

Health Information Technology Oversight Council

Thursday, March 6, 2014

1:00 – 4:30 pm

Council and Ex-officio Members Present: Greg Fraser (Chair), Dave Widen, Erick Doolen, Ken Carlson, Bob Brown

Council and Ex-officio Members by Phone: Ellen Larsen

Council and Ex-officio Members Absent: Judy Mohr Peterson, Katrina Hedberg

Staff Present: Susan Otter, Britteny Matero, Lisa Parker, Karen Hale, Nick Kramer, Tyler Larson, Sharon Wentz, Matt Ausec.

Guests: John Hall (KrySORA, by phone), Tom (by phone), Scott Zacks (by phone)

Welcome, Opening Comments – Greg Fraser (Chair)

Refer to meeting materials: “December 12, 2013, Minutes”

Action: The Chair asked for a motion to approve the meeting minutes. Dave Widen moved to approve the minutes of the December 12, 2013 meeting and Ken Carlson seconded the motion, which was approved by unanimous consent.

HITOC’s Role – Susan Otter

Refer to slides 4-8

- Susan discussed the role of HITOC in the future, which is tied to the goals of HIT-optimized health care that were developed by the Oregon Health IT Task Force. The role of the state in achieving these goals was highlighted (support, standardize & align, and provide some state level services for closing gaps and supporting HIT services available locally). HITOC members highlighted the importance of aligning new metrics with existing ones (i.e. Meaningful Use) and ensuring that existing tools and standards enable this.
- Question: what is HITOC’s role in helping to align these things—what is meant by align?
Answer: HITOC would provide expertise, advice, and feedback when the state is requesting reporting of HIT-related metrics for various programs (e.g., coordinated care organization (CCO) metrics, patient-centered primary care home, OEBB/PEBB, etc.).
- HITOC’s role was then discussed in light of the state’s role. Susan highlighted a new iteration of the former HIO Executive Panel that would provide guidance to HITOC and the state on the health IT implementation efforts in communities and organizations on the ground.
- Question: What is not within the scope of HITOC’s role? Answer: HITOC is not an implementation steering committee, nor is it a steering committee or oversight body for the CareAccord program—HITOC’s role is squarely within strategy, policy and planning. The majority of HITOC’s role is within the bucket of “support.”
- Question: What is the compatibility program? Answer: This refers to requirements or standards for compatibility for users or programs that wish to interact with state-level services, it is not for standards or requirements for anyone using any kind of health information technology or exchange (HIT/HIE) services. It is directly tied to users of state-level services.
- Question: How does the governance work for Phase 1.5 services and will there be other statewide services outside of Phase 1.5? Answer: Greg commented that a lot of things have happened in the five years since HB 2009 when HITOC was formed. There are other very active committees meeting regularly on various pieces of this—the CCO HIT Advisory Group (HITAG) and others. Susan stated that it is HITOC’s specific role to look across the various components of health IT activities happening in the state to see whether we are meeting our big three goals.
- Question: How does the oversight, policy and planning work happen within HITOC if HITOC members aren’t aware/involved in the implementation? Answer: It is the role of OHA and the Office of Health IT to bring this work back to HITOC so that the members can assess progress towards the goals. A good parallel is the Oregon Health Policy Board (OHPB)—they are not responsible for implementation—they are looking at “how we are doing” as a state. Where are the gaps and how do we prioritize strategies going forward?

- Question: Would there be an impact in Oregon if HITOC did not exist moving forward? Answer: Without HITOC, it would be difficult for us to know how these various components come together, whether OHA is proceeding down the right path with its HIT efforts. Bob added that OHA could do this, but HITOC has the ability to bring a broader perspective. Susan added that OHA is looking to HITOC to help redefine its own role and function, by asking questions and requesting information from OHA that members find relevant to answer these questions.
- Question: how can HITOC influence change? What policymakers are listening to these recommendations? Answer: OHA leadership is listening, and the OHPB will listen as they make their transition (new positions to be filled).
- Bob mentioned that HITOC should be framing our meetings around the three goals and should find out more about what is going on within these three goals. Discussion around a report card or finding some way to put the updates and information presented to HITOC into the context of the three goals. Ellen added that updates might be useful in the interim between meetings. Susan suggested deep dive focuses on a few select topics during meetings as opposed to trying to cover everything. Ellen added that supporting materials ahead of time would be useful in order to be prepared for these meetings. Bob added that it will be useful to continually evaluate the meetings moving forward to continually improve them. Greg concluded the discussion.

