. This is the first mention of them and many readers will not have a clue who they are.	Acknowledged - Recommend partial revision/addition	"SureScripts" to be removed from exhibit heading. Though SureScripts is currently the dominant eRx service, we probably do not need to call out this single vendor in the plan and will stick to generic eRx language. Full source information is included in exhibit citing SureScripts as the data source.	Y
24	SP-1	14		Current gap 3 suggest approximately 3/4 of providers are not e-Prescribing. According to Figure 6, only 12% of doctors are routing prescriptions electronically. Isn't this more like 7/8 of doctors not doing this?	Acknowledged - Make Correction		Y
324	SP-1	14	Figure 6	Is there a number for the pharmacies with it activated?	Stakeholder question requires answer	Yes, it is in the exhibit. 244 at the end of 2009.	Y
326	SP-1	14		Same comment above about the reasons for poor eRx use by docs. Perhaps a mandate would help adoption?	Acknowledged - Defer to Future Discussion (After ONC submission)	A mandate is a viable option for future planning. Recommend deferring this to future discussion	Defer
25	SP-1	15		Should table 6 be labeled as cumulative?	Acknowledged - Make Correction		Y
33		15	Table 7	Shows # of facilities vs. # or % of transactions (like eRx data did); # of facilities kind of makes it sound as if the labs are "locked up".	Acknowledged - Recommend partial revision/addition	Recommend adding text to clarify.	Y
153	SP1	15	entire	A huge portion of labs are done by national labs, NOT hospitals. They are very adept at downloading into EHRs and their use is ENCOURAGED by the payors. To get buy-in of major payors, this should be considered	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
250	SP-1	15	table 6	Table 6 is not clearly laid out. It's not easily apparent that the figures are cumulative as you read down the hospital list. All that is needed to be said is that hospital generate the majority (over 90%) of the labs claims in New Hampshire. We suggest that the table is not necessary and to remove it.	Acknowledged - Recommend partial revision/addition	Update the table heading to clarify how it should be interpreted - recommend keeping the table as it provides fact base for environmental scan gaps and recommendations.	Y
133	SP-1	16	last	It should be noted why some providers are not utilizing electronic patient eligibility even though they have capability; there is a fee involved for this	Acknowledged - Recommend revision/addition		Y
311	Enviro Scan	16	2	It should be noted that this data only includes policies written in NH (so someone working in MA isn't counted in this).	Acknowledged - Recommend revision/addition	Clarify in text	Y
104	SP-1	17	1	I think the paragraph should note that outside of Manchester and Nashua, in the absence of local public health departments the local hospital systems generally are expected to fill a limited set of public health duties.	Acknowledged - Recommend revision/addition		Y
313	Enviro Scan	17	2	Drop mention of MU incentives. No longer part of program requirements.	Acknowledged - Recommend no change	The MU incentives, REC, State Level HIE, and Workforce Development programs are all closely linked and intended to work in tandem. Recommend cross-referencing these whenever there is cross-over between program interests.	NA
328	SP-1	17	1	Doesn't adequately describe structure as if the 2 city departments were independent of the state. Jose should comment on this.	Acknowledged - Recommend revision/addition	Jose Montero provided new text.	Y
1	SP-1	18		table not correct that Nashua and Manchester have no access to notifiable lab results as they do have access to the system (I believe this is what Dave said yesterday as well).	Acknowledged - Make Correction		Y
2	SP-1	18		1. first page table 1 - not correct that Nashua and Manchester have no access to notifiable lab results as they do have access to the system (I believe this is what Dave said yesterday as well).	Acknowledged - Make Correction		Y
3	SP-1	18		would take NHEDSS from syndromic surveillance and move it to notifiable conditions	Acknowledged - Make Correction		Y
4	SP-1	18		would add to syndromic STEMS, death database, school surveillance for absenteeism, ILI sentinel reporting and RODS. (If the purpose is to show the many ways in which information gets to PH just naming these without full explanation on each should be enough..	Acknowledged - Recommend partial revision/addition	All systems that are relevant to HIE added to plan	Y

5	SP-1	18		would add to notifiable conditions eHARS (reporting HIV) and Arbonet	Acknowledged - Recommend revision/addition		Y
6	SP-1	18		third page in the table would change #9 as the city PH departments do have access to NHEDSS.	Acknowledged - Make Correction		Y
26	SP-1	18		I think table 8 is misleading to suggest that since DHHS receives ED data, they count as receiving "100%" of syndromic surveillance information. ED data is only one of many possible sources of syndromic surveillance data.	Acknowledged - Make Correction		Y
314	Enviro Scan	18	6	NHEDSS should be in the next section, not in the Syndromic section.	Acknowledged - Make Correction		Y
7	SP-1	19		HELPSS is not yet in production. Delete all in the first sentence up to the dash and it will be correct.	Acknowledged - Make Correction		Y
66		19		This is confusing: "West Nile Virus Access database (West Nile) – Same as above for West Nile Virus." Is it the same as rabies?	Acknowledged - Make Correction		Y
317	Enviro Scan	19		Uniform Hospital Discharge Data Collection System should be mentioned here. Hospitals submit records of all discharges to the state's vendor electronically in a standard claim transaction format. This could be a good candidate for use of HIE.	Acknowledged - Recommend revision/addition	Contacted commenter to get content - Since 1985 DHHS has collected hospital discharge data under RSA 126:25. Data is currently collected from all acute care and specialty hospitals licensed under RSA 151; data from acute care facilities includes both inpatient (general and specialty) and outpatient discharges. Data from the hospital discharge data collection system is analyzed by DHHS staff to generate public health and health care statistics for use by DHHS, other state agencies, other interested organizations, and the public. Subject to confidentiality restrictions under RSA 126:28, He-C 1500, and HIPAA regulations, DHHS provides public use data sets without restriction and releases the extracts of the data set to other state agencies, researchers, and others wishing to perform their own analysis of the data. Data is submitted electronically by hospitals to DHHS's through secure transmission through the Internet.	Y
27	SP-1	20		The recommendation for current gap #7 sounds like there is no expense to creating and maintaining an immunization registry with HIE, but in truth, setting up HIE cannot be considered as being without expense.	Acknowledged - Make Correction	Remove language re. expense	Y
28	SP-1	20		Current gap 9 is somewhat misleading in assuming that sending Manchester and Nashua more data means they will be able to use it. The DHHS Health Statistics unit had agreements with Manchester in the past to make data available to them and they had little or no capacity to analyze it! Usually, Health Statistics did the analysis for them.	Acknowledged - Recommend further discussion		Defer
319	Enviro Scan	20		Not sure what the final bullet in #10 is trying to say. Why is this bad since many times identified data is needed.	Acknowledged - Recommend partial revision/addition	Clarify in text	Y
321	Enviro Scan	20	2	Shouldn't this be the most prominent gap?	Acknowledged - Recommend no change	The gaps are not prioritized.	NA
330	SP-1	20	2	Lack of collaborative HIE networks is the biggest issue. Should be front and center in SP-1	Acknowledged - Recommend no change	This is clearly presented in the strategies	NA
46	SP-1	21		First bullet refers to "the University's..." but I don't know what University is being referred to?	Acknowledged - Make Correction		Y
47	SP-1	21		Fourth bullet - refers to "ePrescribers in NH grew from 247 to 888", however, this data conflicts with the data in Figure 6 on page 14, which indicates that only 272 physicians are routing prescriptions electronically by the end of 2009. Or, is ePrescribers in this bullet referring to patients? It isn't clear.	Acknowledged - Make Correction	Remove bullet - defer to the current statistic from SureScripts that is in the table	Y
323	Enviro Scan	21	2	I thought HISPC was NGA funded.	Acknowledged - Make Correction	Remove "federal" from "received federal funding"	Y
325	Enviro Scan	21	10	Date is 2011. Add to end of sentence, "built with Medicaid Information Technology Architecture (MITA) principals"	Acknowledged - Make Correction		Y
145		22	1st bullet	change winter 2010 to winter 2009	Acknowledged - Make Correction		Y
327	Enviro Scan	22	4	Should be 'Beginning', Summer 2010 not 'During' for develop of Medicaid HIT plan. In last sentence replace 'meaningful use' with 'adoption and meaningful use of certified EHR.'	Acknowledged - Make Correction		Y
154		23		There is at least one other rural health network working toward a community HIE plan: Central NH Health Partnership	Acknowledged - Recommend revision/addition	Reached to commenter for text - text to be added when received	Defer

253	SP-1	23	#10	please define what is meant by "current systems".	Acknowledged - Recommend revision/addition	Change to "current public health reporting systems"	Y
329	Enviro Scan	23	2	Not sure bullet 6 needs to be in here now	Acknowledged - Recommend no change	Though this is one of the smaller gaps, it is still a gap and there is value in identifying it here.	NA
30	SP-2, SP-3	24		In the Vision Statement, item 1, it states that personal health information will be "accessed only with patient consent". Isn't it true in NH that patients have the right to prevent their personal health information from entering the system to begin with?	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
31	SP-2, SP-3	24		How is it a goal to have interstate exchange of electronic health information? Are other states expected to do the some work we hope to do, and are we planning to help other states accomplish this work? If we aren't going to help other states, how can it be our goal?	Acknowledged - Recommend no change	Grant requirement	NA
34		24		The 3 goals on p. 24 ring true. There is, however, zero mention of the consumer, their access to information, their control over information. It seems the consumer has a large role to play for overall healthcare transformation. It is addressed a bit on p. 26, but as a sub-bullet to a strategy (5), it seems like an afterthought.. This feels provider- vs. patient-centric. Not sure if that was the intent, or the composition of the representation, etc. If there was debate, it would be good to capture it somehow. You could say the same for the public health bullet on bottom of p.26. Public health was a key tenet of the 2008 ONC strategic plan and Brook, et al have done a solid of job of developing a plan and promoting it. It might also deserve its own Strategy number vs. being a sub-bullet.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Y
41		24	Goals	Proffer that these are not goals, but technology deliverables. We need consumer-centric goals and as previously mentioned, tie back to page 4. Goal 1 (Security) is not a goal, it is a requirement.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
67		24		Vision 1."Private and Secure. A patient's personal health information will be secure, private, and accessed only with patient consent or as otherwise authorized or required by law." This comment may not be relevant to this HIE plan context, but there is not consensus on this point, specifically about sharing patient information without consent when "authorized" by law. State statute pre-dating the HIPAA Privacy Rule requires consent, although the statute is now interpreted as defaulting to HIPAA.	Acknowledged - Recommend revision/addition	Acknowledge that consent policy and practice remains highly variable in the state and that there is a need to dedicate future planning efforts to clarifying this item.	Y
68		24		2014 goals--There should be a mention of allowing patient choice to participate in HIE. This is an important policy value because we believe that 1) individuals deserve this right, 2) state law provides for consent to sharing health information, and 3) individuals are likely to have more confidence in the system if it is voluntary.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
90	SP-2,SP-3	24	last	first line should read " ... care of <i>any</i> one of New Hampshire's citizens ..."	Acknowledged - Recommend revision/addition		Y
161	SP-2/3	24		Need to add goal for Medicaid	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
162	SP-2/3	24		Need to add goal for Public Health	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
163	SP-2/3	24		Need to add goal for Consumer / Patients	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer

