

Health Information Technology Oversight Council

July 11, 2013, 1:00 – 4:30 pm

Portland State Office Building, Room 1E

800 NE Oregon St, Portland, OR

Webinar Registration: [Register for the HITOC webinar](#)

Meeting Objectives

- Updates on EHR incentive Program and CareAccord
- HIT/HIE Phase 2 process
- HIT/HIE Phase 2 planning: substantive discussion for HITOC input
- Discuss Next Steps

Time	Topic and Lead	Action	Materials
1:00 pm	Welcome, Opening Comments, Approve Minutes – Greg Fraser		1. Agenda 2. May 2, 2013, minutes
1:10 pm	Updates – Karen Hale and Sharon Wentz <ul style="list-style-type: none"> • EHR Incentive Program • CareAccord® 	Information Discussion	
1:35 pm	Announcements – Susan Otter <ul style="list-style-type: none"> • HIT Task Force – call for nominations • CareAccord Program Director position posting 	Information Discussion	
1:50 pm	HIT/HIE Phase 2 process – Susan Otter	Information Discussion	
2:20 pm	HIT/HIE Phase 2 planning: substantive discussion for HITOC input – Susan Otter and Patricia MacTaggart <ul style="list-style-type: none"> • Needs identified so far through stakeholder process • Discussion of Needs 	Information Discussion	3. Working draft of HIT/HIE Needs identified document
3:50 pm	Next Steps – Susan Otter	Information Discussion	
4:15 pm	Public Comment	Information Discussion	
4:25 pm	Closing Comments – Greg Fraser	Information Discussion	

Next Meeting: **Thursday, September 12, 1:00 pm – 4:30 pm**
Oregon State Library
Room 103
250 Winter St.
Salem, OR

**Oregon HIT/HIE Priorities to Support Health System Transformation: Listening Sessions Summary
WORKING DRAFT, 7/9/13**

NOTE: This is an initial draft of a document in progress, and will be updated as additional stakeholder input is received.

Approach

Oregon is developing a Phase 2 HIT/HIE Business Plan framework by working with stakeholders to identify the full set of HIT/HIE needs to support transformation efforts, and to provide clarity on what elements of these needs present a clear role for state government or statewide services. Initial listening sessions/interviews have been held with key stakeholders. Based on this initial input, staff will work with consultants to develop a straw model, which a public task force will vet over summer/fall 2013. Oregon's resulting business plan framework will provide an actionable framework for funding and implementation efforts.

The first stage of this effort includes listening sessions/interviews with key stakeholders, including: Coordinated Care Organizations (CCOs), local/regional health information exchange organizations (HIOs), hospitals and health systems, counties, providers, advocacy and consumer groups, state OHA leadership, the Health Information Technology Oversight Council (HITOC), and commercial health plans.

HIT/HIE Needs Identified for Health System Transformation

Overarching Considerations for State/Statewide Role

In considering the state/statewide role, respondents outlined a number of considerations:

- Infrastructure to support the exchange of information
- Standards to support the quality of the data and resulting information
- Economies of scale, where public and private entities can come to consensus around a mutual need
- Serving a public good

Needs grouped in several areas:

- Mechanisms to Support Care Coordination
- Mechanism to Improve Quality of Care and Support Alternative Payment Models
- Creating the Information Highway
- Standards, Policy and Technical Assistance to Ensure Trust and Public Needs Met
- Public Health/Population Health
- Clarity on the Path toward Transformation
- Financial Capacity to Sustain the Electronic Exchange of Health Information

Mechanisms to Support Care Coordination

1. Sharing information within the physical health care system (traditional HIE uses such as labs, radiology, problem lists/allergies, medication lists, referrals, etc.)
 - a. There was a consistent message that HIT is needed to support the exchange of information; an "information highway" to assure coordination of care and avoid duplication of services is

foundational to support various care coordination mechanisms (“the cars that run on the information highways”).

Local HIE efforts are focusing in this area with a particular strength of local work resulting in trust building and shared goals/value around HIE. “Technology is relatively easy. It’s the culture, training, workflow that is the hard part.”

2. Sharing data across health care systems (physical, behavioral, home health, etc.)
 - a. Many respondents indicated that sharing info across health care systems is important but not happening yet, with barriers – technical, policy/legal, etc.
3. Sharing data across services for the whole person (long term care, housing, education, criminal justice, etc.)
 - a. Some respondents pointed to the need to include exchange of key care coordination data with non-health providers (social services, housing, etc.) over time.
4. Care coordination tools:
 - a. Shared care plans: For individuals with complex case/care management needs, participants identified the need for technical infrastructure to support the electronic exchange of health information that allows for the sharing of a care plan amongst all members of a care team. CCOs with their providers need to appropriately manage the care of the “whole person” in a patient-centric health system that addresses prevention, treatments, transitions of care, and follow-up. They need to be able to identify who is managing the care, as well as provide the critical information from each domain of care that will be relevant to other care providers.
 - i. Role of the state could include convening stakeholders to define the core elements of a shared care plan tool (data elements, definitions, specifications, etc.)
 - b. Hospital alerts/notifications (automated system to inform the primary care provider or care team when his/her patient is seen in the ER, admitted to or discharged from a hospital or other institution).
 - i. An example is to develop an alert system that leverages ADT (admit, discharge, transfer) messages, which are summary of care documents recording health information related to a hospital admission and discharge.
 - ii. Current availability of hospital notifications includes information from some hospitals to providers in their area and from OHSU to referring providers. Providers do not have a system to obtain ADT information from all hospitals across the state.
 - c. Alerts/flags notifying primary care provider/care coordinator of poor outcomes needing intervention: A concern identified was the need to avoid “alert fatigue” due to information overload. Appropriate clinical decision support is desired.
5. Other non-technical care coordination needs identified:
 - a. TA/training is needed to support providers in using health information in a meaningful way, including adjustments to workflow
 - b. The focus needs to be the provider managing information in a clinical setting. The problem isn’t lack of data; it is too much information but not getting the right information to the right people at the right time.
6. Technology considerations for care coordination
 - a. Provider directory/identity management in order to facilitate the timely exchange of information to the appropriate parties, including physical and behavioral providers. As stated by one participant, “a state based provider directory would solve a lot of problems, but this is not a minor effort for ongoing operations as well as development”.
 - i. A provider directory, in this context, is a database that lists information on health care providers that at a minimum includes electronic routing address for a secure e-mail

