

Health Information Technology Oversight Council

Thursday, July 11, 2013

1:00 – 5:00 pm

Council and Ex-officio Members Present: Ellen Larsen, Dave Widen, Bob Brown, Carolyn Lawson

Council and Ex-officio Members by Phone: Judy Mohr Petersen (partial meeting)

Council and Ex-officio Members Absent: Greg Fraser, Erick Doolen, Bridget Barnes, Mel Kohn, Ken Carlson

Staff Present: Susan Otter, Matt Ausec, Karen Hale, Nick Kramer, Mary Kukowski, Kate Lonborg, Patricia MacTaggart, Lisa Parker, Sharon Wentz, Sarah Young

Welcome, Opening Comments, and Approval of Minutes – Greg Fraser (Chair)

- **Action:** Approval of minutes held until next time for quorum

EHR Incentive Program and CareAccord® – Sharon Wentz and Karen Hale

Refer to meeting materials: “EHR Incentive Program Update”; “CareAccord Update”; slides 4-16

- Expect number on EPs for 2012 to continue to increase because still a few apps pending
- Expected to have 57 hospitals participate; currently at 50 unique and expect to have 4 more soon
- Question: Could you walk thru MU? Response: Walked through overview of MU requirements and CEHRT requirements. Medicaid EHR IP does a lot of prepayment auditing before making payments.
- Comment: should talk more later about how MU ties to CCO requirements?
- 34% of physicians have come back and received MU payments
- Lion’s share of PY 2012 applications came in in March, near the deadline. If all of those applications are approved, our MU return rate could be 54%
- Question: What percentage of physicians reaching MU are in large groups? How many providers are eligible for EHRIP? Response: hard to identify how many providers are eligible, because of lack of data about Medicaid patient volume, eligibility criteria. Only way to tell about practice size is when a provider assigns payment to a clinic. No data on that at present, but we are looking for ways to get that kind of data to share.
- Providers can cancel registration or stop process at any time, so sometimes providers start application and cancel it repeatedly before submitting a final application. Sometimes may start registration to get feet wet. Sometimes a provider left clinic or had MMIS registration canceled, which cancels the application. Higher percentage in 2012, as many times more information is needed after application is submitted. Considering approaches for earlier intervention to help providers through process.
- CareAccord org level has remained roughly the same this quarter, but individual accounts within those organizations are increased. Bulk upload process was perfected in April and that has increased registration. Linn County signed on 77 users in a single bulk upload.
- Seeing increased use and sent messages
- A few independent pathology labs registered
- Starting to see more dentists on.
- Recently POLST registry pilot using CareAccord.

Phase 2 HIT/HIE Planning Process – Susan Otter

Refer to slides 17-23

- OHA will be sending out call for nominations for Task Force within the next few days. It will go to HITOC members and to stakeholders who have been participating in listening tour. And to HITOC website and listserv.
- Question: would this go into OHA newsletter? Response: Staff will follow up on that
- CareAccord Program Director position posted today. Will send email to HITOC members and listserv with posting. Want to make sure program is being operated to meet customer needs so

it gets the attention it needs and build up staffing while related but separate work on Phase 2 strategy is going on.

- Question: who approves the multi-year HIT/HIE business plan? Response: it will be OHA's plan.
- Question: what is the role of HITOC? Response: Task Force will make recommendations to OHA, Bruce to approve. HITOC will participate in stages of the planning and some members to participate in Task Force. After framework in place, HITOC will carry out some of the framework and have ongoing oversight. Task Force is short lived. HITOC is advisory on framework with touchpoints at various stages.
- OHA has met with 14 ½ CCOs (one of PacificSource's two locations) so far. OHA is working internally to develop straw model, using consultants from George Washington University and KrySORA.
- Task Force probably will start in early Sept. will release straw model in Sept. will bring to HITOC at Sept. meeting.
- Question: Members would like to see list of orgs talked to so far. Response: Staff will provide that list.
- Task Force would wrestle with governance at a high level and look at what HITOC has done in the past and that there would then be more work to flesh out
- Comment: Members concerned about HITOC role. What is the charge to the Task Force? Response: The Task Force will have a charter but it isn't prepared yet. The call for nomination will talk about the areas to be addressed in the framework. The Task Force may also make recommendations for bodies of work for the state and give input on priorities for ongoing OHA and HITOC work plans.
- Question: [Re: the bodies of HIT/HIE future work identified in the slides] we don't see anything about how to get people to use the system – communications, outreach, goals for market penetration. How is that being handled? Response: That is a part that needs to be added to the plan.