164	SP-2/3	24		Goal 2 - is Full adoption too ambitious? What about other providers other than ambulatory - hospital in patient, end, etc.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
238	2014 Goals	24		Would prefer to avoid pronouns and use specific attribution for clarity.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
254	SP-2 SP-3	24	top of page	It's not clear to the hospital participants that the Citizen's Health Initiative vision and principles document was brought forward and adopted fully to represent the current 2010 project. Also, there is no mention that the NHHA visions and principles document was also shared with the workgroups.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Y
255	SP-2 SP-3	24	middle of page	We were unaware of the following action as stated in the middle of page 24 "the goals and strategies developed through the 2010 HIEPI project and presented below are built upon a concensus-based vision". We did not know that there was a goal of the year 2014 established. And, we have several comments about the goal #2 (see below)	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
331	Sp-2,3	24	1	Should explain who Citizens Health Initiative is	Acknowledged - Recommend revision/addition	Add text	Y
332	Sp-2,3	24	3	Should say that in the SLHIE process the vision statement didn't change if it didn't, and what it is now if it changed. Put another way, is the CHI vision the vision the SLHIE process adopted?	Acknowledged - Recommend revision/addition	This section to be updated	Y
334	Sp-2,3	24	Goals	Goal 1 seems like a sentence fragment to me. Goal 2, perhaps a qualifier on 'Full' or another word that doesn't set 100% as the goal because it is impossible. Goal 3 seems like a sentence fragment too.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
43		25	Goals	Goal 3: While I agree that interstate HIE is important, I believe this is over-reaching for 2014 and would prefer to see focus on state-wide HIE deliverables that are considerate/conformant with national standards ergo makes interstate possible.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
48	SP-2/SP-3	25		Goal 2 - last sentence. It states that our goal is to "have all of NH's ambulatory providers using EHRs by 2014". Since we are all working toward meaningful use obtaining incentive money, I suggest that we change this to indicate that we will "meaningfully use" EHRs.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
70		25		HIE strategy section: add build system with allowance for patient to opt-out.	Acknowledged - Recommend partial revision/addition	Agree that opt out message should come through in the plan but not in this section.	Y
91	SP-2,SP-3	25	first	Recommend eliminating the phrase "and will occasionally point out opportunities that are outside the current legal framework" Replace with something like "We also identify opportunities for exchange now prohibited by law where the gains in privacy, security, and efficiency such exchanges would produce seem sufficient to motivate the state legislature to change the law."	Acknowledged - Recommend revision/addition	Section removed	Y

165	SP-2/3	25	2	Goal 2 - ALL of NH's ambulatory providers using EHR's by 2014? Maybe most? What about hospitals and other healthcare providers?	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
166	SP-2/3	25		Add Strategy 6 - Work with neighboring state HIT/HIE organizations to connect inter-state entities to exchange clinical information.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
167	SP-2/3	25	6	Note about HIO - HIE... I do not understand.	Acknowledged - Recommend revision/addition	Clarify in text	Y
239	Strategies for HIE	25		Goals 2 and 3: add reference to the specification and adoption of relevant and applicable standards in order to achieve these goals.	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.		Defer
257	SP-2 SP-3	25	strategy #3	It may be helpful to include some examples here (such as broadband, REC, meaningful use, Medicaid)	Acknowledged - Recommend revision/addition		Y
259	SP-2 SP-3	25		I do not see an explicit strategy to "develop a <u>financing</u> model that ensures economic viability and sustainability" of the HIE. This may be suggested in Strategy 1 but I don't see the word "financing" anywhere. I think this is totally mission critical. I see there is an expanded section on HIE Sustainability later in the document, but this may warrant an explicit strategy statement too in my opinion.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
87	SP-2	26	4	Strategy 4 - The last sentence - Current working - We will provide an "on ramp" .....I recommend that it should be reworded to include "Hub" because I did not understand what it meant until I read page 53	Acknowledged - Recommend revision/addition	New terminology added and explained in beginning of plan - "HIE Clusters"	Y
92	SP-2,SP-3	26	first/second	This is the first use of "hub" since a single reference in the Environmental Scan. I think the reader will need a little help to recapture what's meant by "hub"	Acknowledged - Recommend revision/addition	New terminology added and explained in beginning of plan - "HIE Clusters"	Y
168	SP-2/3	26	top	Has "hub" has been defined?	Acknowledged - Recommend revision/addition	New terminology added and explained in beginning of plan - "HIE Clusters"	Y
258	SP-2 SP-3	26	strategy #3	As stated earlier, the HIE's role is not to give providers an EMR, rather to know about and coordinate with other projects (like REC) that will perform that function. May want to include the clarification here as well.	Acknowledged - Recommend revision/addition		Y
260	SP 2	26	3	Clarification: if the premise is that the HIE infrastructure will simply offer connectivity and not software/hardware/etc, then perhaps it should be explicitly stated. Not sure "on ramp" is concrete enough.	Acknowledged - Recommend revision/addition	New terminology added and explained in beginning of plan - "HIE Clusters"	Y
261	SP-2 SP-3	26	strategy #4	Please provide more details for what is meant by an "on-ramp".	Acknowledged - Recommend revision/addition	New terminology added and explained in beginning of plan - "HIE Clusters"	Y
262	SP-2 SP-3	26	strategy #5	would suggest that the word "state-level" be added to the second sentence so that it reads "Transactions through a state-level HIE are only allowed..." By adding the word "state-level" is helps distinguish that the state law is only targeted at the state-level HIE and specifically exempts regional or local health exchanges.	Acknowledged - Recommend revision/addition	Clarify in text	Y
336	Sp-2,3	26	3	Strategy 3, perhaps say EMR instead of HIT?. Add "HIT planning efforts" and Medicaid in the last sentence.	Acknowledged - Recommend partial revision/addition	The term HIT is inclusive of HIS, EMR, EHR so was used here.	Y
338	Sp-2,3	26	7	Add to Meaningful use bullet, or make its own bullet the sharing of patient clinical information to the NH Medicaid program for the purpose of quality measurement and Medicaid program improvement.	Acknowledged - Recommend revision/addition	Add text	Y
35		27	Figure 9	Very straightforward and helpful.	Acknowledged - Recommend no change		NA
146		27	figure 9	remove the reference \$1.8 M per year for 3 years	Acknowledged - Recommend revision/addition		Y
147		27	last	should we just be forthright about the uncertainty and the challenges in securing funds for both matching and on-going sustainability ??	Acknowledged - Recommend partial revision/addition	Cover this point in the risk section.	Y

71		28		In "Overall HIE Design" section, suggest the following wording changes (original in parentheses): "Given interest by (demand from) stakeholders to provide additional capabilities, and given potential relaxation of current constraints, the HIE could (will) take on higher value and higher complexity building blocks over time..."	Acknowledged - Make Correction		Y
134		28	HIE design diagram	I don't recall agreeing to include the community record in the model; is this included to meet the ONC grant requirements?	Acknowledged - Recommend partial revision/addition	The document contains a framework of what could be done and this includes the community record. The document then goes on to explain what we thing we will do, which may or may not include the community record given the need to pass new legislation, raise additional funds, etc... Recommend that we make a more clear distinction between the framework of what could be done in the future, and what we actually plan to do at this moment in time.	Y
263	SP-2 SP-3	28	end of page	would suggest that a description be included for specifically stating that the secure routing process can be for BOTH textual information and structured data elements that would be incorporated directly into an EMR.	Acknowledged - Recommend revision/addition	Add text	Y
264	SP-2 SP-3	28	2	Paragraph should acknowledge the dependency that receiving entities are responsible for developing the technologies necessary to integrate the "pushed" information into their unique systems and processes. For example, no mechanism for patient matching will be provided to facilitate integration into existing EHR's.	Acknowledged - Recommend revision/addition	Revise text to be more clear	Y
265	SP 2	28	4	Clarification: secure routing includes discrete or structured data that can be electronically shared and integrated within EMR. There was significant "value-added" in structured data being securely routed, and not so much value in non-structured data. Emphasizing structured data will help convey the value added.	Acknowledged - Recommend revision/addition	Add text	Y
14	SP-2, SP-3	29	2 & 7	Strongly agree that it is important to incorporate feasible future planning for "Secure routing to public health and patients" and for a "Community Record". These two components are critical to truly coordinated care across all domains interacting to meet and maintain individual and holistic health care needs.	Acknowledged - Recommend no change		NA
36		29		Mention of a PHR. Kind of inconsistent with lack of patient-centric model on pps 24-25. Is the PHR something the work groups wanted and specified? Or is this more conceptual?	Acknowledged - Recommend revision/addition	Clarify in text	Y
72		29		Secure routing section: Mention that public health reporting through HIE will be more secure than as currently performed.	Acknowledged - Recommend revision/addition		Y
94	SP-2, SP-3	29	4	I wasn't aware that Medicare/Medicaid meaningful use quality measure reports were public health data. They certainly are different in rationale from the other public health reports mentioned and deserve their own, separate discussion.	Acknowledged - Recommend revision/addition	Clarify in text	Y
105	SP-2	29	4	I'm not sure how using the HIE as a patient portal became such a highlighted activity, yet there is no mention so far in the document about the ACO and Medical Home efforts in the state, where the patient would basically look to their provider system as their relationship manager who will actively manage their care throughout the health system.	Acknowledged - Recommend partial revision/addition	Recommend adding content that explains the ACO and PCMH efforts in future versions given more time for gathering content. Re. the HIE's role with PHRs, the strategy has not been determined and requires additional discussion.	Defer
106	SP-2	29	7	It should be noted that health systems in the state see great clinical value in having this record locator service, to be able to retrieve relevant patient information in urgent or emergency patient encounters.	Acknowledged - Recommend revision/addition		Y
135		29	last	I don't recall that the group agreed upon merging of records as part of the model.	Acknowledged - Recommend partial revision/addition	The document contains a framework of what could be done and this includes the community record. The document then goes on to explain what we thing we will do, which may or may not include the community record given the need to pass new legislation, raise additional funds, etc... Recommend that we make a more clear distinction between the framework of what could be done in the future, and what we actually plan to do at this moment in time.	Y
234	Constraints	29	Last under community record	Should we mention patient Opt-In in this paragraph?	Acknowledged - Recommend no change	Opt out discussion to be covered in legal policy section	NA