- address but is expandable to include contact information, location of practice sites, licensing, etc.
- ii. A provider directory could be used to locate providers and attribute them to practice sites, health plans, hospitals, and individual patients in order to identify provider eligibility to receive notifications, etc. regarding a particular patient. Dependencies: cross-index existing sources of directory information to establish current baseline and resources.
 - b. Several respondents felt there is an important role for Direct secure messaging in transporting information, particularly exchanging information among health care providers and non-health systems (social services, e.g.) that do not have an EHR.
 - c. For health care providers with EHRs, the ability to access data via their EHR and not require an external “sign-on”.
 - i. Single “sign-on” allows the user to view multiple applications from one screen. For example, the process authenticates users for all the applications they have been given rights to and eliminates further prompts when they switch applications during a particular session.
 - d. Several respondents indicated that the state could add value by providing access to state data that can be useful to the CCOs, such as public health, foster care and prescription drug monitoring program information.

Mechanism to Improve Quality of Care and Support Alternative Payment Models

CCOs are accountable for both population health management and population risk management, the ability to identify high risk/high needs patients. Both responsibilities require capacity for data collection, aggregation, analysis and reporting. The state also needs to provide public reporting on CCO and state health system performance metrics, including new clinical quality metrics that could be reported from EHRs. Capabilities in these areas are dependent on the quality of the clinical data entered into EHRs or other systems and adequate business intelligence tools.

1. A focal point for almost all participants is the ability to aggregate clinical data for performance metrics, monitoring and designing interventions, and support for alternative payment models.
 - a. OHA’s CCO metrics include 2 EHR-based clinical metrics, and CCOs are particularly interested in the ability to access aggregated clinical data to track/monitor/intervene for members/providers related to these metrics.
 - b. Some respondents were interested in collecting/aggregating the screening-related performance metrics, such as screening registries for SBIRT, depression, developmental screening, etc.
 - c. Longer term, some participants identified the need for aggregation of claims and clinical data, separately and integrated with each other and with other administrative and performance data (survey). Data aggregation for performance metrics and monitoring is needed at some level for OHA/CCO metrics and analysis, as well as for performance metrics monitoring.
 - d. The need for a clinical data warehouse/repository was discussed in context of data aggregations and dissemination. A clinical data warehouse/repository is a database which collects clinical information directly from EHRs and from other data sources.
2. Other non-technical needs identified:
 - a. Improvement in the quality of data available was identified as a more immediate need by many.
 - i. A data dictionary is a resource that precisely specifies the structure and content of data elements. Uniform use of a data dictionary ensures that all users know what to expect from

- the health data. Model dictionaries exist and have been implemented by other states (e.g. Vermont).
 - ii. Working directly with providers to improve the quality of the data entered into EHRs, and building processes into provider workflows to ensure high-quality data come into the system is also needed.
3. Other considerations:
- a. Health care providers may want access to data on cost, utilization, and outcomes on the whole picture to demonstrate the value of their part – for example, to demonstrate that increases in primary care achieve savings and improved outcomes by reducing hospitalizations. Data is needed to be able to assess the total costs and outcomes beyond the data that primary care providers have in their EHRs.
 - b. For at least one program, being able to identify the mother for each infant and to establish that relationship would allow for the ability to evaluate clinical outcomes related to prenatal care, etc.
 - c. OHA could provide vital statistics information to CCOs/plans/providers on providers and patients who have passed away.

Creating the Information Highway

1. Assuring there is a trusted, supported infrastructure to connect local exchange of health information efforts, including regional health information exchange organizations (HIOs) that support various local HIE services, as well as trust communities across the state to connect any Health Information Service Providers (HISPs) in Oregon that support Direct Secure Messaging.
 - a. The state can play a role in ensuring/providing information highway capabilities in the “white space” where none exists.
2. Non-technical needs identified:
 - a. There was agreement that statewide standards, aligned with national standards where national standards exist, are required for: (1) data and transport, and (2) connection, participation and use whether the health information technology is operated by the state, the CCO or individual providers.
 - b. Policy considerations, including consent, would be important to address.
3. Technology considerations:
 - a. Direct Secure Messaging: Shorter term, the emphasis appeared to be on ensuring Oregon providers have the ability to provide clinical information electronically to entities that are known (push) to reduce duplication of services, lower cost and improve the quality of care. There was some support for CareAccord (the program). As one participant stated, “it has an important role for Direct exchange. Although Direct exchange is not enough, it is a critical piece for planned care, such as referrals.”
 - b. Query Capacity: There was some interest in the state advancing toward providing the exchange of health information when entities are not known (query/pull), as Direct does not support unplanned care. However, others felt it was better to wait because of the instability and evolving nature of query technology.
 - i. Query requirements and specifications are more complex than secure messaging, including the need of a record locator and a person index. The record locator system (RLS), a key part of Query-Based information exchange capabilities, identifies all of the sites and providers with health records about an individual (at least all that are available electronically). The service may simply give notice that the record exists or it may be matched with query

- capability so that the investigating provider can electronically request the health information.
- ii. A person index is master list to identify that an individual is the same person, particularly when he or she receives care from multiple providers and sites.
- c. Consumer mediated exchange: There was some interest, although not immediate, “eventually record really needs to belong to patient.”

Standards, Policy and Technical Assistance to Ensure Trust and Public Needs Met

For the information highway to be of value and sustainable, it must be used. CCOs consistently identified that the state has a role in assisting them to remove barriers to moving forward, ensure trust by providers and patients, and meet a public need.

