

Health Information Technology Oversight Council

Thursday, September 12, 2013

1:00 – 4:30 pm

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

Council and Ex-officio Members by Phone: Bridget Barnes, Ken Carlson, Greg Fraser, Katrina Hedberg

Council and Ex-officio Members Absent: Erick Doolen, Judy Mohr Petersen,

Staff Present: Matt Ausec, Karen Hale, Nick Kramer, Tyler Larson, Kate Lonborg, Patricia MacTaggart, Mindy Montgomery, Susan Otter, Sharon Wentz (by phone)

Guests Present: Kim Klupenger, O-HITEC

Welcome, Opening Comments, and Approval of Minutes – Greg Fraser (Chair)
Refer to meeting materials: “May 2, 2013, Minutes” and “July 11, 2013, Minutes” <ul style="list-style-type: none">• Action: Ellen Larsen corrected the spelling of her last name in the minutes. In response to Greg Fraser’s request, Dave Widen moved to approve the minutes of the May 2 and July 11 HITOC meetings as corrected and Carolyn Lawson seconded the motion, which was approved by unanimous consent.
Opening Comments – Greg Fraser
<ul style="list-style-type: none">• Greg noted that Bridget Barnes is ending her HITOC membership and thanked her for her service.
EHR Incentive Program Update – Karen Hale
Refer to slides 4-13 <ul style="list-style-type: none">• Question: For electronic health record (EHR) adoption statistics, will we be able to look at urban/rural split? Answer: Yes, staff will bring that information back next time.• Question: Can the distribution of incentives be weighted to reflect possible receivers of incentives? Answer: It is possible to do weighting by population and percentage of payments. Getting to the denominator of eligible providers is hard.• In the slide on EHR systems used in hospitals, the EHR system listed is the system reported in the hospital’s attestation; some hospitals have changed or are in the process of changing EHRs.• HITOC members discussed EHR adoption rates. It is important to see the full landscape, including providers who are not eligible for incentives and providers using EHRs that are not certified. Measuring EHR incentive payments is a surrogate for measuring actual adoption.
CareAccord[®] Update – Sharon Wentz
Refer to slides 14-20 <ul style="list-style-type: none">• CareAccord is participating in a National Association for Trusted Exchange (NATE) pilot on use of personal health records (PHRs). HITOC members requested more information, including stories of people who are out in front with PHR use, greater explanation of how the pilot will create a framework of trust, and what the pilot will look like from a user’s perspective.• Question: Are staff hearing that integration in existing workflow is an important piece for increasing CareAccord use? Answer: Absolutely. As the integration happens, there will be more seamless flow for clinicians to send messages.• Question: Can CareAccord be used to connect health information service providers (HISPs)? A: Yes, there is a goal of statewide Direct secure messaging in Phase 1.5 of health information technology (HIT)/HIE services. There is good buy-in on that as a priority that includes HISP-to-HISP connections. CareAccord is participating in NATE and is working on Direct Trust accreditation. There are a lot of questions to think through with this group.• HITOC members noted that HITOC needs to be aware of the direction on this.
O-HITEC Update – Kim Klupenger
Refer to slides 21-31 <ul style="list-style-type: none">• O-HITEC received a grant of up to \$14 million from the Office of the National Coordinator for

Health IT (ONC) to provide technical assistance. The original sunset date was February 2014, but ONC recently announced the opportunity to apply for an extension of up to 12 months. This will allow O-HITEC to continue assisting providers through February 2015.

- O-HITEC is doing a lot of face-to-face outreach with clinics, including outreach to shared membership in partnership with Acumentra.
- Question: Any view in from a regional extension center (REC) perspective to understanding how to help make CCOs successful? Answer: The Oregon Health Network (OHN) worked a lot with CCOs on infrastructure over the years. From a REC perspective, CCOs need people to understand internal resources and skill sets and to recognize specific barriers for each unique CCO. Assistance needs to be “boots on the ground.”
- The ONC grant extension is an extension of time, not additional funding.