Phase 2 HIT/HIE Plan – Susan Otter and Patricia MacTaggart

Refer to slides 24-34

- Themes heard so far about what needs have to be addressed:
 - The first two came through in every session – mechanisms to support care coordination and mechanism to improve quality of care and support alternative payment methods.
- Question: Is this info heavily weighted to CCOs? Who else has been talked to? Response: Yes, heavily weighted toward CCOs at this point. CCOs are thinking about care coordination in a way that other stakeholders may not be yet.
- Question: would like to see consumer perspective too. Response: One of the hopes is that, with the themes heard so far, we can circle back with more groups to run these ideas by and get more input. Want to work with consumer and advocacy groups and also with provider professional groups.
- Public Comment: All of these things are so patients can avoid unnecessary tests and the resulting risk of harm. Need to bring all of these ideas back to the support of the patients.
- Question: In talking with CCOs, did you talk with the clinical advisory panels of CCOs? Their priorities and view may be different from business perspectives. Response: every CCO brought different groups of people to their listening sessions, most included both a clinical and business perspective, and some included consumer representation and public health.
- Public Comment: Information is needed to support best care for patient. With more data available, can improve care. At what point, do you say that it is the standard to have a certain level of being connected and that there will be no contracts unless connected?

- Question: Community health workers (CHW) bring a certain set of skills but technology is often not one of them. If this is very user friendly, the experienced CHW can still be an integral part of getting information into system for coordination of care.
- Question: How does a system ensure the quality of data? Response: The need identified was to have high-quality data, including things like standardization of data and a data dictionary. Making sure that the data is accurate is something that is not dealt with.
- Comment: When a person puts in data, it can be of various levels of quality, but can run algorithm to ensure that it makes sense and send it back if it doesn't. Don't necessarily expect it to be pristine when first submitted Response: Also, stakeholders raised who works with providers to make sure that data is entered in the correct format and workflow works. Not necessarily a technology role but a need related to HIT infrastructure.
- Comment: We have struggled with a roadmap forever because there are many rules and things that are not clear. Federal rules are changing, as are community needs. Things evolve – that needs to be part of the context. Response: Some stakeholders talked about needing to get some short term successes as we're thinking about longer term. Need to document this is where we thought we were going and this is what happened and why we changed this. Need to preserve a historic understanding.
- In terms of finance, CCOs were concerned that this would be built with focus on CCO investment and let other payers off the hook. Also, we heard concerns that some providers feel like they invested in EHR and expected it to have everything, so they are not happy about having to pay for additional things like HIE.
- Comment: Thought needs list looked pretty complete. Agree with other members about difficulty with quality of data.
- The needs document is a working document that will updated as we receive more input.
- Question: When report is done, will you go back to participants and get validation? Response: yes, will feed back to CCOs at CCO meeting. We'll feed back what we heard to stakeholders, particularly as we present on this (e.g., in webinars).
- Comment: This would have been helpful to have two years ago, but then no one knew what they needed.
- Question: What is the value proposition? Comment: that's the conversation nationally about the economic value [of HIE/HIT]. Comment: what will people find valuable and be willing to pay for needs to be teased out in the conversations.
- Comment: Value is different in Oregon because of shift away from paying for encounters. There is less of a territorial tone now.
- Public Comment: OHA created a value proposition with CCO rates [and holding the cost trend down]. The gap is being created – can technology cover that gap and change the cost curve? Hard to figure out the money you're going to save in advance. It's a chicken and egg question. Many institutions are already using technology. And many won't hit quality targets without the technology. CCOs need to make the investment because we're already committed to the savings.
- Question: At a future meeting, would be nice to have some folks from CCOs come and talk about their needs – How does health systems transformation efforts mesh with data and information exchange. Response: Staff will set that up.
- Comment: CCOs are in very different places.

Public Comment Period

- Public comment was allowed throughout the meeting, so there were no comments held until the

end.

- With no additional comments, the Chair declared the public comment period called to a close at 2:25 p.m.

Closing Comments – Susan Otter

- At this point our next scheduled HITOC meeting is Thursday, September 12, 1:00-4:30 at the Oregon State Library in Salem.
- Will have a draft framework for HITOC to review and discuss at the September meeting.
- Meeting was adjourned at 2:30 p.m.

DRAFT