1. There was agreement that the state has a leadership role to facilitate, convene, and encourage collaboration and economies of scale; however, demands on CCOs’ and their providers’ time are immense so carefully considering when and how to convene is essential.
 - a. Clarifying policy “rules of engagement for sharing data,” including privacy, security, and consent policy for the exchange of health information. Current Direct secure messaging “doesn’t require a lot from policy but when get into queries, the state needs to address meaningful choice and consent policies. We are waiting for state to give some guidance.”
 - b. Clearing policy barriers regarding information sharing where possible, clarifying privacy policies, providing templates that meet privacy standards
 - c. Convening for collaboration and economies of scale in areas of major concern, such as navigating the vendor market.
 - d. HIO/HISP standards and qualifications/certification
 - e. Ensure the quality of the EHR data
 - f. The state should provide the “Guide Rail” to facilitate best practices.
 - g. There was discussion of the ability for the state and stakeholder group to collaborate to negotiate favorable group pricing.
 - h. Providing clarity and information on federal requirements and standards as they evolve
4. Key trepidation: a common understanding of privacy, security and consent legal and operational requirements, chiefly related to behavioral health.

Public Health/Population Health

The exchange of health information is critical for individual, public and population health management to further accountability, assure transparency, and improve population health.

- a. Leverage infrastructure and best practices that support and address population/public health risks and operations, including requirements for public health reporting, meeting public health meaningful use objectives, support public health efforts to exchange information with and alert providers, etc.
- b. TA and guidance to promote activities at the individual and population levels that move towards a community rather than medical approach.
- c. Guidance regarding and access to data for secondary public/population health purposes.

Clarity on the Path toward Transformation

Each effort demands a financial and human investment at the state, local, CCO and provider level, so providing clarity on the state/statewide HIT/HIE plans with a supporting vision and aligning timelines is a serious concern of all entities. This is especially true as there are multiple moving components of Oregon's health system transformation and new, and evolving, thought processes and demands to support the "system we are creating".

1. CCOs and their providers expressed the need to know the state strategy and the roadmap; they need to know the blue print "yesterday" for now and two years from now.
2. Practicality demands scope management. "Let's get something done – expansive vision is fine but targeted implementation is needed."
3. Providing clarity and information on evolving technology and promising approaches (e.g., mobile devices)
4. Key trepidations:
 - a. Timing of policies and specifications, particularly those with financial implications such as quality metrics

Financial Capacity to Sustain the Electronic Exchange of Health Information

An underlying concern among some respondents is the long-term viability of an electronic health information infrastructure on which more and more entities will depend for support as they deliver health care. The potential opportunities and limitations of Medicaid investments in state HIT/HIE infrastructure was a part of each discussion.

1. There is agreement that ensuring financial sustainability of critical HIE/HIT infrastructure to support HST is a must and that it is not the sole responsibility of the state or its CCOs.
2. Full and appropriate utilization of available federal dollars is a given; however, how the private shared responsibility is to be addressed was not fully elucidated. While many respondents expressed willingness to participate financially in supporting statewide HIT/HIE services that met their needs, several also expressed the criteria that financing plans must be equitable (not just CCOs, but also commercial plans, etc.).

Health Information Technology Oversight Council

July 11, 2013

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, sans-serif font above the word "Health" in a large, blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, sans-serif font. The entire logo is centered within a light blue, curved banner.

Oregon
Health
Authority

Agenda

1:00 pm - Welcome, Opening Comments, Approve Minutes – Greg Fraser

1:10 pm - Updates – Karen Hale and Sharon Wentz

1:35 pm - Announcements

1:50 pm - HIT/HIE Phase 2 Planning Process – Susan Otter

2:20 pm - HIT/HIE Phase 2 Needs: substantive discussion for HITOC input – Susan Otter and Patricia MacTaggart

3:50 pm - Next Steps – Susan Otter

4:15 pm - Public Comment

4:30 pm - Adjourn

Meeting Objectives

- Updates on EHR incentive Program and CareAccord
- Update HIT/HIE Phase 2 planning process
- HIT/HIE Phase 2 planning: substantive discussion for HITOC input
- Next Steps