EHR Incentive Programs – Karen Hale

Refer to slides 9-17

- Karen discussed updates to the EHR incentive programs. Discussed “MAPIR,” the software solution that collects attestations for Meaningful Use (MU) for 13 states. Reviewed numbers for incentive programs including number of providers, amount of payments, increases in EHR adoption among measured providers, etc. Discussed the switch from a carrot to a stick for MU in 2015. There was mention during HIMMS in softening these penalties, but no guidance yet.
- Question: What are providers attesting to? Answer: That they have met the requirements for MU and staff then goes in and assesses/validates this eligibility.
- Question: Can this funding run out? Answer: This is almost all federal funding (100% Federal funding for incentive payments, and 90% Federal funding/10% state match for program/staff/operations) and there is no risk of it running out before the program ends in 2021.
- Question: How much has been spent nationally on incentive payments? Answer: Greg stated that they have passed the \$20 billion mark. Karen stated that she will get that information.
- Karen asked the group about the way this information is presented to HITOC. Several members approved of the way that Karen presented it. Bob mentioned that he would like to hear some stories about how this work is impacting people on the ground.

CareAccord® update – Sharon Wentz

Refer to slides 18-22

- Sharon presented updates on CareAccord operations, including the number of organizations signed up, the type of organization, and the number of messages sent per month (for an 18 month period).
- Question: So what is counted towards the 1,000 users? Answer: there is a person behind each of these numbers, so there is a person checking this inbox. Ken added that many organizations are opting to use one account and route it within the organization, as opposed to offering accounts/inboxes to individual providers.
- Question: What is the value of the CareAccord program? Discussion on cost and current use of CareAccord, and the need for a “tipping point” for Direct secure messaging more broadly for it to be really used in day-to-day workflows and for CareAccord to be really useful. CareAccord fills gaps in HIE in Oregon – supporting state programs, providers without EHRs or local HIEs, CCOs and other entities that can benefit from electronic health information exchange but do not have local resources available to do so.

Phase 1.5 Update – Susan Otter

Refer to slides 23-29

- Susan reviewed the Phase 1.5 services with the group and updates on the status of some of these services. Susan introduced Britteny Matero, the new Director of CareAccord. OHA has also posted for an Implementation Director for Phase 1.5 HIT services, and a consultant, Terry Bequette (formerly the State Coordinator for Health IT for Vermont) will be acting as an interim Implementation Director. OHA is pursuing federal funding for the Phase 1.5 services.
- Susan reviewed status updates specifically on hospital notifications (the Emergency Department Information Exchange, or EDIE) as well as the statewide Provider Directory project. Ellen mentioned that there is another program within OHA called “EHDI” that focuses on early detection of hearing loss and that OHA should be careful when communicating EDIE to stakeholders to avoid confusion.
- Question: How does EDIE work? Answer: The vendor, Collective Medical Technologies (CMT), receives ADT feeds from the hospitals in the state. When a new event occurs, the vendor can push out a notification to the participating emergency departments. So when the patient is admitted, it pings the system and the notification can assist the emergency doctors in caring for the patient with more comprehensive health information. EDIE is very focused on the ED interaction. For care teams, health homes, CCOs, health plans, etc., there is a sister product: PreManage that provides real-time notifications when their members/patients have a hospital event. PreManage is based on a subscription model, and the availability of this service would be a later stage.
- Question: Have EMS and other emergency professionals been involved in this? Answer: OHA spoke with EMS at the state level on their registries and health IT opportunities so it is a good reminder to circle back with them. EDIE is really focused on EDs and overutilization.
- Susan then continued by discussing the Provider Directory in more detail. This is a provider resource for information (including Direct secure messaging addresses, as well as affiliations, hours of operations, etc.). This is critical to the exchange of information and to data analytics for the purposes of patient-provider attribution.
- Question: What is the status of the other Phase 1.5 activities? Answer: Provider Directory and hospital notifications are where we have had a lot of activity recently, we will be reporting on other initiatives as they progress.