240	Community Record	29		Can anything be said about general cost implications regarding a Community Record? This is a leap in technology and capability implying a burden on the sustainability model. Don't need numbers, but perhaps a relative sizing compared to Phase 1 (and Phase 2) perhaps.	Acknowledged - Recommend no change	This is clear in the discussion of approach relative to the constraints.	NA
340	Sp-2,3	29	2	Add 'Medicaid' to heading. Add a sentence at the the end of the section that says, "see SP-4, Coordination with Medicaid, how HIE can assist NH's Medicaid program"	Acknowledged - Recommend revision/addition	Medicaid added to all sections where regarding future expansion of HIO to non-provider stakeholder groups	Y
169		30	bullet	Other ARRA Programs Summary - delete word "Summary"	Acknowledged - Make Correction		Y
136	SP-4	31	5	clinical reporting by provider is problematic without risk adjustment; patient populations are very different at CHCs.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
171	SP-4	31	1	ADD: State HIT Coordinator is on Medicaid HIT Project Steering Committee.	Acknowledged - Make Correction		Y
333	SP-4	31	1	"Medicaid Leaders" implies more than it really is. HIEPI team has been working regularly with OMBP & Medicaid Director, but that covers only the general acute/chronic care side of Medicaid, not the folks in long term care, disability care, behavioural health center, or foster care services. While the HIE project is certainly focussed around traditional medical care, these other parts of Medicaid might have just as much, if not more to gain.	Acknowledged - Defer to Future Discussion (After ONC submission)	Recommend engaging additional Medicaid leaders in future discussions	Defer
335	SP-4	31	2	Should be 9% not 7%. 7% is the number excluding those who also have Medicare in addition to Medicaid.	Acknowledged - Make Correction		Y
337	SP-4	31	3	List should be bullets, not numbers. These aren't prioritized	Acknowledged - Recommend no change	Acknowledge that these are not prioritized - However, numbers are used for later references - leave as is	NA
339	SP-4	31	4	Should add to the coordination of care paragraph discussion of the HIE benefits to home and community care waiver population and for the issue of enrollment churn (a lot of Medicaid shifts between Medicaid, uninsured, commercial and back again). ACA will escalate this as more people come into care.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
341	SP-4	31	5	There is a good possibility mandates on state quality reporting will be forthcoming from CMS	Acknowledged - Recommend no change		NA
342	Sp-4	31	2	Say "important" instead of "significant". Also should add that NH's Medicaid patients use the same care network as other payers.	Acknowledged - Recommend revision/addition	Clarify in text	Y
344	Sp-4	31	4	Pt Centered Coord of Care, second line should be "have a mechanism in place FOR coordination of care." not 'to'	Acknowledged - Recommend revision/addition		Y
346	Sp-4	31	6	Payment reform para. Strike "has many provisions that must be implemented over the coming decade and".	Acknowledged - Make Correction		Y
348	Sp-4	31	8	Add Surveillance to bolded text at the beginning. Replace "the NH All Payer Database" with "claims data". Deleve the first part of the next sentence that reads "Fraud and abuse account for a significant portion of Medicaid costs and any". <-not true, but the rest of the sentence is true.	Acknowledged - Recommend revision/addition	Clarify in text	Y
172	SP-4	32	chart	Confused; does Employer mean commercial group health plans obtained from employers?	Stakeholder question requires answer	Employer refers to an organization that employs citizens (and residents) and in most cases, is partially or fully responsible for paying for health benefits through commercial health insurers	Y
173	SP-4	32	bottom	ADD: Bullet 5 - NH CC - I can provide text on Friday	Acknowledged - Recommend revision/addition	Reached to commenter for text - text added	Y
266	SP-4	32	end of page	We were unaware that specific seats have been chosen for various stakeholders on the future governance structure. So, we were surprised to see a definitive statement of "#1. Medicaid will have formal representation in the governance structure of the HIE". Would suggest changing the wording to be more like... Medicaid representation should be considered in the HIE governance structure because....	Acknowledged - Recommend revision/addition	Transitional governance sections to be rewritten and expanded. Also, a proposal is on the table for the creation of a stakeholder committee representing the current workgroups be added to the transitional governance model in order to supplement the Steering Committee, which is made up only of State employees.	Y
343	SP-4	32	3	Delete the "Medicaid leaders recognize that they have a lot to gain..." paragraph	Acknowledged - Recommend revision/addition	Section removed	Y
350	Sp-4	32	3	Delete the paragraph that starts "Medicaid leaders..."	Acknowledged - Recommend partial revision/addition	There is a valuable information in this paragraph - recommend keeping the conclusion but removing the "Medicaid Leaders..." language.	Y
351	Sp-4	32	4	In the Heading replace "Meaningful" with "EHR Incentives and Medicaid Program Improvement"	Acknowledged - Recommend no change	Recommend keeping as is - "Meaningful Use" is a widely accepted and understood term	NA
174	SP-4	33	bullet 7	Reword - New Heights is the application / eligibility check system; MMIS is the claims processing system	Acknowledged - Make Correction		Y
345	SP-4	33		Need to add the issue of enrollment churn and shifting between Medicaid, uninsured, other payers	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer

49	SP 5.1	34		In the paragraph "Coordination with CDC" there are a lot of acronyms that will need to be added to Appendix B.	Acknowledged - Recommend revision/addition		Y
107	SP-5.1	34	2	end of paragraph should include "standards-based" as one of the ways we want to conduct all information transactions	Acknowledged - Recommend revision/addition		Y
74		35		SORH section: is it necessary to name the individual in the referenced position?	Acknowledged - Make Correction		Y
175	SP-5.1	35	bottom	Is NE Telehealth Consortium a Federal Program? Does it belong in here. Needs to be researched.	Acknowledged - Recommend revision/addition	Changed heading to "Broadband Initiative." It does belong in this section as it is a Federal program under FCC that is operated as a State Based program	Y
241	SORH	35		Repeated sentence beginning with: "The HIT Coordinator..."	Acknowledged - Make Correction		Y
347	Sp-5.1	35		Name of Department of Community and Family Medicine is incorrect, also in next paragraph should take out Alisa's specific name	Acknowledged - Make Correction		Y
176	SP-6	37	WF Dev	ADD: State HIT Coordinator is on NHCC Workforce Development Program Project Steering Committee.	Acknowledged - Recommend no change	Change made in next version and then removed given NHCC's decision to not participate in program	NA
8	SP-7	38		City health depts. do have limited access to electronic health information -- see comments above.	Acknowledged - Make Correction		Y
9	SP-7	39		Move the 3rd bullet to the next page under the "importance of privacy and security section"	Acknowledged - Make Correction	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
10	SP-7	39		The correct citation for the immunization statute is RSA 141-C-20-f	Acknowledged - Make Correction		Y
50	SP-7	39		PHWG? Is that Public Health Workgroup? Another good acronym for the Appendix. (My apologies if you consider these grammar, but I considered them questions requiring clarification!)	Acknowledged - Recommend revision/addition		Y
113	SP-7	39	bullet 3	The phrase "...with minimal exposure of PHI." might be more clear if we substituted something like "...using the minimum necessary HIPAA standard."	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
177	SP-7	39		This is the first time a reference to Work Group did something, recommends something, etc. At first I thought these references should be removed. And in many cases I still do. This is a formatting / style point that applies to the document from this page on. I'd like to discuss.	Acknowledged - Recommend revision/addition		Y
267	SP-7	39	1st paragraph	why is this section "interim solution for public health information flow from providers" be in this document about HIE? It actually doesn't help the HIE case if this paragraph was left in because it insinuates that public health can still conduct its work outside of an HIE. Would suggest removing this section altogether.	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
51	SP-7	40		Under the "Capabilities of the system" section, items #1 and #2 refer to the ability to receive reports from providers. If you read further, the requirements shift to being able to aggregate and report on data. While I believe the intention is to capture discrete data elements to facilitate aggregation and reporting, items 1 and 2 are contradictory to being able to do this since they specifically refer to receiving reports (versus discrete data elements via an electronic interface).	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
15	SP-7	41	2	Under content of measures: Though it is not collected by the division public health there is an additional measure that should be included. The Bureau of Developmental services collects (through required reporting by statute) data on all newly diagnosed individuals with Autism Spectrum Disorders. It would be ideal if when the system is established for some of the other diagnoses to be automatically transmitted that this reporting to the Autism Registry also has such a mechanism.	Acknowledged - Recommend no change	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law. Recommend that we do not propose sending personal health information to another party (BDS in this case) that is not considered public health	NA

128	SP-7	41		Parameters regarding the provider identified need to be clarified. Provider Identification needs to be further explained as to the reasoning why this is needed. If the intent is for Public Health use, provider id is not needed. Aggregate data should be sufficient and this was discussed in the public health work group.	Acknowledged - Recommend partial revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
137	SP-6	41	2	there are those uninsured who choose to be uninsured for privacy reasons and do not want their data shared with public health.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
178	SP-7	41	bottom	Starting with bullet 2 at bottom of page, the "capabilities" of the system confused me. This goes on thru the entire section SP-7. Are we saying that the HIE should do data aggregation and analysis, or will enable data exchange to allow data aggregation and analysis? I think that data storage and analysis is not within the scope of an HIE. Let's discuss. For example - bullet 4 on page 41 - the HIE should pass data from PH to providers. The "send" functionality is a function of a PH system - I think.	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
179	SP-7	41	bullet 7	Have we defined "node" yet?	Acknowledged - Recommend partial revision/addition	Section with "node" to be removed	NA
129		42	1	Social Security number should not be included in any way to identify the population for security reasons and that a good deal of patients lack a social security number and many agencies do not collect this for security purposes	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
180	SP-7	42	footnote	The footnote numbers are not proper.		This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
181	SP-7	42		FYI: NJ has an Immunization system that includes exchange of data that they offer to other states for free.	Acknowledged - Make Correction	Acknowledged	NA
11		43		State cannot mandate which measures a provider chooses. However, NH will make an effort to negotiate a common list of measures that all providers will be asked to submit.	Acknowledged - Recommend no change		
11	SP-7	43		State cannot mandate which measures a provider chooses. However, NH will make an effort to negotiate a common list of measures that all providers will be asked to submit.	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
183	SP-7	43	top	Do not like the wording of this - (human, not "epi-speak", local when possible, economic argument, not for "big brother" purposes) - especially the big brother part	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
114	SP-8.1	44	Figure 12	The current operational structure shows 5 workgroups and does not mention public health. This is not consistent with page 4, paragraph 4 which indicates 6 workgroups.	Acknowledged - Make Correction		Y
184	SP-8	44	top	Need a section introduction - SP-8 HIE Planning Domains - and a brief paragraph explaining the next series of sections.	Acknowledged - Recommend no change	There is an introduction on p. 30	NA
185	SP-8.1	44	1	CHANGE: "mainly by volunteers who" to "mainly by a broad cross-section of stakeholders who".	Acknowledged - Recommend revision/addition		Y
75		45		Organizational form: Isn't it more correct now to refer to CHIP rather than SCHIP?	Acknowledged - Make Correction	Healthy Kids and SCHIP reference to be removed	Y
186	SP-8.1	45	1	Title: "Current governance - Future governance" - remove "Current governance".	Acknowledged - Recommend revision/addition		Y
187	SP-8.1	45	1	Here is where I get confused... Are we going to introduce the term HIO as the HIE entity which governs the HIE? The HIE is the technology to enable the exchange of health information. Yes? "a new HIE" sounds like the entity. Should we say "HIE entity"? Later we refer to it and an SDE? See #46	Acknowledged - Recommend revision/addition	Clarify in text. Introduce terms in beginning of document:	Y
188	SP-8.1	45	1	Need to state the assumption that is implied - there is to be one and only one HIO / HIE entity.	Acknowledged - Recommend further discussion	Whether there will be an allowance for more than one State Level HIE has not been discussed yet. Recommend further discussion before stating that there is to be only 1.	Defer
349	SP-8.1	45		Fix choice for governance model so it doesn't mention NHHK and is vaguer	Acknowledged - Recommend revision/addition		Y
77		46		organizational form: it's the 2011 legislative session where a bill will need to be introduced.	Acknowledged - Make Correction		Y