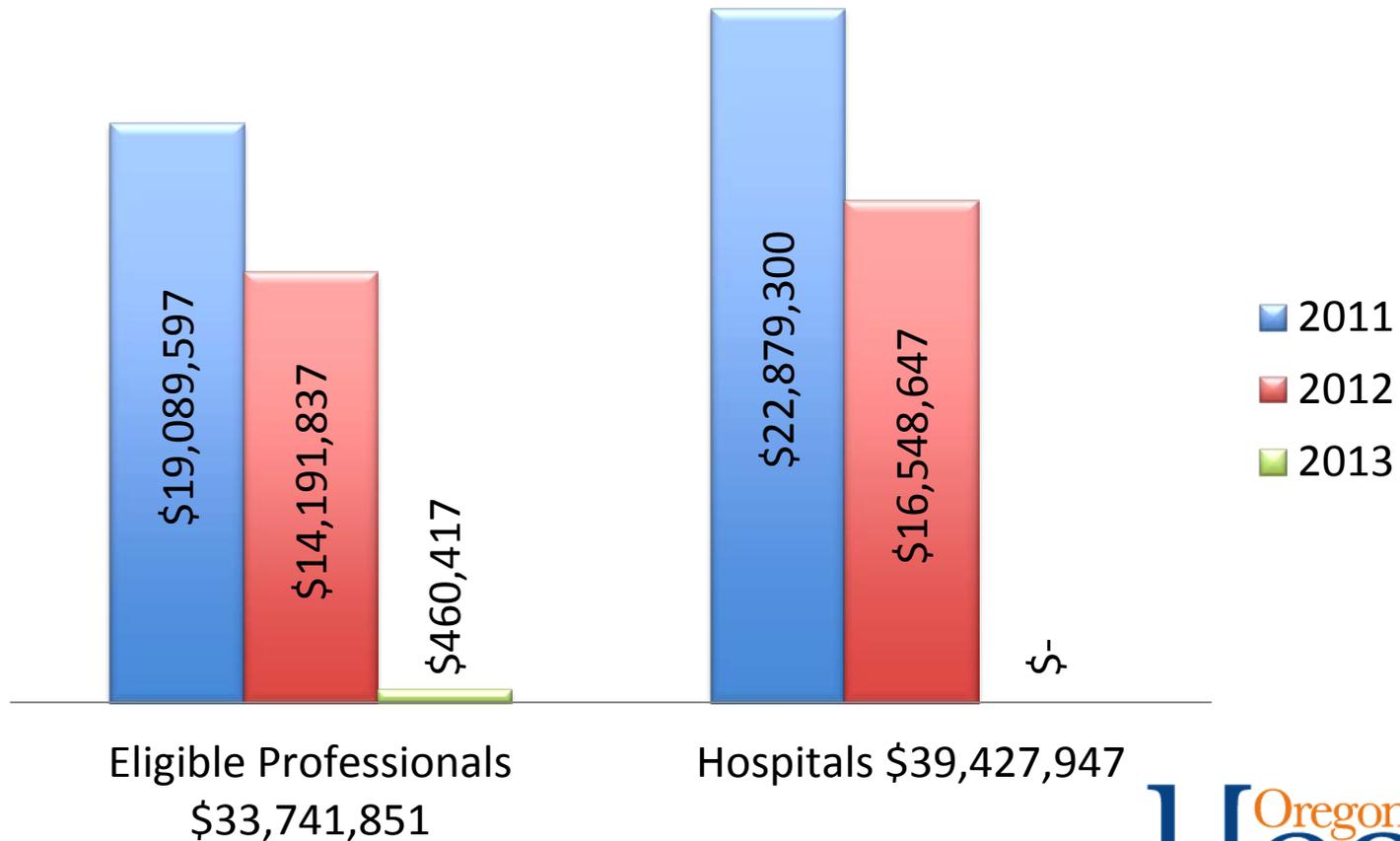
Medicaid EHR Incentive Program

Karen Hale



Medicaid EHR Incentive Program update

Total Oregon Medicaid incentives paid to date
= \$73,169,798



Medicaid EHR Incentive Program update

Number of Payments					
	2011	2012	2013	Total Payments	Total Unique Participants
Eligible Professionals (EPs)	912	898	22	1832	1455
Hospitals (EHs)	30	28	0	58	50
Total	942	926	22	1890	1497

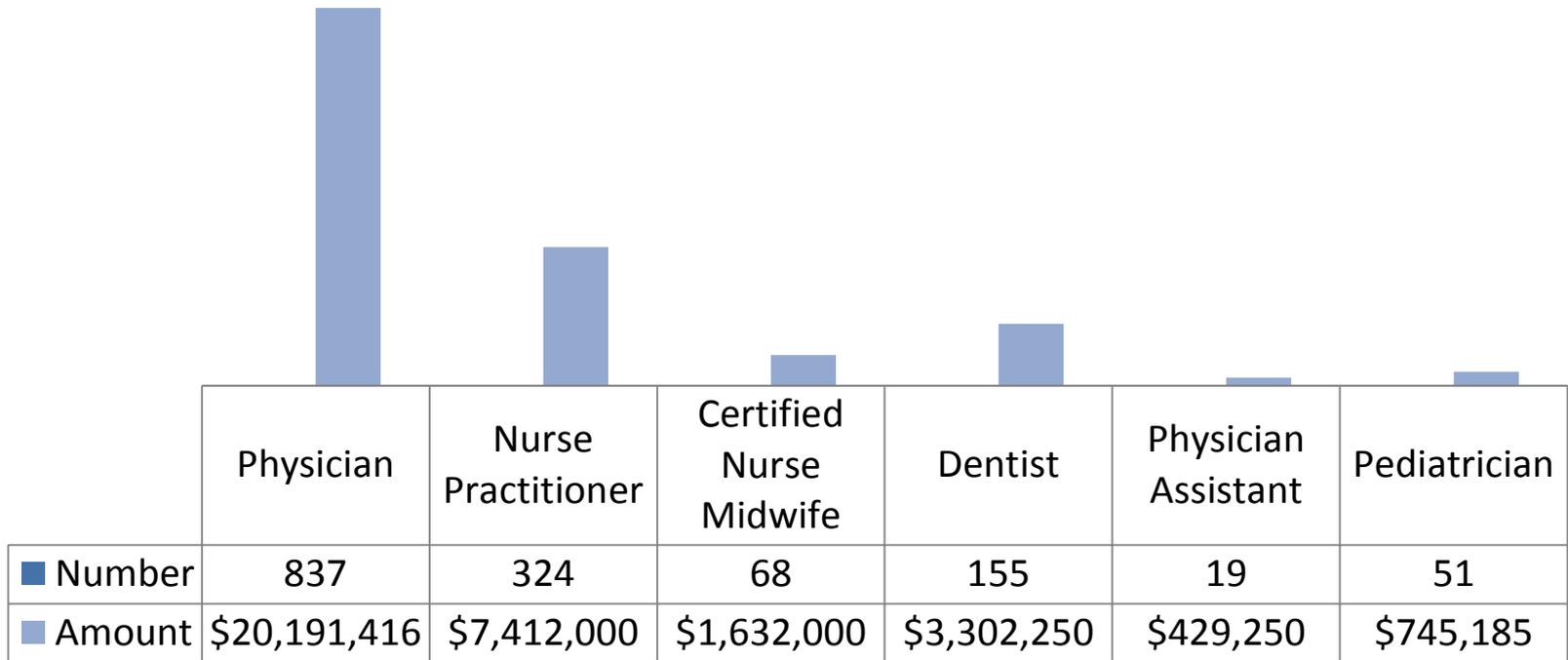
Payments by application type					
	2011		2012		2013
	AIU	MU	AIU	MU	AIU
Total EPs	912	0	521	376	22
Total EHs	24	6	15	13	0
Total	936	6	536	389	22

Over 41% of those who applied in 2011, received an MU payment in 2012

AIU – Adopt, Implement, or Upgrade
 MU – Meaningful Use

Medicaid EHR Incentive Program update

Payments by EP Types



Medicaid EHR Incentive Program update

Pending applications by AIU and MU					
	2012		2013		Totals
	AIU	MU	AIU	MU	
Eligible Professionals	86	124	153	42	405
Hospitals	0	0	3	6	9
Total	86	124	156	48	414

If all 2012 applications for MU are approved, Oregon 's MU return rate would be as high as 54%