Statewide Direct Secure Messaging Plan – Lisa Parker

Refer to slides 31-49

- Lisa discussed a plan for statewide Direct secure messaging—including the current landscape and a vision for the future. Lisa reviewed current policy levers and activities that can promote Direct secure messaging across the state.
- Lisa continued by reviewing state policy levers to promote Direct secure messaging such as contracting for PEBB purposes and the Patient-Centered Primary Care Home (PCPCH) criteria.
- John Hall explained what a trust community is to the group—a collective of organizations that can share Direct secure messages between each other to increase efficiency of the service (through shared policies, procedures, and technical logistics). More detailed explanations were given for two prominent national trust communities, DirectTrust and NATE.
- Lisa then described some of the HISPs (Health Information Services Providers – vendors offering Direct secure messaging services) operating within the state of Oregon, including CareAccord and several regional health information exchanges. Lisa also reviewed the most prominent EHR products in Oregon and which HISPs are associated with those products.
- Question: Wasn't Epic going to create their own HISP? Answer: John mentioned that Epic decided not to go with their own HISP and allow Epic customers to select their own HISP. Epic entered into a strategic partnership with SureScripts, and most Epic customers in Oregon are likely selecting SureScripts as a HISP. Susan added that some EHR products allow you a choice in the HISP you use, others like Cerner require you to use a certain HISP.

- Question: These DirectTrust-certified HISPs can then communicate with CareAccord. Answer: Yes. Accreditation through EHNAC allows HISPs to join the Direct Trust community, which enables interoperability. CareAccord became accredited in October 2013, and many HISPs are joining Direct Trust and becoming accredited. See the up to date list of accredited HISPs here: <http://www.directtrust.org/accreditation-status/>
- Lisa continued by reviewing what OHA is doing around Direct secure messaging, including CareAccord. OHA is piloting integration CareAccord HISP into an EHR so that providers can use CareAccord to achieve MU.
- Question: So this is to target vendors that won't have a HISP? Have folks asked for this? Answer: OHA expects large hospitals and health systems to select a HISP as they upgrade their EHRs and seek to achieve MU stage 2. Other providers want to use CareAccord as their HISP with their EHR to achieve MU stage 2. OHA has a programmatic decision about whether CareAccord wants to offer EHR integration services and what that would cost. The current platform for CareAccord is web platform-based to reach folks that do not have an EHR. The question now is: which providers with an EHR would need this service from CareAccord? OHA doesn't have the legislative authority to charge fees, so there are some considerations to make. OHA has been approached by a handful of providers to ask if they can shift from the web portal to their EHR.
- Question: How long is the pilot? Answer: A few months, then OHA will be looking on what the next steps are.
- Lisa emphasized that a provider directory is critical to the promotion of Direct secure messaging so that providers know where to send messages. She mentioned the Flat File Directory, a low-cost interim solution for providers to access Direct secure messages across the state. OHA will provide more information on this in future HITOC meetings.
- Question: What are the benchmarks, or objectives, to determine success in this arena—perhaps this can be discussed at a future meeting. Susan noted this.

Personal Health Record Pilot – Sharon Wentz & Ken Carlson (HITOC)

Refer to slides 50-53

- Sharon discussed the background of the Personal Health Records (PHRs) pilot which was to explore the use cases, data flows to facilitate bi-directional sharing of information between providers and patients who have free standing PHRs. Participants included three PHR vendors, Oregon, California, and Alaska.
- Ken discussed more details about the pilot, including recruitment of patients in his pediatric clinic and issues that were identified in the technology. Ken remarked that it is exciting to think that market forces will push increased sophistication in PHR technologies moving forward.
- Sharon mentioned a video associated with this work that was made which OHA will send out when it is finished.
- Group discussion continued around the integration of EHR and PHR.
- Question: Why is there interoperability issues—is it a standards problem? Answer: There are existing standards but they are open to interpretation and the implementation of the standard is variable. Market forces will hopefully play a role in changing this over time. HITOC could create a “rattle list” to put pressure on the market.

Public Comment Period

- With no public comments, the Chair declared the public comment period called to a close at 4:17 p.m.

Closing Comments – Greg Fraser (Chair)

- Greg concluded that it is encouraging to know that there is a place for HITOC moving forward.
- The group discussed meeting logistics and did a process check. The next meeting will be in June.
- Meeting adjourned at 4:25 p.m.