
HIT/HIT Community and Organizational Panel

Office of
Health Information Technology

May 21, 2015

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font above the word "Health" in a larger, blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, serif font. A thin blue horizontal line is positioned between "Health" and "Authority".

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Welcome, Introductions, Agenda Review



Agenda

- Welcome and agenda review
- Introductions: Roundtable of Initiatives
- State Environment Overview and the Role of HITOC
- Break
- Discuss charter and role of HCOP
- Group Brainstorm: HCOP Priority Topics
- Process Discussion: HCOP structure and function
- Conclusions, Next Meeting and Agenda Items

Introductions: Roundtable of Initiatives

- The problem you are aiming to solve
- The sources of data/participants contributing to your project
- The users of the data
- The use cases/value propositions you have identified thus far
- The stage your project is in (development, implementation, operations, etc.)
- Your top 2-3 successes
- Your top 2-3 challenges



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Connecting Oregon Providers for Better Patient Care

HIT/HIE Community & Operational Panel
May 21, 2015

Gina E. Bianco , MPA
Acting Director

The Problem...

- ▶ Individual EHRs are the center of the data (provider centric model)
- ▶ Only include information received via interface with outside sources (lab/hospital) or input into the record (scan, data entry)
- ▶ Still requires significant amount of human interaction involved in obtaining records
 - Phone, fax, printer, scanner, etc...
- ▶ Orders & referrals are usually not integrated and closing the loop is difficult



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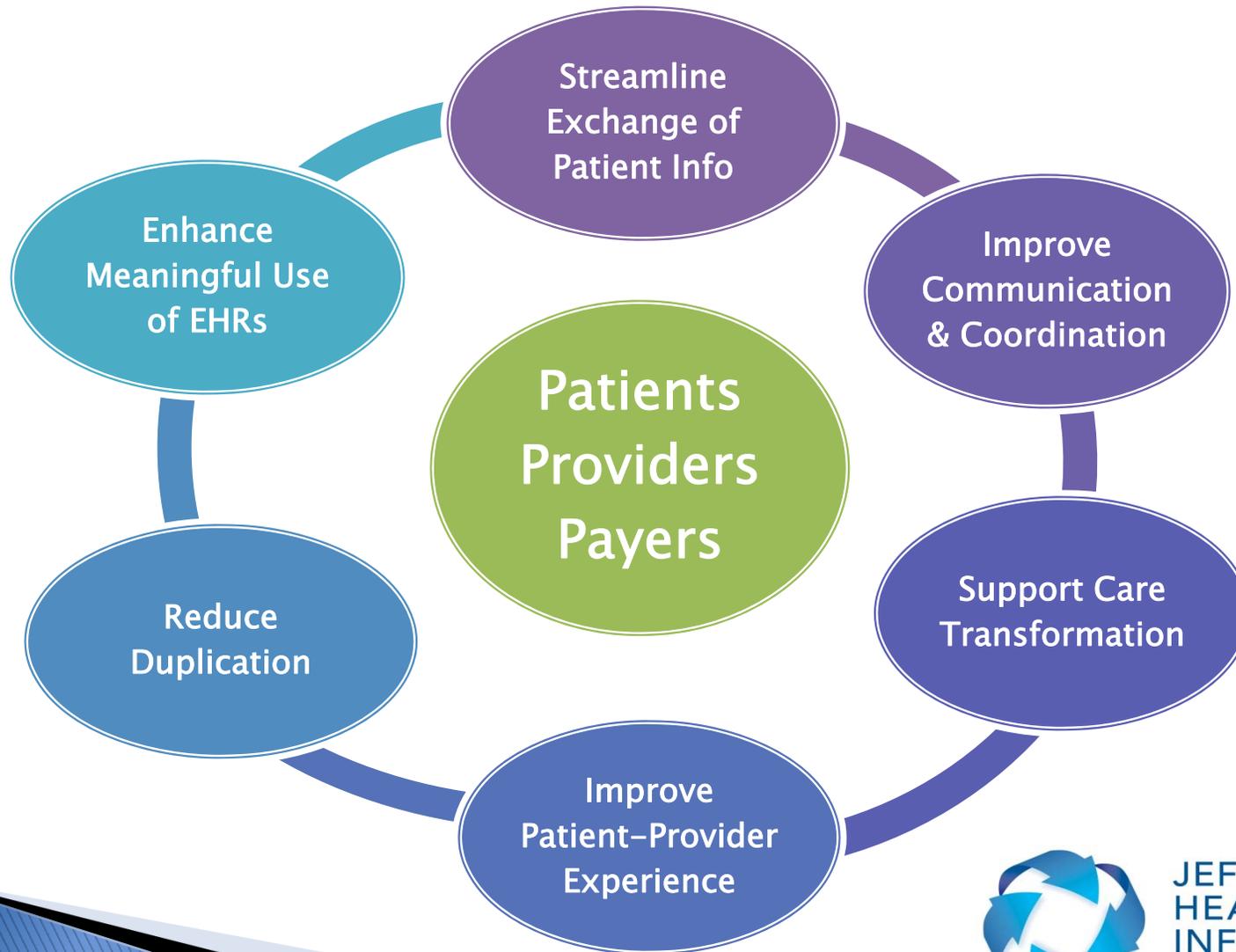