Medicaid EHR Incentive Program update

Applications that didn't cross the finish line

	2011	2012		Totals
	AIU	AIU	MU	
EPs	120	104	37	261
Hospitals	3	1	1	5
Total	123	145	38	266

Medicaid EHR Incentive Program update – Oregon comparison

Overall EHR payment counts (Medicare and Medicaid), since inception

- Oregon ranks 21st out of 58 programs – \$167,534,728 paid to 5,848 hospitals and EPs as of May 2013¹
- California, Texas, and New York are the top 3; Washington is 12th
- Oregon's population is 27th highest out of 51 states²

Proportion of Meaningful Use payments paid under the Medicaid EHR Incentive Program

- Oregon ranks 10th overall with 20% of total Medicaid EHR incentive payments made for meaningful use
- Delaware (35%), Iowa (28%), and Maine (25%) are the top 3

1 – State Breakdown of Payments to Medicare and Medicaid Providers through May 31, 2013;
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html>
2 - <http://www.ipl.org/div/stateknow/popchart.html>

CareAccord®

Sharon Wentz

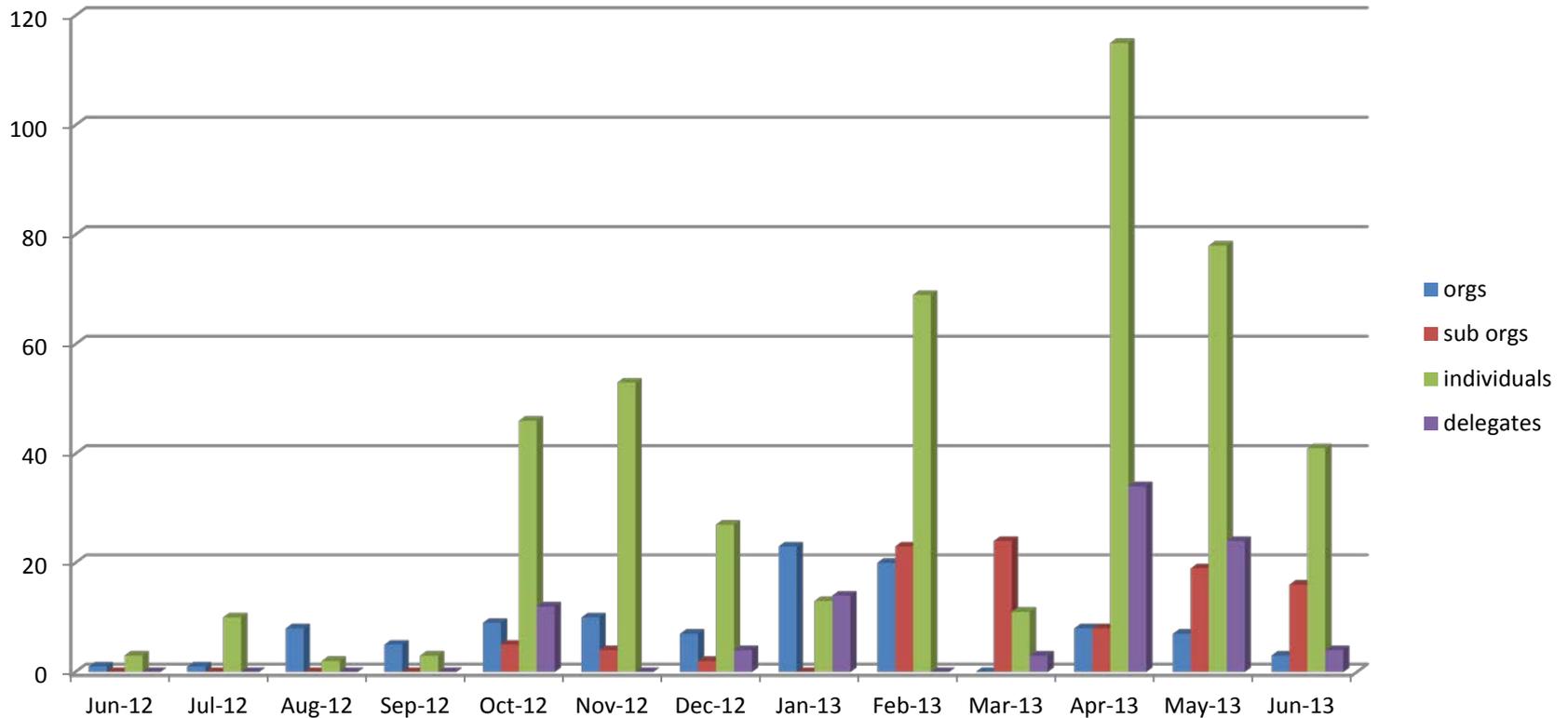
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CareAccord Cumulative Total Registered Users Chart

Account Type	Total CareAccord Registered Accounts June 1, 2012 - June 30, 2013
Organization	104
Sub-Organization	105
Individual User	471
Delegate	97
TOTAL	777