State Near-Term HIT/HIE Development Strategy (“Phase 1.5”) – Susan Otter and Patricia MacTaggart

Refer to meeting materials “State Near-Term HIT/HIE Development Strategy (“Phase 1.5”); slides 32-38

- The stakeholder process has moved faster than expected. The HIT Task Force now meeting is focused on the framework for Phase 2 in 2015 and beyond.
- Question: How does 1.5 fit into the longer-term vision? Answer: Phase 1.5 builds a foundation. Phase 1.5 is not building “the HIE” but is the near-term steps to get us there.
- Question: How does the provider directory in Phase 1.5 relate to the CareAccord directory? Answer: The current CareAccord directory is limited to CareAccord users and some access to federated directories. The statewide provider directory will go further to facilitate exchange regardless of HISP and to support analytics and metrics.
- HITOC members noted the importance of identifying access to the information, as well as the usefulness of the directory for better denominator data.
- The patient index element is affiliating patients to providers and care settings, to start identifying providers who see a patient and make a link for exchange and analytics. This is developing in the context of statewide notifications, where providers identify their panels of patients or health plans identify their members. More functions could be added over time.
- HITOC members noted the importance of patient identification and matching, as well as consent issues. We need to know that those requesting the information have the right to it, which could be verified against a claim or something to determine that there is a relationship to patient.
- Some hospital notifications are in place in some parts of the state, with varied coverage. The Phase 1.5 notifications service will wrap around existing services.
- HITOC members discussed various transitions that affect care. Notifications could be expanded beyond hospitals, for example, to developmental screening outside the health care system. Notifications also could be helpful in the context of emergency medical services (EMS), for example, where a primary care provider needs to know that a patient fell and was seen by EMS, even though the patient was not taken to a hospital. Notifications serve many needs. A provider directory is a key element of notifications, and a patient index also plays in.
- HITOC members stressed the need to look to the patient and family as part of the care team. Tools are needed to support that.
- In Phase 1.5, the clinical quality data registry would be incrementally developed. The initial focus is on electronic clinical quality measures (eCQMs) for meaningful use and on CCO clinical quality metrics collection. The data could be collected directly from the CCO, from a data intermediary/ aggregator/hosted EHR solution, or directly from providers on behalf of CCOs.
- Question: Could indicator data be sent back out? A: Yes, the data could feed back into community health assessments with whatever aggregated data can be provided.
- Question: Thinking of Patient Centered Primary Care Home (PCPCH) metrics, does this involve a similar kind of partnership that PCPCH and Q Corp have? Answer: It is the same model. There is a lot of interest in contracting out services, which would probably involve a procurement

process. It is unknown who would respond to a request for proposals.

- Question: Would data be individually attributable? Answer: For Phase 1.5, the next step is to get more specific about requirements and needs to be met immediately and long term.
- HITOC members discussed patient involvement in data collection. If a patient can correct data or identify data to be corrected, accuracy is enhanced. The patient portal component of meaningful use Stage 2 – setting it up and getting patients to use it – is difficult. Schools could be a good avenue for families to be involved in health of the student and to correct data.
- HITOC members emphasized the need to coordinate with Cover Oregon on quality metrics and provider directory.
- As private investors contribute to Phase 1.5, the technical advisory group (TAG) would morph to steering committee. In discussion of governance, concern was raised that the model is not egalitarian or inclusive enough; it would help to make sure that Community Advisory Council members are part of the TAG.

HIT Task Force Update – Susan Otter and Patricia MacTaggart

Refer to meeting materials “Task Force Member List” and “Task Force Charter”; slides 40-54

- Question: Is the HIT Task Force accountable to OHA? Answer: OHA sets out the questions that need to be answered and works through the Task Force process to come up with recommendations to OHA, which is ultimately responsible for carrying out. Question: Who is responsible within OHA? Answer: Susan Otter.
- The first meeting offered lively discussion. Many members had been involved in HITOC workgroups, which made for a very informed task force. HITOC members commented that a lot of the work called for in the HIE Strategic and Operational Plans now is being acted on. Some of the work that the task force calls for might require legislative change, which will take time.
- The next HITOC meeting will be December 5. Staff will send HITOC members information about the Task Force meeting times and locations.

Public Comment Period

- With no public comments, the Chair declared the public comment period closed at 3:35 p.m.

Closing Comments – Susan Otter

- Next scheduled HITOC meeting is November. Question: would HITOC prefer to meet in December and receive a full report on the HIT Task Force recommendations? HITOC would prefer to meet in December. The next HITOC meeting will be December 5.
- Staff will send HITOC members information about the Task Force Meeting times and locations.
- The meeting was adjourned at 3:47 PM.