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What we do...

**Better information at the
time and place of care that
follows the patient**

Primary Goals for JHIE



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JHIE Governance

- ▶ Non-Profit (501 c3) Corporation
- ▶ All Volunteer Board of Directors
- ▶ Multi-Stakeholder Decision-Making
- ▶ Committees & Workgroups
 - Consumer
 - Provider
 - Governance
 - Finance
 - Technology
 - Policy
 - Behavioral Health
 - CCO



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JHIE Participants

- ▶ Region
 - Jackson, Josephine, Klamath Counties and Columbia Gorge Region
- ▶ Hospitals
 - 7 hospitals in Southern Oregon and Columbia Gorge
- ▶ Payers
 - 5 CCOs covering Southern Oregon and Columbia Gorge
- ▶ Providers
 - 600+ Enrolled at 160+ Clinics
 - <http://jhie.org/participants/participating-clinicspractices/>



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Phase I: (2013)

Point-to-Point Data Exchange

- ▶ Closed Loop Clinical Referrals
- ▶ Direct Secure Messaging



- JHIE to/from JHIE
- JHIE to/from “Trusted” EHRs
- JHIE to/from CareAccord



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Phase II: (March 2015) Robust Data Exchange

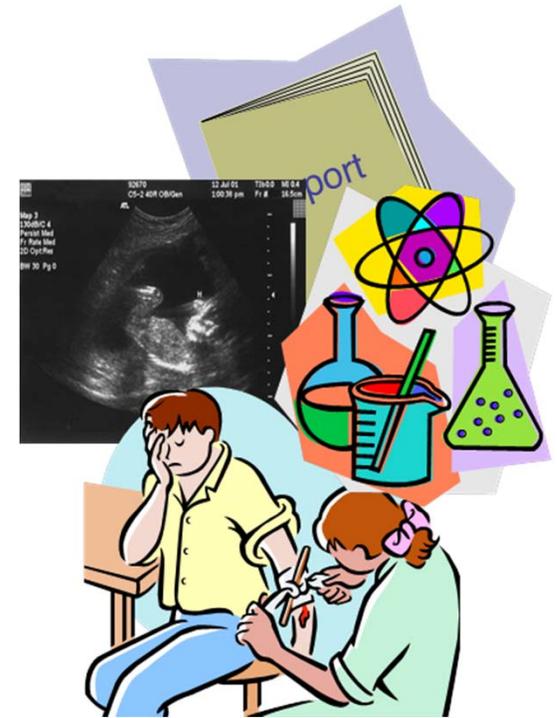
- ▶ Community Health Record
 - Patient Search
- ▶ Hospital Notifications
- ▶ Clinical Results Delivery
 - EHR Integration
 - Clinical Inbox
- ▶ Care Summary Exchange
 - From Hospitals for Transitions of Care
 - From EHRs for Transitions of Care & Coordination
- ▶ Payer Care Coordination



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Data Types Exchanged

- ▶ Labs and Pathology
- ▶ Radiology Reports (images later)
- ▶ Transcribed Reports
- ▶ Cardiology Studies
- ▶ Care Team List
- ▶ Admission, Discharge, Transfer Notifications
- ▶ Care Summaries



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Focus on patient centered care where information follows the patient