115	SP-8.1	46	Figure 14	Under DHHS as organizational form in the cons column, I don't think that it is true that it would require a statute to launch. RSA 332-I:1(2)(c) authorizes a DHHS HIE. It is my understanding that the Commissioner has promised the HHS oversight Committee that he would seek legislation before going forward, but technically it is not required.	Acknowledged - Make Correction		Y
116	SP-8.1	46	Figure 14	Under organizational form "attached" the term of art is "administratively attached." Also, I'm not sure that it is accurate to say under "pros" "easy access to state resources" I think I would phrase that "potential access to state resources such as administrative staff, payroll and mail services." Also under "pros", third bullet, the word "insulated" is not entirely clear. I think it might be better to say it can be operationally nimble if structured that way by the legislature.	Acknowledged - Recommend revision/addition		Y
117	SP-8.1	46	Figure 14	Under organizational form "not for profit" in the "pros" column, it is unclear what we mean by "going concern." Also, in the "cons" column I think we can say it "would" require competitive process, not "may."	Acknowledged - Recommend revision/addition	Replace "going concern" with "sustainable with private funding"	Y
118	SP-8.1	46	3	The fourth sentence that starts, "A precise structure has not yet been recommended..." although technically true I think it might be better to say something like, "The group has recommended a public instrumentality with a board small enough to..."	Acknowledged - Recommend revision/addition		Y
235	Collaborative Governance Model	46	1st	Creation of a public instrumentality... 2010 legislative session..." should be 2011.	Acknowledged - Make Correction		Y
269	SP-8.1	46	1st paragraph	need to update the year reference. It should be 2011, not 2010.	Acknowledged - Make Correction		Y
119	SP -8.1	47	1	The transition of governance section needs more. In general, we talked about and I think reached consensus on modifying the current governance structure to add stakeholder input at a higher steering committee level and to better reflect where we eventually end up (public instrumentality 501c3), but to until that entity can be created legislatively we will have DHHS governance.	Acknowledged - Recommend revision/addition	Transitional governance sections to be rewritten and expanded. Also, a proposal is on the table for the creation of a stakeholder committee representing the current workgroups be added to the transitional governance model in order to supplement the Steering Committee, which is made up only of State employees.	Y
120	SP-8.1	47	3	The second paragraph in the accountability and transparency section needs more detail. It is not clear if the paragraph is speaking to the transition period or to the long term solution. As a workgroup we talked about the legislature setting up the structure and charge of the HIE and having general oversight through reporting and representation on the board, but accountability would be with the board as they would adopt bylaws, develop a mission statement apply for 501 c3 statute an, etc. being accountable	Acknowledged - Recommend revision/addition	Need to add detail & specify transition and future state transparency and accountability; Add information regarding 91a compliance	Y
130	SP 8.1	47	1	I wonder if enough info was included in this section. We agreed that this could be an extended time frame and discussed possibility of somehow merging or integrating Governance work group with the Steering Committee and/or Leadership team to enhance trust building, as these committees consist strictly of DHHS staff.	Acknowledged - Recommend revision/addition	Transitional governance sections to be rewritten and expanded. Also, a proposal is on the table for the creation of a stakeholder committee representing the current workgroups be added to the transitional governance model in order to supplement the Steering Committee, which is made up only of State employees.	Y
189	SP-8.1	47	State HIT Coordin	First paragraph in this section - rewrite - Health Care Reform is Affordable Care Act and remove SC on Health Information Exchange; ADD Medicaid HIT Steering Committee	Acknowledged - Recommend revision/addition		Y
270	SP-8.1	47	end of page	would also suggest that in addition to the duties mentioned for the State HIT Coordinator, that this person should also be responsible for building and enhancing relationships with hospitals and healthcare providers to keep a finger on the pulse of their needs, concerns and future directions.	Acknowledged - Recommend revision/addition		Y
271	SP 8.1	47	4	Delete: parenthetical statement adds no value (	Acknowledged - Recommend revision/addition		Y
95	SP-8.2	49	second	The last sentence in the paragraph is so "packed" I couldn't figure out what was meant. I think it should be rewritten in a set of simpler sentences.	Acknowledged - Recommend revision/addition	Finance workgroup to meet regarding the new budget and section to be re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y

138	SP 8.2	49	last	there is a concern about cost of reporting and the burden this, plus a fee for utilizing the HIE may place on providers.	Acknowledged - Defer to Future Discussion (After ONC submission)	This concern is recognized and will be further explored as a business case is developed over the next 9 months. This topic will be deferred to future planning.	Defer
148	SP-Fin	49	entire section	I would prefer to simplify the entire section; no specifics such as "NH has committed to fund the first year matching requirement etc"- 1. Acknowledge the importance of securing funds for both matching and long-term sustainability and our approach 2. Discussion on the value of HIE services (market opportunities) 3. Guiding principle 4. Various revenue opportunities/assumptions explored 5. Discussion on continued need for on-going studies/research and other state's approaches to come up with a various scenarios; 6. Assurance of financial controls	Acknowledged - Recommend revision/addition	Finance workgroup to meet regarding the new budget and section to be re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
272	SP-8.2	50	1st paragraph	The Finance work group discussed (among many potential sources) that subscription fees could be considered, but the first paragraph suggests that hospital subscription fees were the way to go. Would suggest re-wording the section of the sentence that says "hospital subscription fees were identified as a viable revenue source to fund and maintain the NH HIE." or removing the entire sentence.	Acknowledged - Recommend revision/addition	Finance workgroup to meet regarding the new budget and section to be re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
273	SP-8.2	50	3rd paragraph	there are several references to "will" and "will include". We would suggest "might include" instead. Again, the Finance work group did not make any definitive decisions about funding amounts or funding mechanisms.	Acknowledged - Recommend revision/addition	Finance workgroup to meet regarding the new budget and section to be re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
108	SP 8.3	51	several	I believe there is inconsistent use of the terms NH HIE and "state" throughout the list. If the NH HIE is not state-run, why does the term "the state" exist anywhere n this list?	Acknowledged - Recommend revision/addition		Y
191	SP-8.3	51	1	Do not mention what stakeholder groups were represented on this Work Group unless you do so for all Work Groups.	Acknowledged - Recommend revision/addition	Remove text	Y
192	SP-8.3	51	bullet 2	"The state should focus..." Should be "The HIO should focus..."	Acknowledged - Recommend revision/addition	Remove references to "the State"	Y
193	SP-8.3	51	bullet 6	"The state will act..." Should be "The HIO will act..."	Acknowledged - Recommend revision/addition	Remove references to "the State"	Y
194	SP-8.3	51	bullet 11	There are no "local HIEs"; I would reference the "provider networks" as the entities who are doing HIE activity within the State today.	Acknowledged - Recommend partial revision/addition	Change to "The HIE will act as a trust broker between the various hubs facilitating local exchange of health information in the state."	Y
274	SP-8.3	51	#4	would suggest adding more specificity here relative to validation of mobile addressing services.	Acknowledged - Recommend no change	Addressing is at the node level only - additional addressing to be done by organizations outside of the HIE proper	NA
53	SP-8.3	53	3	The last sentence of this paragraph (relative to Phase 1) indicates that the state could potentially provide some support for formation of a new hub for physicians who are unable to participate in an existing hub. I would suggest adding a reference to this again in Phase 3 on page 55 as a point where it might become feasible.	Acknowledged - Defer to Future Discussion (After ONC submission)	State is not planning to provide resources for new hubs at this point as this is not feasible within current budget. This will need to be part of future planning efforts contingent upon funding.	Defer
195	SP-8.3	53	3	Change "not participating with any exchange" to "not participating with any provider network".	Acknowledged - Recommend revision/addition	Change to "Independent physicians (34%) who are currently not affiliated with a hospital system or other hub of health information technology capabilities, will be encouraged to join an existing hub."	Y
275	SP-8.3	53	whole page	same comment we gave on page 28...would suggest that a description be included for specifically stating that the secure routing process can be for BOTH textual information and structured data elements that would be incorporated directly into an EMR.	Acknowledged - Recommend revision/addition	Text added to value propositions throughout the document to make this clear.	Y
54	SP-8.3	54		Define EMPI; not defined in this section or in the Glossary. I also see it referred to later as MPI, so we should be consistent. Diagrams display it as EMPI.	Acknowledged - Recommend revision/addition	Recommend using EMPI consistently - there is a definition in the tech infrastructure and this can be moved to the glossary	Y
96	SP-8.3	54	first	In the first sentence I'm not sure what's meant by "both know and have any health information about a particular patient." The illustration is both helpful and troubling. I thought that the requests to be transmitted in Phase 1 involved a sender's surety that they had been authorized to send their "load" and knew where it was supposed to go. The example opens the spectre of broadcast requests sent to places that neither had prior contact with the patient involved nor could anticipate any. This stretches the idea of "push" too far for my comfort.	Acknowledged - Recommend revision/addition	Needs further clarification in the document regarding the framework of what we could do vs. what we plan to do. Also need clarification of this type of "modified pull" process. This is a phase 2 concept and is shown as a potential path, not one in which we will take on without further discussion and planning.	Y