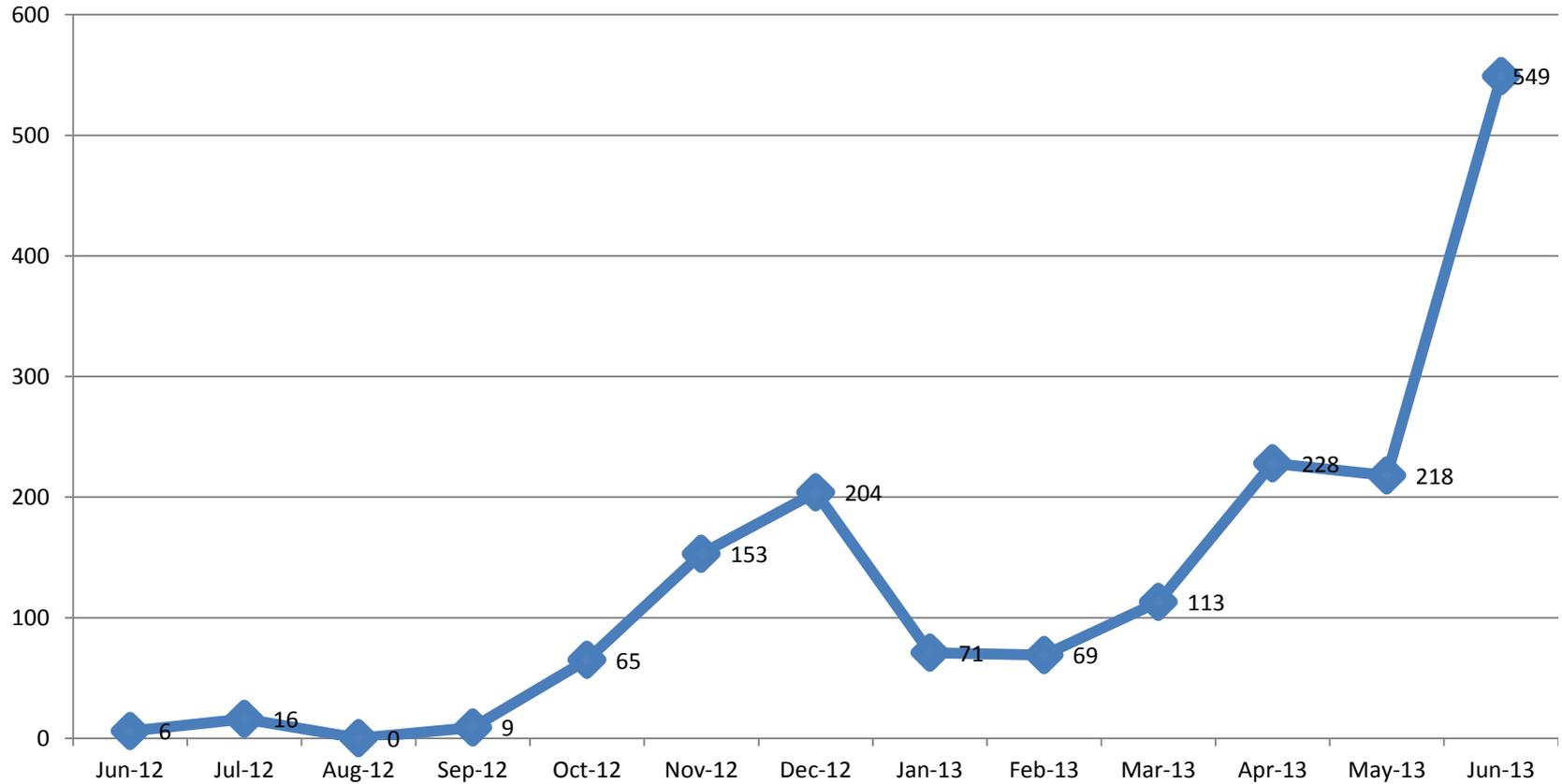
CareAccord Registered Users per month

June 2012 – June 2013

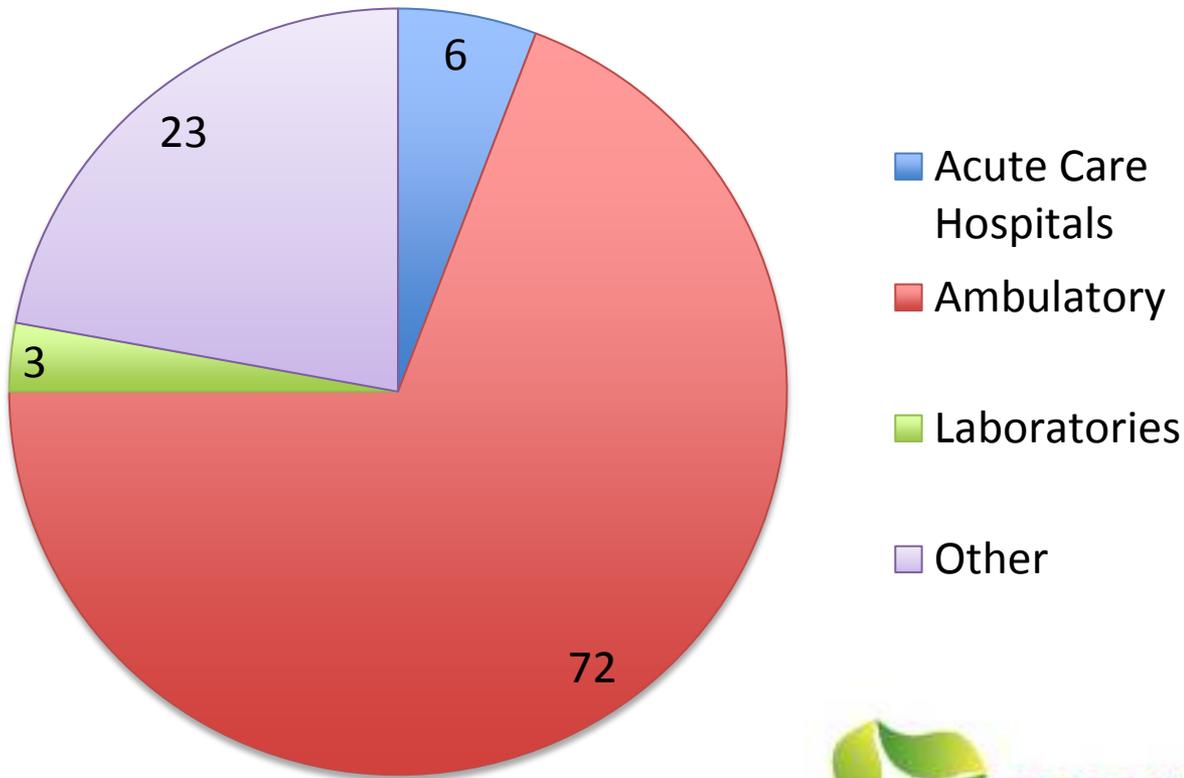


CareAccord Direct Secure Message Transactions by Month

June 2012-June 2013

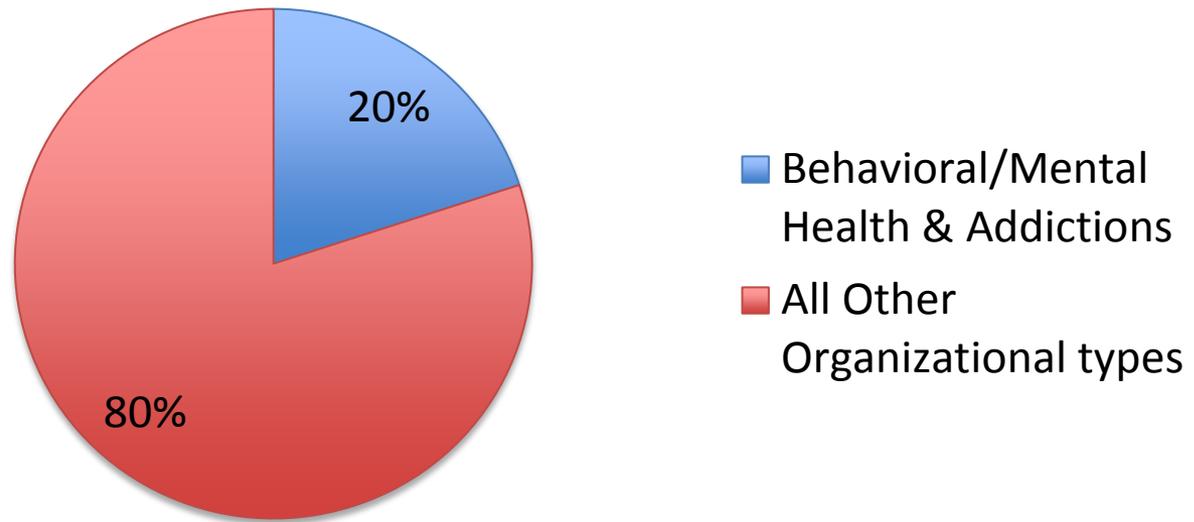


Organization Types Participating in CareAccord Direct Secure Messaging June 2013



Behavioral/Mental Health and Addictions Organizations

June 2013



HIT/HIE Phase 2 Planning Process

Susan Otter



Objective

- Multi-year business plan framework for the critical HIE/HIT services necessary to support to Oregon's Health System Transformation, in particular:
 - Exchange of clinical, patient information for:
 - care delivery models, supporting integrated, coordinated care, alternative payment mechanisms, etc.
 - sharing information for care coordination and addressing the whole person
 - quality reporting and accountability purposes
 - other state purposes such as supporting public health objectives
 - Supporting statewide transformation: Medicaid CCOs and other payers

Oregon's Phase 2 business plan framework

- High level advice and recommendation to OHA, with OHA to work out the details
- HIT/HIE Priorities for Phase 2 and role of the state
- Governance and operations
- Technical infrastructure
- Financing for implementation and ongoing sustainability
- Related policy issues and stakeholder engagement

Phase 2 HIT/HIE Planning Process

- May: ONC approval of Phase 1 to Phase 2 template
- Spring/Summer: Listening sessions with key stakeholders,
 - including each CCO, health systems, plans, advocates, providers, HITOC, counties, and internal state leadership
- Summer: Develop straw model(s)
 - for technology services, state role/governance, finance
- Late summer/fall: Task force to vet straw model
- Fall: Phase 2 HIT/HIE Business Plan framework in place
 - Some “fast track” implementation work begins including federal funding requests in Summer

Work Ahead on Governance

- State ongoing role, which could include:
 - HIT standards and guidance
 - Technical Assistance
 - Principles
 - Priorities and Timing
 - Implementation advice
- Operational entity
 - Consider state vs. non-state entity
 - Selection criteria for entity

Work Ahead on Finance and Services

- Implementation financing structure
- Ongoing sustainability financing structure

- Build objectives for HIT/HIE services
- Develop business and technical requirements
- Prioritize and phase service implementation
- Implement and run HIT/HIE services