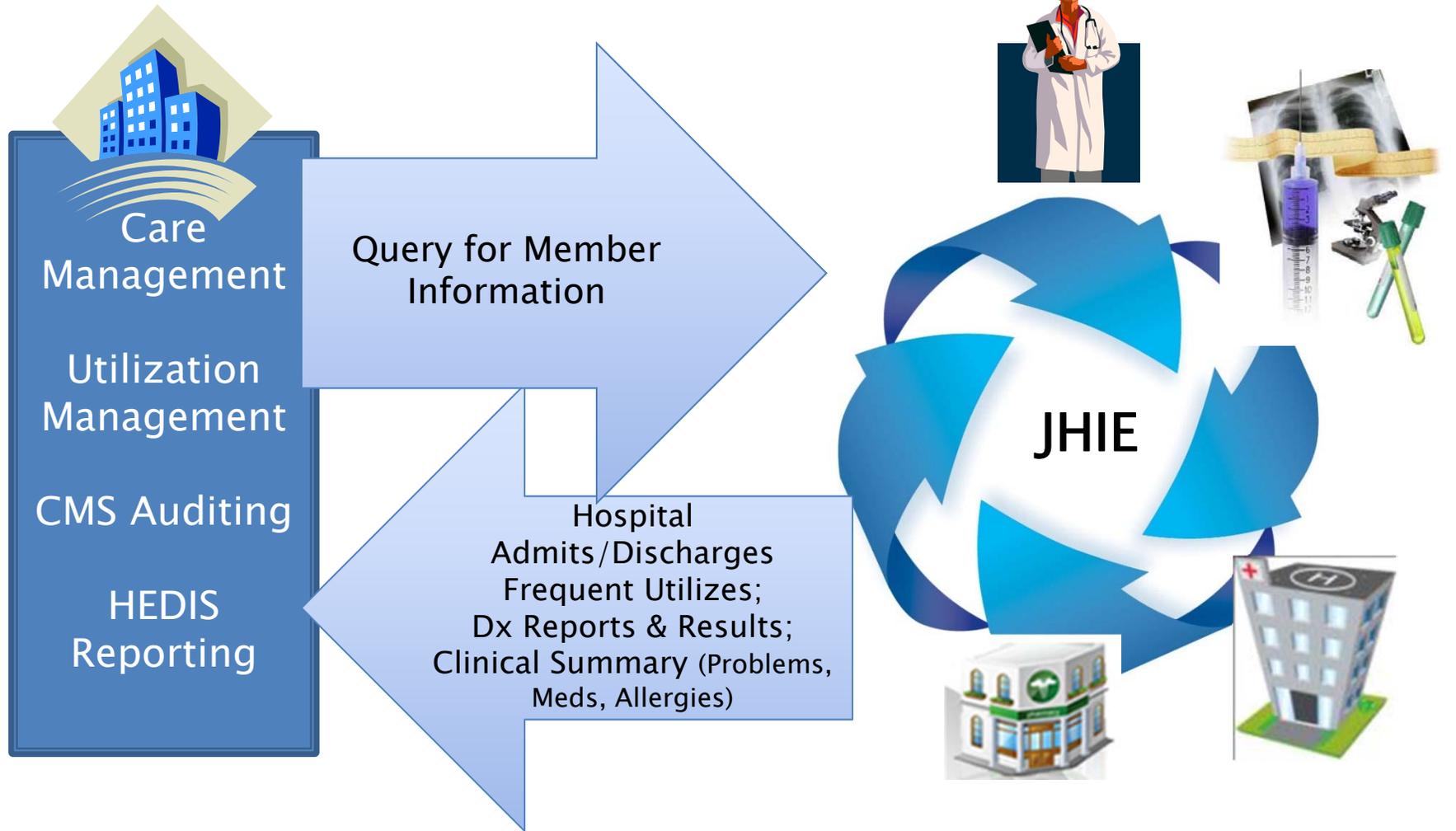
Secure and trusted information sharing

Provider-led Community-driven



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HIE for CCOs & Payers



Employs National Interoperability Standards & Technology Neutral



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Privacy and Security Considerations

- ▶ Patient Non-Participation (opt-out)
- ▶ User Roles and Access Controls
 - Based on patient-provider relationship
 - Based on User's "need to know"
- ▶ User training to reinforce appropriate use
 - Privacy & security policies (HIPAA, 42CFR Part 2)
- ▶ Monitoring usage
- ▶ Sanctions for misuse



What's Coming?

- ▶ Hospital Notifications
 - Goal to integrate with Statewide EDIE data
- ▶ Healthway Connectivity
 - Veteran's Administration
 - Social Security Administration
- ▶ Population Health Management
- ▶ Reporting to State Registries
 - Immunizations, Diabetes, Cancer, etc...