196	SP-8.3	54		What are the three Phases? Do they align exactly with the three Levels of HIE / building blocks that were described in SP-2/3? They seem to in this section, where there is no Community Record in Phase 2 and the Limited EMPI and RLS - just used for Consumer / Patient access(?). Phase 2 adds Public Health, Consumer and other healthcare provider types and more use cases - but still no PULL to see a Community Record. Yet pg 54 below graphic says that there is a Pull. Are we still just pushing. On pg 59, the use cases 48 and 49 include the Community Record in Phase 2. Page 60 (below table) states that Phase 3 includes the Community Record and a Pull capability. I need clarification.	Acknowledged - Recommend revision/addition	Phases clarified throughout plan	Y
109	SP 8.3	55	1	Add sentence to end of paragraph."This does not mean all patient records must be physically stored in a centralized database. This function could also be accomplished by storing only a record locator service centrally, with the actual PHI still being stored only within the individual local health information exchange networks." A statement like this mitigates arguments against a centralized database of everyone's PHI.	Acknowledged - Recommend revision/addition		Y
294	SP 8.3	55	1	We need to distinguish between centralized logical access to information "a centralized, aggregated and merged community record". A community record doesn't imply a centralized repository as this wording does.	Acknowledged - Recommend revision/addition	Clarify in text	Y
295	SP 8.3	55	2	NHIN Connect is an open source SW platform; I believe what is desired here is NHIN Exchange, referring to specifications not SW.	Acknowledged - Recommend revision/addition	Acknowledge - NHIN Exchange is a broader concept where NHIN Direct is a particular instantiation. Use NHIN Exchange.	Y
55	SP-8.3	56		Last sentence; indicates that "Current and future hubs and provider organizations will be strongly encouraged to select only those vendors...". Under the Content section also on this page, there is a commitment to use designated standards per Hitech. My concern is how we will be able to meet this commitment if we don't REQUIRE (versus strongly recommend) that certified vendors be used by the hubs. Note: my apologies if this is covered later in the Governance section.	Acknowledged - Recommend no change	This idea has been discussed multiple times in the workgroups. Current thinking is that the Meaningful Use incentives, which define the certified systems that can be used by providers and the standards for exchange, will accomplish this goal without additional rule making required by the HIE.	NA
56	SP-8.4	57	3	The first sentence of the third paragraph refers to "...e_prescribing is already in place with approximately 96% of active use from providers who are already on an EMR." This conflicts with the data in Figure 6 on page 14 that indicates only 12%. The text beneath the Figure 6 on page 14 indicates that NH isn't using e-Prescribing to the extent that it could, yet this section clearly indicates something different!	Acknowledged - Make Correction		Y
296	SP 8.4	57	3	96% stat is wrong - was corrected so there is some version skew here - 96% refers to pharmacy connection not eRx rate.	Acknowledged - Make Correction		Y
242	Phase 1	58	Figure 19	It might be helpful to highlight those use cases that satisfy Stage 1 specifically among the other use cases.	Acknowledged - Defer to Future Discussion (After ONC submission)	Agree - Defer to future versions	Defer
276	SP-8.4	58	whole page	since the NH HIEPI project began, the finalized national meaningful use rules were released. There should be some mention here (and perhaps throughout the document) that the items listed under figure 19 will need to be revised in light of the finalized meaningful use rules. For example, advance directives are now part of meaningful use and should be considered a possible use case for HIE.	Acknowledged - Recommend revision/addition	Added new text in introduction to prioritization "Note: Meaningful Use was one of the main demand drivers considered for prioritization. The final rule was released after the prioritization was completed and vetted with stakeholders for consensus agreement. We plan to revisit the use case prioritization in light of the final rule, make adjustments, and vet the changes with stakeholders."	Y
277	SP 8.4	58	1	Clarification: secure routing includes discrete or structured data that can be electronically shared and integrated within EMR. There was significant "value-added" in structured data being securely routed, and not so much value in non-structured data. Emphasizing structured data will help convey the value added.	Acknowledged - Recommend revision/addition	Text added to value propositions throughout the document to make this clear.	Y
57	SP-8.4	59		The last item on the page lists "Add Delivery Adaptor" and this is not defined. I'm not even sure it's clear to me, although it sounds like a patient portal.	Acknowledged - Recommend revision/addition	Define in glossary	Y
58	SP-8.4	60		In the list below Figure 21 that lists items of significance that have been added in Phase 3, I would recommend adding the patient as a new "customer" of the HIE. In this phase we begin delivering information to the patient and in my mind this is significant.	Acknowledged - Defer to Future Discussion (After ONC submission)	The question of how the patient will engage with the HIE (directly or via a PCP) still requires discussion - deferring to ongoing planning process	Defer
198	SP-8.4	60	bottom	DELETE: "As identified in the environmental scan."	Acknowledged - Recommend revision/addition	Section removed	Y
297	SP 8.4	60	1	another version issue I think - scrambled bullet formats and a fragmented sentence at end of first bullet	Acknowledged - Make Correction		Y

59	SP-8.4	61	3	In the first sentence starting with "The statewide NH HIE would serve as a collaborative HIE network that will enable all participating providers to achieve Stage 1 MU requirements", I would caution using the word "participating". We just finished saying that it's the employed physicians that are poised to take advantage of this, so perhaps using the word "employed" would be more consistent and better reflect the population that could take advantage of it (because other non-affiliated cannot).	Acknowledged - Recommend partial revision/addition	Earlier in the document, we need to explain what participating providers we are talking about. Needs clarification that we are talking about people who already have EHRs & EMRs. However, this is not limited to those that are employed by hospital systems.	Y
199	SP-8.4	61	2	Replace ""hubs"" with "provider networks".	Acknowledged - Recommend partial revision/addition	"HIE Clusters" used as new term for Hubs, Nodes, and On-Ramps	Y
60	SP-8.4	62		Approach to Staffing and Hiring; there is a reference to a diagram that isn't present; I assume it was an oversight.	Acknowledged - Make Correction		Y
121	SP-8.4	62	bullets	Governance alignment with NHIN as mention in this section is not well reflected in the governance section (8.1). Section 8.1 needs to be beefed up to include more detail to match this section.	Acknowledged - Recommend partial revision/addition	Provide more detail re: alignment with emerging NHIN governance principles	Y
200	SP-8.4	62	Staff and Hiring	Align terminology" Public Instrumentality/SDE" - change to HIO or HIE entity". Another reference SDE below and also bottom of pg 63.	Acknowledged - Recommend revision/addition	Clarify in text	Y
236	approach to staffing	62	1st	indicates "diagram below". Diagram missing	Acknowledged - Make Correction		Y
278	SP-8.4	62	3rd paragraph from bottom	there's mention of a diagram, but the diagram is missing.	Acknowledged - Make Correction		Y
298	SP-8.4	62	5	Refers to diagram of staffing that was taken out	Acknowledged - Make Correction		Y
62	SP-8.4	63		In the last section, "Approach to Risk Management", there is a reference to the HIE Management team. Is this the same as the Program Management team referred to on page 62 in the "Approach to Hiring and Staffing" section? If so, we should be consistent in the terminology. If not, we should define how they are different.	Acknowledged - Recommend revision/addition		Y
12	SP-8.5	65		HIPAA rule is not a law.	Acknowledged - Make Correction		Y
279	SP-8.5	65	1st paragraph	"Business Association Agreement" should be "Business Associate Agreement"	Acknowledged - Make Correction		Y
16	SP-8.5	66	4	It seems that it would be a good idea to add the privacy provisions of the Autism Registry here	Acknowledged - Defer to Future Discussion (After ONC submission)	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Defer
81		66		1st paragraph: Probably better to refer to RSA 332-I as the Medical Record Statute rather than Patient Bill of Rights law.	Acknowledged - Recommend revision/addition	Section removed	Y
97	SP-8.5	66	first	There are differences among New Hampshire hospitals about the need to secure patient consent when the patient's health information is sent outside of the hospital system. It's my understanding that some hospitals would prefer not to segment the patient's medical record because of the way they function and because they aren't sure that the segmentation can be done reliably. Faced with the NH (and some HIPAA requirements) for consent for sharing specific parts of the record they opt to require consent for any sharing of the record beyond their own system, usually gathered as a kind of standing, universal consent to sharing the information in the record. Other hospitals find this over-punctilious. Thus the disagreement is less over the meaning of the law than over how to deal with the array of specific consent requirements in NH law. I agree that it would be desirable to have all NH hospitals in agreement, especially if they all adopted the more stringent consent requirement, but I doubt that an attempt to change the patient bill of rights will lead us to this agreement. Any HIE legislation coupled with such an attempt could be put at risk by the association.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
98	SP-8.5	66	second	From the discussion above it should be obvious that I don't want to be associated with this paragraph.	Acknowledged - Recommend no change		NA
13	SP-8.5	70		"General Assembly" should read "General Court"	Acknowledged - Make Correction		Y

99	SP-8.5	70	first	This discussion strikes me as unreal. I doubt that a one-ten-swoop revision of applicable New Hampshire law is possible, given the privacy concerns of the Legislature, and I believe it would be undesirable. Any change in NH law related to privacy will have to demonstrate, not merely claim, that it offers superior privacy protections and doesn't introduce new risks. In my opinion, the argument for Phase 1 of the projected HIE meets that standard. The argument for allowing HIE to include public health reporting could meet that standard under an appropriate set of conditions. From the little that I understand about the requirements for quality reporting it appears that variations on whatever is worked out for public health might provide a workable model for privacy protection, but whether the HIE needs to be involved in quality reporting is less clear, since providers have the most direct access to the data that would be summarized at intervals to form the reports. Any functionality that requires constructing, maintaining, and securing a master patient record identifier for the state faces a very large, uphill, and I suspect currently unwinnable, battle in the legislature.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
100	SP-8.5	70	second	From the discussion above it should be clear that I'd recommend a strategy for engaging the legislature that is much more step-by-step. I'd recommend initial attention to the most immediate needs and to changes that seem to me most likely to pass, i.e. the 501c(3) public instrumentality governance legislation and the expansion to public health reporting with agreed-upon safeguards. Given my experience with omnibus bills, I'd present these as two separate bills. In succeeding years I'd pick specific uses where the balance sheet looks good and the privacy argument is persuasive.	Acknowledged - Recommend no change	This is being addressed by submitting separate bills as suggested. Recommend that tactics for moving legislation through the General Court are not appropriate for a strategic and operational plan.	NA
122	SP-8.5	70	bullet 3	The creation of the public instrumentality and the 501c3 are different - Legislation is required to create the public instrumentality that will be the governance body for the HIE. Legislation is probably also needed or at least recommended if the public instrumentality is going to apply for 501c3 status, which is obviously granted (or not) by the IRS. I think it better to leave out the 501 c issue here and just say, "Establish HIE governance by creating a Public Instrumentality."	Acknowledged - Recommend revision/addition		Y
201	SP-8.5	70	bullet 2	Should references to DHHS be changed to DPHS?	Acknowledged - Recommend no change	Recommend that DHHS is the right entity to take on this task. Alternatively, a multi-stakeholder committee may be well suited to perform this task.	NA
280	SP-8.5	70	whole page	"General Assembly" should be "General Court" to identify the NH Legislature correctly.	Acknowledged - Make Correction		Y
281	SP-8.5	70	end of page	The last paragraph says "We thus also recommend that the bill sponsors give consideration to..." The Legal/Policy work group did not explicitly make these recommendations (ambiguity of consent, and provider liability). Rather, they were discussed in the context as potential barriers, but in no way was there a conclusion that these two issues would limit HIE development. Therefore please remove these two items from this document.	Acknowledged - Recommend revision/addition	Text removed	Y
101	SP-8.5	71	first	Exploring what is or will cause difficulties in exchange across state lines seems necessary. However, before looking to New Hampshire to adopt the lowest common denominator of the protections in other states it would make more sense to discuss with other states the rationale for their and our consent requirements to see if the values sought by the different states could be reached by mutual adjustments, some of which might involve legislative changes. However, I don't believe that the value of exchange trumps all others, and it seems to me entirely conceivable that differences in state law will remain after these discussions have concluded. If so, HIE will have to find a way to work around the differences.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
202	Intro	71	2	Is "Director of the HIE" the same as "Executive Director" (pg 62)/ Should be consistent.	Acknowledged - Recommend revision/addition		Y
282	SP-8.5	71	1st paragraph	change reference to 2010 to 2011.	Acknowledged - Make Correction		Y
203	Intro	74	1	"Upon ONC's request" - what does this refer to. Is there a better reference - e.g. per the PIN.	Acknowledged - Recommend revision/addition		Y
204	Intro	74	1, 2	Eliminate references to "draft". We are submitting a Plan. We expect to refine the plan.	Acknowledged - Recommend revision/addition		Y
205	OP-1	74	bullets	The DHHS sub-bullets should be Office of Medicaid Business and Policy, Office for Health Information Technology - State HIT Coordinator, Division for Public Health Services	Acknowledged - Recommend revision/addition		Y
206	OP-2	75		Have he defined Core Team - in the Governance Org Chart? Is that sufficient?	Acknowledged - Recommend no change	This is well covered in the roles and responsibilities exhibit.	NA
207	OP-2	75	Mass	State Designated Entity RESPONSIBLE FOR HIE in Massachusetts	Acknowledged - Recommend revision/addition	Clarify in text	Y
208	OP-2	75	bottom	CHANGE: Office of Health Information Technology led by the State HIT Coordinator...	Acknowledged - Recommend revision/addition		Y
123	OP-3.1	76	General	I think that this section reflects the consensus of the group.	Acknowledged - Recommend no change		NA
210	OP-3	76	top	Need a section introduction - OP-3 HIE Planning Domains - and a brief paragraph explaining the next series of sections.	Acknowledged - Recommend revision/addition	Add structure to Operations Plan introduction	Y
211	OP-3.1	76	3	Who is "we"?	Stakeholder question requires answer	"We" is used to reflect the voice of the participants in the HIEPI project representing the stakeholders of NH.	Y