Work Ahead on Potential Legal and Policy Issues

- Fees
 - No existing authority to impose fees
- Consent policy
 - Option to reconvene the Consent Implementation Subcommittee, as well as continuing Consumer Advisory Panel's role
- Possible updates to HITOC statutes, ORS 413.301-413.308

Phase 2 HIT/HIE Plan

Susan Otter, State Coordinator for HIT

Patricia MacTaggart, Consultant from
George Washington University



Listening sessions to date: Overarching Considerations for State/Statewide Role

- Infrastructure to support the exchange of information
- Standards to support the quality of the data and resulting information
- Serving a public good
- Economies of scale, where public/private entities can come to consensus around a mutual need

Listening Sessions: HIT/HIE Needs to Support Health System Transformation

- Mechanisms to Support Care Coordination
- Mechanism to Improve Quality of Care and Support Alternative Payment Models
- Creating the Information Highway
- Standards, Policy and Technical Assistance to Ensure Trust and Public Needs Met
- Public Health/Population Health
- Clarity on the Path toward Transformation
- Financial Capacity to Sustain the Electronic Exchange of Health Information

Needs Identified through Listening Sessions

Mechanisms to Support Care Coordination

- Share patient information:
 - Among physical health providers, between physical/behavioral/dental providers, including providers with no EHRs
 - Across entire care team, including long term care and social services, and extending into education, criminal justice, etc.
- Shared care planning spaces to support virtual teams
- Help providers with workflow to integrate EHR/shared information, make data actionable and useable
- Local HIE efforts: importance of trust, buy-in, shared goals
- State roles: Make state data on patients accessible, remove or clarify policy/legal barriers to sharing information

Needs Identified through Listening Sessions

Mechanisms to Support Care Coordination

- Technical:
 - Electronically sending the right patient data to the right clinician and back with a closed-loop referral
 - Sending automated alerts when patients are discharged or admitted to the ED or hospital to help providers with follow-up and the facilitation of critical transitions
 - Leveraging data to pinpoint high ED or inpatient utilizers and increase appropriate primary care and health care system utilization
 - Key foundational components such as a provider directory, secure messaging.

Needs Identified through Listening Sessions

Mechanisms to Improve Quality of Care and Support Alternative Payment Models

- CCOs/plans need to:
 - Monitor provider performance for quality, cost, outcomes
 - Track and submit quality metrics to OHA
 - Target populations/providers to support new care models
 - Design and implement alternative payment models
- Providers need to:
 - Report metrics data to multiple entities
- Oregon Health Authority needs to:
 - Collect, analyze, report on metrics for CCO Quality Pool, monitor performance of health system and effectiveness of model
 - 2 MU CQMs, screening measures
- All need to:
 - Ensure quality/completeness of clinical data

Needs Identified through Listening Sessions *Creating the Information Highway*

- Oregon providers should have a trusted, supported HIT/HIE “highway” to provide clinical information electronically
 - Hub of regional HIEs and HISPs for exchange when entities are known (Direct) and when entities are not known (query)
 - Consumer mediated exchange: “eventually record really needs to belong to patient.”
 - Continued need for Direct Secure Messaging

Need Identified through Listening Sessions

Standards, Policy and Technical Assistance to Ensure Trust and Public Needs Met

- Clarifying policy “rules of engagement for sharing data”
 - including privacy, security, and consent policy for the exchange of health information
- Establish state standards
 - using national standards where exist; Industry standards or best practices where national standards are maturing
- Clearing policy barriers and setting the right policy where needed (e.g., consent policy for HIE)
- Convening for collaboration and economies of scale in areas of major concern.
- Provide the “Guide Rail” to facilitate best practices.
- Ensuring HIE/HIT infrastructure is properly operated, meets public need

Needs Identified through Listening Sessions

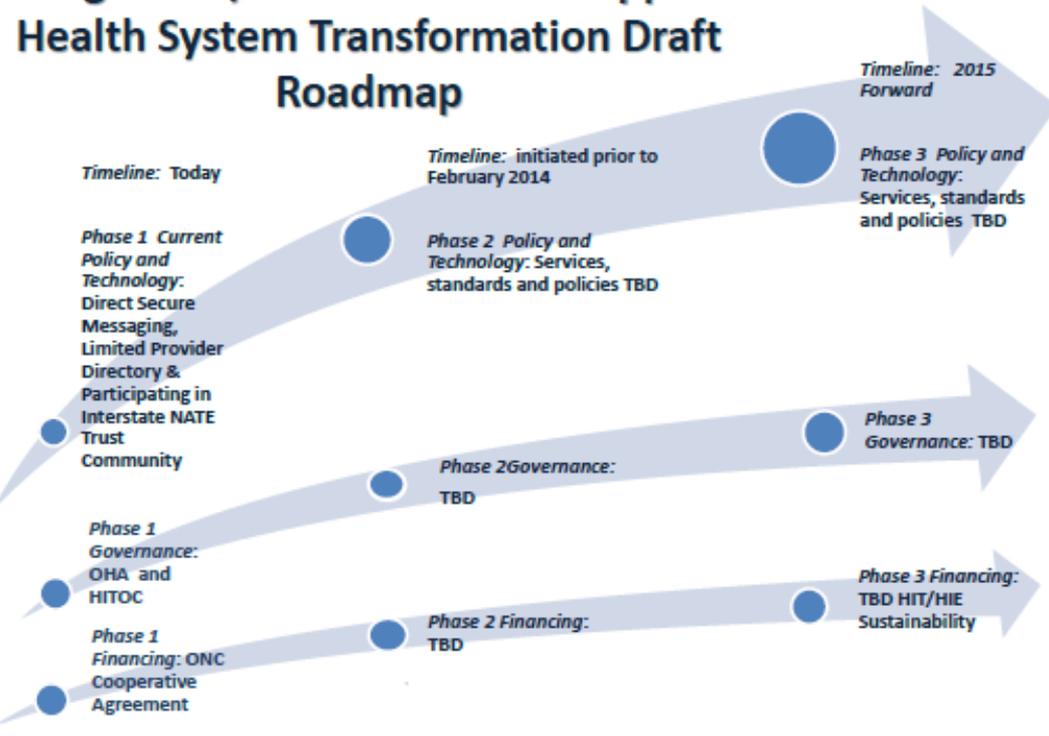
Public Health/Population Health

- TA and guidance to promote activities at the individual and population levels that move towards a community rather than medical approach.
- Guidance regarding and access to data for secondary public/population health purposes.
- Decrease dependency on “point to point” and utilize “hub” where possible
- Leverage infrastructure that support and address population/public health risks and operations, including requirements for public health reporting, meeting public health meaningful use objectives, support public health efforts to exchange information with and alert providers, etc.

Need Identified through Listening Sessions

Clarity on the Path toward Transformation

Oregon HIT/HIE Priorities to Support Health System Transformation Draft Roadmap



- Providing clarity and information on the state strategy and roadmap;
- Providing clarity and information on federal requirements and standards as they evolve
- Providing clarity and information on evolving technology and promising approaches (e.g., mobile devices).

Needs Identified through Listening Sessions

Financial Sustainability

- Concern that ensuring financial sustainability of critical HIE/HIT infrastructure to support HST is a must and that it is not the sole responsibility of the state or its CCOs.
- Using available federal/state dollars in conjunction with financial participation by stakeholders was discussed
- Many respondents expressed willingness to participate financially in supporting statewide HIT/HIE services that met their needs, several also expressed the criteria that financing plans must be equitable

Discussion



Next Steps

Susan Otter



Next Steps – Phase 2 planning

- Task Force call for nominations coming
 - Task Force to provide recommendations to OHA
 - Specifically regarding: Governance and operations, Technical infrastructure, Financing for implementation and sustainability
- July/August: Continue listening sessions
 - Produce Straw Model
- September/October: Task Force
 - Produce HIT Business Plan Framework

Next Steps - HITOC

- No HITOC meeting scheduled for August (email update)
- Next meeting (September 12th, State Library in Salem)
 - Discuss draft Straw Model
 - Receive update from O-HITEC

Public Comment



Closing Comments

Next HITOC meeting:

Thursday, September 12, 2013, 1:00-4:30 pm

Oregon State Library

Rooms 103

250 Winter St. NE

Salem, OR

Questions or Comments:

Susan Otter

State Coordinator, Health Information Technology

Director, HITOC

Susan.Otter@state.or.us



Oregon Health Authority