				same comment that we made on page 32: We were unaware that specific seats have been chosen for various stakeholders on the future governance structure. So, we were surprised to see a definitive statement of "#1. Medicaid will have formal representation in the governance structure of the HIE". Would suggest changing the wording to be more like... Medicaid representation should be considered in the HIE governance structure because....	Acknowledged - Recommend revision/addition	Transitional governance sections to be rewritten and expanded. Also, a proposal is on the table for the creation of a stakeholder committee representing the current workgroups be added to the transitional governance model in order to supplement the Steering Committee, which is made up only of State employees.	Y
284	OP-3.1	76	middle of page				
212	OP-3.1	77	table	UNH - REPLACE "research and legal" with "support".	Acknowledged - Recommend revision/addition	Table to be redrafted	Y
213	OP-3.1	77		What RFIs / RFPs do we need through 06/30/11? Create a list. Incorporate into Plan.	Acknowledged - Recommend revision/addition	Included in project plan	Y
				Under the Governance section, the transition state appears to have two separate activities going on. We were under the impression that the DHHS Steering Committee and the current Governance Work Group membership would merge to have a closer relationship overseeing the project and to create a unified transition process. The separation of duties is a surprise.	Acknowledged - Recommend revision/addition	Transitional governance sections to be rewritten and expanded. Also, a proposal is on the table for the creation of a stakeholder committee representing the current workgroups be added to the transitional governance model in order to supplement the Steering Committee, which is made up only of State employees.	Y
285	OP-3.1	77	figure 22				
82		79		Figure 23: note that dollars are in thousands.	Acknowledged - Make Correction		Y
88	OP-3.2	79	Figure 23	I am not sure if the amounts on Figure 23 mean thousands or millions.	Acknowledged - Make Correction		Y
				Revenue from other participants and other sources starts in FY 11. FY 11 budgets are already set across the state and its safe to say no provider has allocated any operating budget money for the statewide HIE in FY11.	Acknowledged - Recommend no change	Recognize this challenge. This will be dealt with through the drafting of a business case over the next 9 months	NA
110	OP-3.2	79	Fig 23				
214	OP-3.2	79	table	CHANGE FY to FFY	Acknowledged - Make Correction		Y
215	OP-3.2	79	table	Indicate that figures are in 000's.	Acknowledged - Make Correction		Y
				The funding is from Feb 2010 through Feb 2014. The analysis stops at 09/13/13. Reconcile.	Acknowledged - Recommend no change	Recommend we use a standard calendar to keep things more clear. A February to February calendar will be difficult to explain.	NA
216	OP-3.2	79	table				
217	OP-3.2	79	table	How do these operating costs compare to VT (VITL) and ME (HealthInfoNet)?	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
218	OP-3.2	80	2, 4	Paragraph 2 is repeated in paragraph 4.	Acknowledged - Make Correction		Y
				In reference to the state bond, it was discussed at the Finance Work Group as one of the many options for consideration, but it's not certain that the State is even considering a bond issuance at this point.	Acknowledged - Recommend revision/addition	Finance workgroup to meet regarding the new budget and section to be re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
289	OP-3.2	81	3rd paragraph				
				numbered item 3 refers to NHIN Connect again, should be NHIN Exchange	Acknowledged - Recommend revision/addition	Acknowledge - NHIN Exchange is a broader concept where NHIN Direct is a particular instantiation. Use NHIN Exchange.	Y
299	OP-3.3	82	4				
219	OP-3.3	85		Can we implement Phase 1 without a Technology Vendor?	Stakeholder question requires answer	A technology vendor will be required	Y
220	OP-3.4	87	bullets	Unclear if bullets apply to Phase 1 or all phase.	Acknowledged - Recommend no change	Clarify in text	Y
221	OP-3.4	87	bottom	Another reference to SDE.	Acknowledged - Make Correction		Y
				it appears that the statistic of 43% is incorrect. Isn't it 34% of providers have no .EHR?	Acknowledged - Recommend no change	Verified that 43% do not have EHRs.	NA
290	OP-3.4	87	1st paragraph				
				Explain the routing - Node + Provider? Are we routing to 26 nodes (hospitals) plus a few others and the hospitals are responsible for routing to provider?	Acknowledged - Recommend revision/addition	Text removed	Y
222	OP-3.4	88	3				
				Explain "three practice locations".	Acknowledged - Recommend revision/addition	Clarify in text	Y
223	OP-3.4	88	3				
				please double check the statistics of 75% of NH providers are not eRx.	Acknowledged - Make Correction		Y
291	OP-3.4	88	last paragraph				
				There really is not a HIPAA "consent," just an explanation of how information is used. The HIE will have to use different language for the HIE opt-out.	Acknowledged - Recommend revision/addition		Y
84		91	E				
				Governance: draft and file legislation and specific legislative detail points--better date is 12/1/2010	Acknowledged - Make Correction		Y
85		94					

86		94		Governance: we can't really appoint board members until legislation is signed/enacted.	Acknowledged - Recommend revision/addition	Transitional governance sections to be rewritten and expanded. Also, a proposal is on the table for the creation of a stakeholder committee representing the current workgroups be added to the transitional governance model in order to supplement the Steering Committee, which is made up only of State employees.	Y
102	OP-4	96	first	I agree that the HIE organization should be clear on its legislative goals for each year. As I indicated above I believe it would be a mistake to put everything ever wanted into a big omnibus bill and have described a more extended process, over several years, to expand the disclosures that HIE could undertake in New Hampshire. If providers are insistent on pushing forward with a master patient index, I'd put that in a separate bill. I, personally, will oppose undertaking a master patient index for NH, and don't want to be put in the position of voting against provisions I could support (e.g., public health reporting) to defeat it. It would probably be useful to be in contact with legislative leaders who are typically central in debates over privacy-related bills as bills are outlined and drafted to see if constructions can be found that would minimize opposition.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
226	OP-4	96	bottom	HIO - first reference to	Acknowledged - Recommend revision/addition	Definition of Entity required early in the document	Y
227	OP-4	96	bottom	What years?	Acknowledged - Recommend revision/addition	Finalize Project Plan - Correct date formatting	Y
228	OP-4	98	2/3 down	Implement Phase 2 Core Services at ALL locations - ALL?	Acknowledged - Recommend revision/addition	Finalize Project Plan	Y
229	OP-4	98	2/3 down	Need to align schedule for (1) Project Plan, (2) Budget, and (3) Overall Timeline - Gantt Chart	Acknowledged - Recommend revision/addition		Y
230	OP-4	98	2/3 down	Should we go beyond 02/2014? - Maybe 09/30/13?	Stakeholder question requires answer	We will revisit timing and determine how far out we go with the project plan - detailed plan will cover year 1 only	Defer
124	OP-5	99	Risk Assess chart	Should address delay or failure of legislature to authorize a public instrumentality governance structure.	Acknowledged - Recommend revision/addition	Contingency plan is detailed in governance section - operations will remain with OHIT.	Y
293	OP-5	99		general comment: please note that a complete risk assessment was not shared with work groups and is included for illustration purposes only and will be refined at a later date using work group input.	Acknowledged - Recommend revision/addition		Y
251	SP-1	22-23	summary	We suggest that each item be given a heading to tie it back to the previous pages. For example, for item #1 include the heading "State of Health Information Technology Adoption in New Hampshire"; item #2 including the heading "The State of Patient Care Summary Exchange in New Hampshire", etc.	Acknowledged - Recommend revision/addition		Y
252	SP-1	22-23	summary	general comment.... May want to consider adding a statement at the beginning of the summary (and at the beginning of the document) that says the environmental scan is an analysis of a point-in-time (summer 2010) and that the current landscape is going through tremendous growth because of national and local pressures including continued EMR adoption and meaningful use requirements for hospitals and physician practices. And, because of the anticipated growth, expectations for using a state-level HIE will continue to evolve.	Acknowledged - Recommend revision/addition	Added text: The environmental scan is an analysis of a point-in-time (summer 2010) in a landscape that is going through tremendous growth including continued EHR adoption and activity to help hospitals and healthcare providers meet meaningful use requirements. The following sections outline the state of the State regarding HIT and HIE capabilities and progress and provide a foundation of fact upon which to determine strategies moving forward.	Y
256	SP-2 SP-3	24 & 25	goal #2	why would there be a goal of "full adoption and meaningful use of electronic health records (EHRs) among ambulatory providers" for the state-level HIE? We believe that this type of goal is most appropriate for a Regional Extension Center (REC) project - not for the HIE. Also, there should be mention of the fact that NH's providers already have a high EHR penetration rate and should be noted that a lot of investment at the local level has (and will continue)been undertaken. Please provide clarification here.	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer
42		24-25	Goals	In page 24 & beyond, suggest the goals need to have measures of success. Some of this is implied, e.g. all providers using EHR by 2014 but what tangible benefit will this have for consumer?	Acknowledged - Recommend revision/addition	For the ONC draft, the goals section is to be revised taking into account earlier consensus processes (e.g., Citizen's Health Initiative, NHHA) and the environmental scan. Consensus building and refinement of the Goals is planned for the next draft of the plan post ONC submission.	Defer

93	SP-2,SP-3	26-27	re. Strategy 5	Discussion of this strategy seems over-long in comparison to what's said about the other strategies. I recommend keeping only the first paragraph for Strategy 5 and extending its last sentence to read " ... to explore use of the HIE for patient engagement (communicating their personal health information to patients, etc.), meaningful use reporting to Medicaid & Medicare/quality reporting, and public health reporting." A fuller discussion of these issues occurs in several places later and should be discussed in the report of the legal/policy workgroup. Also, where the paragraph indicates that stakeholders have reached consensus on the need to reconsider state law I wonder if that's all the stakeholders categorized in Appendix A, just the hospital reps, or who? I'm not part of a consensus on all the issues listed.	Acknowledged - Recommend no change	This strategy is longer than the others but covers more material - recommend keeping this as is.	NA
73		31/32		Fraud and abuse section. What is documentation for the claim that fraud and abuse account for a significant portion of Medicaid claims? We have not heard this as a fact before in New Hampshire, so it definitely needs a source citation.	Acknowledged - Make Correction	Removed text	Y
268	SP-7	38-43	all pages	general comment: the public health section of this draft plan is very lengthy and doesn't seem to fit with the flow of the document. In addition, many of the points made throughout this section are redundant of other sections (like privacy/security). Also, it's not necessary to list out all PH approaches, capabilities, and measures for this type of strategic plan document. The most important points about including public health in HIE are articulated on page 38.	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
76		45/46		organizational form: I think we should another bullet point that statute could dictate the appropriate level of transparency and accountability. This comment applies to both the text and Figure 14.	Acknowledged - Recommend revision/addition	Bullet to be added	Y
190	SP-8.2	49-50	all	Section needs to be re-written in style of other sections. I have numerous comments that I would like to discuss and can not document here.	Acknowledged - Recommend revision/addition		Y
283	OP sections	74-103		general comment: if there are any specific comments that you adopt based on our notes above, please be sure to have them flow through to the Operations Plan section of the document.	Acknowledged - Recommend partial revision/addition		Y
149	Op-Fin	78 -81	entire section	Figure 23 "Finance Workgroup Initial Budget Exercise" - This is the first time I have seen this worksheet and I have no clue about the basis for both expense/revenues ; Does the expense is based on build or buy or partner with neighboring states?? The expense estimates seem too high... It is unclear as to how the revenue estimates are substantiated..	Acknowledged - Recommend revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
150	Op-Fin	78 -81	entire section	Is this budget agreed upon/concurred by Business & Tech team? I understand that this is an initial proposal but this is the first I am aware of a \$13 +M budget.. There are several decisions that are referenced in this section that I don't recall having been discussed at the Finance Work Group meetings; There are references such as 'capital of federal \$5.5 M and state matching' and 'state-matched funds' - prefer to use 'other' funds required for matching instead of a reference 'state' matching; I am very concerned about the \$13+M budget included in the "Operational Section" of the plan as this is the first I have seen the budget and have no idea about the basis for both revenue estimates and expenses..	Acknowledged - Recommend revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
151	Op-Fin	78 -81	entire section	Reference " state is considering the issuance of a bond for HIE support" - state is only exploring this as one of the options and I am not aware of any consideration for issuance - delete the reference;	Acknowledged - Recommend revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
152	Op-Fin	78 -81	entire section	This would be a section that needs to be brought to Steering Committee's attention - especially the budget of \$13 M...	Acknowledged - Recommend partial revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
286	OP-3.2	78-81		general comment: where did the budget (figure 23, page 79) and the description of the budget building process come from? Figure 23 is labeled "Finance Workgroup Initial Budget Exercise", but the Finance Work Group did <u>not</u> discuss a budget at all. We would highly suggest that this proposed budget be removed and all associated assumptions about the budget be removed from this draft document. It's our opinion that a budget should be developed through a deliberative and inclusive process and not just show up in a proposed operational document.	Acknowledged - Recommend revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y

287	OP-3.2	78-81		general comment: any place in section OP-3.2 where there are definitive statements (such as "the gap between these costs and the total capital...is covered through a hybrid of multiple revenue streams..." (middle of page 78) should not be included in this proposed operational plan. Again, the Finance Work Group did not make specific recommendations for funding - either for the match or for operations.	Acknowledged - Recommend revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
288	OP-3.2	78-81		general comment: any consideration for creating a budget should also include a detailed description of the timeline for implementation of a governance structure, timeline for Phase I, Phase II, etc. Since we have recommended that the budget be removed, these considerations should be set aside for future discussion.	Acknowledged - Recommend partial revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
143		8 & 9	Table 2 & 3	% References made below the table - may be add another row or a column to the existing table to readily depict the %s referenced??	Acknowledged - Recommend no change	This is clearly presented in current table.	NA
292	OP-4	94-98		general comment: please note that a detailed project management timeline was not shared with work groups and is included for illustration purposes only and will be refined at a later date using work group input.	Acknowledged - Recommend revision/addition	Text to be added	Y
37		All		The document has good content but needs leadership-level discussion and refinement to make the program achievable and align it with page 4. We would prefer to see strong focus on a few areas to make visible, measurable progress.	Acknowledged - Recommend no change	This plan is the result of leadership level discussions from stakeholders across the state. Agree with an approach that is focused and can demonstrate meaningful progress.	NA
39		All		General - Document should be "fronted" by a 1-2 page executive summary that synthesizes key data points, the 12 gaps/recommendations, and the recommended approach. Need to let people know quickly what the key messages are.	Acknowledged - Recommend revision/addition	Executive summary added	Y
40		All		General - the Figures and Tables are very helpful. Appreciate the use of data to support the gaps/recommendations.	Acknowledged - Recommend no change		NA
52	SP-7	ALL		General comment regarding this section re: Public Health. This is definitely an important area of focus and certainly a place for collaboration with the HIE. What doesn't "fit" is that all sections up to this point have been very conceptual and emphasize the fact that the first phase of our proposal does not require local storage of information. Yet, pages 40-41 are dedicated to very detailed specifics that require exactly that (and in an area - PH - that isn't the focus of MU in Stage 1. I am in agreement with the concepts and the requirements but they contradict the sections leading up to it. It could be confusing to the team evaluating the proposal (my opinion).	Acknowledged - Recommend revision/addition	This section of the report is to be rewritten in a way that points to the benefits of sending certain types of information to public health and a recommendation that the legislature take up the topic for discussion and potential change in law.	Y
61	SP-8.4	ALL		I see the acronym SDE used multiple times throughout this section without definition.	Acknowledged - Make Correction		Y
44		General		The value proposition for employers, who are facing rising costs and have increased interest in the health of their employees and the quality of care received, is not discussed in this document. Quality improvement and cost reduction for employers and their employees is an important consideration for the HIE.	Acknowledged - Recommend revision/addition	Recommend specific mention of benefits to employers within the introduction.	Y
315	SP-1	General		Need to say more about FQHCs specifically. They are big players in HIT in NH, have big political standing and have a prominent role in ACA legislation. Katie suggests having Bistate write something up for inclusion.	Acknowledged - Recommend revision/addition	Text on FQHCs added to Executive Summary and beginning of Environmental scan	Y
17				I would like to see more information about estimated costs to achieve different levels of HIE. These estimates might be based on the costs of re-creating existing systems.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
18				I didn't find any mention of the fact that existing systems are not necessarily compatible. If data elements are defined differently in different systems and do not measure equivalent things, they often cannot be combined in meaningful ways. How much would it cost to get everyone who is currently collecting data to collect it the same way? Are hospitals going to change what they are collecting now to accommodate a statewide system, when such changes are expensive?	Acknowledged - Defer to Future Discussion (After ONC submission)	The plan does address this concern. Recommend that we continue in future versions post ONC submission to be sure this concept is clear.	Defer
19				It seems to me that something is missing in the assumption that doctors who currently lack access to electronic medical records will suddenly have all their data in electronic format if they link up with hospitals that do have electronic medical records. Hospital systems are set up to handle the data they need and I doubt they are set up to handle the needs of independent doctors.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer

20			Doctors have traditionally ordered the data they need. This system is certainly not perfect, but it works pretty well. The big advantage is that the doctor obtains exactly what he needs in a very targeted manner. While this is not a universal data system, I think it should be acknowledged that data is often exchanged very well from one system to another using this "old-fashioned" approach. Doctors don't need the whole universe of data; they need data for a specific patient. Maybe some information should be included in this document to suggest why this type of data exchange is inadequate.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
21			It would be helpful to always define acronyms where they first appear.	Acknowledged - Recommend revision/addition		Y
22			I think it would improve the credibility of the document to reduce the use of superlatives such as "highly" and "very".	Acknowledged - Recommend revision/addition		Y
29			There is a common myth that having access to vast quantities of data means that people will have access to vast quantities of information. Data has to be skillfully analyzed and interpreted and that is rarely done, even with the more limited data we currently have available. Also, it is a huge assumption that having access to vast quantities of data means we would have access to vast quantities of good data. For example, not having data from Massachusetts means NH data will be skewed in many disturbing ways.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
63			Overall comment: Could there be a reference to which hospitals responded to the survey? This would perhaps help to weight the information.	Acknowledged - Recommend revision/addition		Y
64			Overall comment: the environmental scan is extremely interesting and helpful.	Acknowledged - Recommend no change		Y
69			Overall comment/question--At a recent national conference of state legislatures meeting, the presenter defined EMR as within an organization and EHR as across organizations. Our HIE plan definition is in conflict with this. Which is correct?	Acknowledged - Recommend no change	We have a glossary of definitions in the document, which is what we will be using as there is inconsistency in the industry on the use of those acronyms	Y
78			Overall comment General Court, not General Assembly whenever the reference occurs	Acknowledged - Make Correction		Y
79			Overall comment: It would be helpful, at least for NH use, to identify in Appendix A who the individual representatives of each stake holder were.	Acknowledged - Recommend revision/addition	Under discussion by core team - decision not reached by ONC submission date - defer to future versions	Defer
80			overall: the different workgroups seem to have varying interest in what services are offered by the HIE. This would necessarily influence complexity, privacy and security concerns, and timing of the various phases. This plan assumes there was consensus on later phase development, when there has not actually been consensus. When do we need to reach consensus on where the HIE will finally go?	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
83			overall question on proposed budget: are the projections based on the more robust vision of where HIE could go, or on a minimalistic HIE?	Acknowledged - Recommend partial revision/addition	Finance workgroup met regarding the new budget and section was re-drafted. Cost information is required by ONC and will be included. Revenue information is not required so we will explain the options explored but defer the decision on revenue model.	Y
103	Overall		It was my impression that the understanding of what would be done in the different Phases of HIE development varied across the document, particularly as the text for each different work group was encountered. I believe this was most noticeable regarding exchange to and from individual patients which was discussed as a very late and fairly difficult and complex undertaking in the initial overview but by two work groups as an undertaking to be begun in Phase 2 with preliminary preparations in Phase 1. I've signaled the problem I think HIE will face in the legislature if a master patient index is broached, but I also think there are technical and organizational complexities associated with exchange with patients that would be better deferred to a time when the initial kinks of the HIE machinery have been worked out.	Acknowledged - Recommend revision/addition	Identify and reconcile document	Y
125			Over all accurate summary of various stake holders issues, concerns and status.	Acknowledged - Recommend no change		Y
126			While the summary was accurate Elliot does have concerns since there is still many unknowns in this report. Governance will be critical and understanding what roles hospitals will have in the governance process. We feel governance will need to be comprehensive and include large stakeholder hospitals. Funding and sustainability is also a concern since matching funds have not been identified and many of the healthcare organizations are dealing with many unfunded mandates.	Acknowledged - Defer to Future Discussion (After ONC submission)		Defer
127			In terms of what is missing Elliot believes there was not enough recognition of what area organizations have done to assist non affiliated practices obtain state of the art technology and assist them in being positioned to obtain meaningful use. A number of organizations have made substantial investment in assisting community providers who otherwise would not be able to afford the technology. Also missing was assessment and discussion about the role of the consumer and the focus on patient portals as a meanings of health information exchange.	Acknowledged - Recommend revision/addition	Additional language to be added to environmental scan regarding the investments of the hospital systems and other non-hospital entities in the State	Y

139			General Comment: The tone of the entire document needs to be looked at closely as it varies with each domain.. Pg 4,24,30,49,76,78,79 - tone?	Acknowledged - Recommend revision/addition		Y
140			Due to time constraints, I was only able to review a few sections of this document such as environmental scan, governance and finance;	Acknowledged - Recommend no change		NA
141	Enc Scan		Excellent environmental scan details; a score card (as discussed at the core team meeting) will further depict the current strengths;	Acknowledged - Recommend no change	"Scorecard" to be added as a summary of the env. Scan in the executive summary	Y
155	General		Has the Plan been cross-walked against the HIE FOA, RFP, ONC Requirements Spreadsheet and the PIN?	Stakeholder question requires answer	Yes	Y
170		bullets	Are these the correct 5 domains? Are the names OK with ONC?	Stakeholder question requires answer	Plan sections are aligned with updated headings from ONC found at <a href="http://statehieresources.org/wp-content/uploads/2010/07/PIN-Comparison-Table-for-HTML_7-6_1419.htm">http://statehieresources.org/wp-content/uploads/2010/07/PIN-Comparison-Table-for-HTML_7-6_1419.htm</a>	Y
182	SP-7		I find the acronym "PH" annoying. Should be change to Public Health or Division of Public Health Services or DPHS or what?	Acknowledged - Recommend revision/addition		Y
197	SP-8.3		Need a way to simply show what is included in each phase and the timeline of those phase (Gantt chart). The use case tables in SP-8.4 are good, but not sufficient a summary.	Acknowledged - Recommend partial revision/addition	Recommend no change in this section - Can be accomplished in project plan	Y
209	OP		CHANGE all reference of Office of Health Information Technology to Office for Health Information Technology.	Acknowledged - Make Correction		Y
224	OP-3.5		Phase are references by Roman numerals.	Acknowledged - Recommend revision/addition	This will be handled as the entire document is "harmonized"	Y
225	OP-4		Show the additional Milestones: - Enabling Legislation passed - 06/30/11 - HIO Business Plan approved - 06/30/11 - HIO Established - 09/30/11 - Initial Phase 1 Operational - 09/30/10 (Proof of Concept) - Phase 1 Operational - xx/xx/xx - Phase 2 Operational - xx/xx/xx - Phase 3 Operational - xx/xx/xx	Acknowledged - Recommend revision/addition		Y
231	OP-5		Communication Work Group needs to address - Develop Topics to Educate On - Audience, Type, Method, ... (Find example of Communication Schedule).	Acknowledged - Recommend revision/addition	Section added on Communication	Y
232	App A		Do we want to list Stakeholder Reps?	Stakeholder question requires answer	Under discussion by core team - decision not reached by ONC submission date - defer to future versions	Defer
233	App B		Add terms: EMPI, RLS, MPI, HIO	Acknowledged - Recommend revision/addition		Y
237	General		Propose an addition glossary item: <b>HIO</b> - An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.	Acknowledged - Recommend revision/addition		Y
243	General		The NH Legislative body is commonly referred to as the General Court, not the General Assembly.	Acknowledged - Make Correction		Y
302	General		Given some people will just look at certain chapters, perhaps defining acronyms at their first appearance in each chapter.	Acknowledged - Recommend partial revision/addition	Make changes where practical.	Y
352			Page 3 figure 1 it may be so misleading to talk about 33% of the state health departments receiving syndromic surveillance data, because the percentage is based on lumping the state health department with 2 full-service local health departments. It may be better to say the state health department has this capacity while only two of the state's nine city health departments have this capacity. Not a major point, but I wanted you to be aware of it.	Acknowledged - Recommend partial revision/addition	ONC specifically requires a % which is why it is presented this way. Add some text to clarify	Y
353			Page 5 figure 2, subject 15. My concern, as stated in earlier e-mails to you, is that the wording of this section may cause those unfamiliar with the DPHS emphasis on security and privacy to believe there are existing privacy and security risks. This is not the case, because we have instituted policies, procedures, and practices as needed to ensure that the individually identifiable data is maintained in a private, confidential manner, and is used only by those entitled to do so by law for lawful purposes. It might be better to reframe your statement to say that and HIE would be intrinsically more protective of privacy and security due to the use of encryption, secure routing, another security factors that are native to the electronic storage and retrieval of data.	Acknowledged - Recommend revision/addition	Reword	Y

354			Page 5, figure 2, section 15, fourth bullet. Again, it's important to note that these systems are critical public health systems that require the use of identifiable information in order to carry out the department's duties under law. Also important to note that these systems exist behind the state's firewall, and therefore have all the built-in intrusion detection, antivirus, anti-malware and other state-of-the art protections expected in an enterprise level security environment. Access is limited to individuals who have a work-related need to be this data and who are further required to execute privacy oaths before access is granted.	Acknowledged - Recommend revision/addition	Reword	Y
355			Page 6, last sentence, Gen. comment, I know in some places the document refers to the state as the party to carry out the work. In other instances the plan refers to "we".	Acknowledged - Recommend revision/addition	References to "State" changed to "we"	Y
356			Page 7, strategy five, bullet one: the correct number of public health reporting systems is 35, and should be reported as such consistently throughout the document.	Acknowledged - Recommend revision/addition		Y
357			Page 7 strategy five, bullet three: you may wish to check with Frank in regard to the ability of patients to legally access their own data to an HIE.	Acknowledged - Recommend no change	Reached to commenter for verification - current interpretation is that patient may not participate in HIE entity though they own their data: the language in RSA 332-E:3 is as follows - "only a health care provider, for purposes of treatment, may have access to protected health information in a health information exchange."	NA
358			Page 20, table 7, should list the source of this information.	Acknowledged - Recommend revision/addition		Y
359			Page 29 first paragraph. It might be better to state that "all of the residents of the New Hampshire are served by a state health department. In addition, two of the state's nine cities have full-service health departments (Manchester and Nashua)..."	Acknowledged - Recommend revision/addition	Per an earlier comment, this paragraph to be replaced with text from Director of Public Health	Y
360			Page 29, second paragraph --replace "40 public health systems" with "35 public health systems"	Acknowledged - Recommend revision/addition		Y
361			Pages 30 - 32-- I'm not sure the purposes of this report are advanced by listing which data sets within DPHS contain identified versus de-identified data. As mentioned earlier, any data set with personal identifiers in it is properly protected, and limited in use to those required to do so in the general execution of their duties. Therefore, please delete these references.	Acknowledged - Recommend revision/addition	Core team deliberated on this point - references removed	Y
362			Page 40, bullet one -- replace "50 separate systems" with "35 separate systems".	Acknowledged - Recommend revision/addition		Y
363			Page 44 paragraph 1 -- It's not by policy that patients own their own data and that they have the choice to opt out of the HIE. This is state law, and should be reflected in such.	Acknowledged - Recommend revision/addition		Y
364			Page 52 2nd paragraph I think you should mention that the state offices of rural health policy is a program within the Division Public Health Services. As the noted earlier by others, Alisa's name should be deleted from the plan.	Acknowledged - Recommend revision/addition		Y
365			Pages 55 and 56 -- SP seven -- I like the rewording, looks fine as you drafted it.	Acknowledged - Recommend no change		NA
366			Page 62 paragraph 4 -- well stated public health benefit, leave as is!	Acknowledged - Recommend no change		NA
367			Page 75, fifth paragraph -- well stated. Leave as is.	Acknowledged - Recommend no change		Y
368			Page 80 sentence beginning with "Disclosure... Needs to be clarified.	Acknowledged - Recommend revision/addition		Y
369			Page 81 second bullet recommend that term "transmissions" be replaced with the term "reporting".	Acknowledged - Recommend partial revision/addition	Change 1 of 2 instances of "transmissions" to "reports"	Y
370			Page 82. We agree that it is appropriate to review our data sets to make sure that no more data than is actually necessary is collected and processed by the state health department.	Acknowledged - Recommend no change		NA
371			Page 87, we support bullet 4 as a good public health practice.	Acknowledged - Recommend no change		NA
372			Page 98 -- the sentence at the bottom of the page, beginning with "a detailed description... is repeated above the bullets on that same page.	Acknowledged - Recommend revision/addition	Delete duplication	Y
373			p.8 "public instrumentality" - define	Acknowledged - Recommend revision/addition	Define more clearly	Y
374			p. 9 Does phase I require change in law?	Stakeholder question requires answer	Phase I is within the current legal framework and requires no changes to that framework	Y
375			p. 21 SNF?	Stakeholder question requires answer	SNF = skilled nursing facility	Y
376			p. 32 RADS - change from Prevention Services to DPHS or Rad health	Acknowledged - Make Correction		Y
377			HAN - I think we send info/alerts to selected list of providers - not just CDC	Acknowledged - Make Correction		Y
378			p. 33 untethered and tethered - define	Acknowledged - Recommend revision/addition	Language changed to be more clear	Y
379			Overall, a very comprehensive and ambitious plan.	Acknowledged - Recommend no change		NA