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CareAccord Direct Secure Messaging



Provided by:



Powered by: **HARRIS**

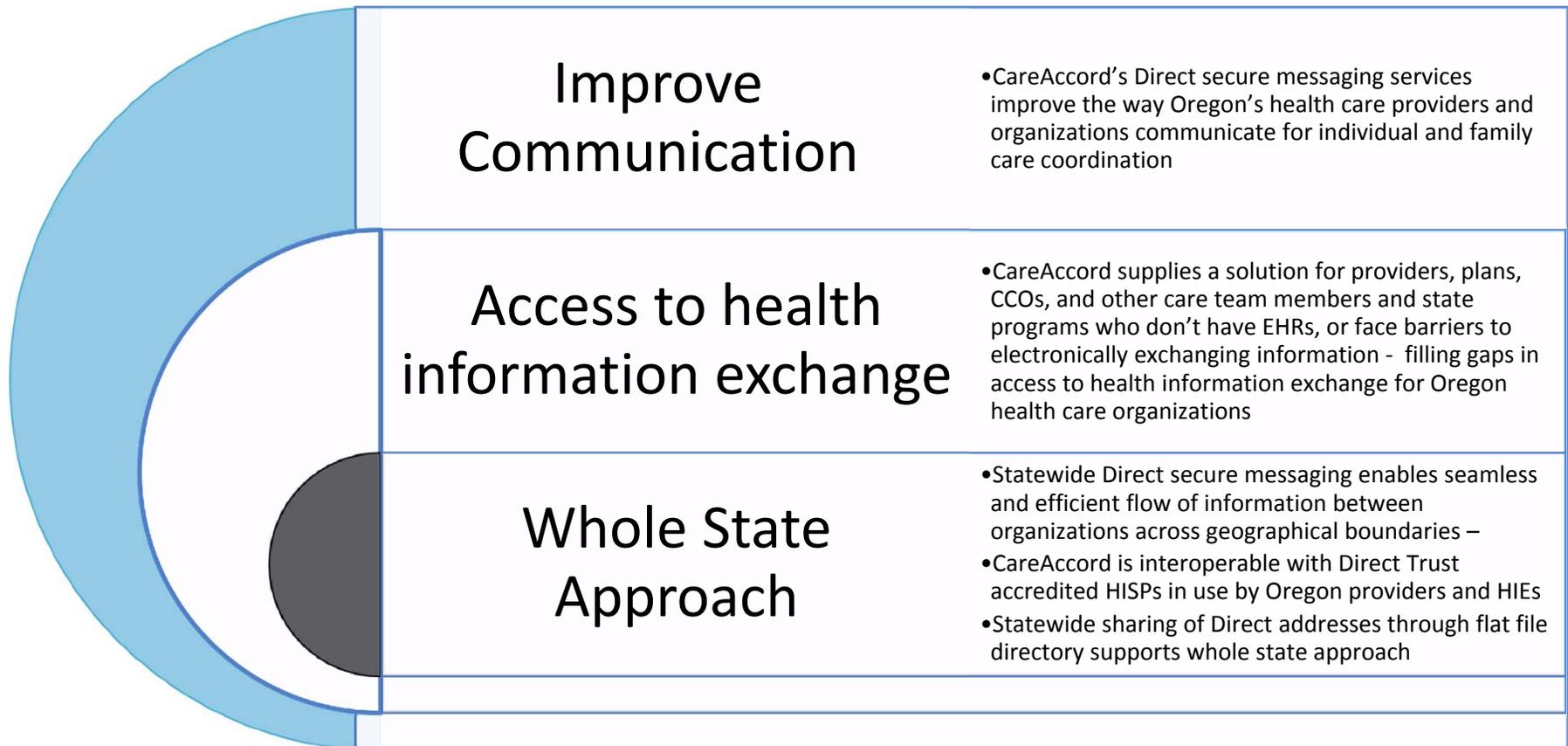


Overview of CareAccord

- EHNAC/DTAAP accredited Health Information Service Provider (HISP)
- Provide Direct secure messaging
 - Via web portal
 - Accessible by PC or mobile device
 - Searchable provider directory
 - Includes secure chat feature
 - Piloting EHR integration for Direct
- Currently no cost
- Statewide Flat File Directory for Direct secure messaging addresses

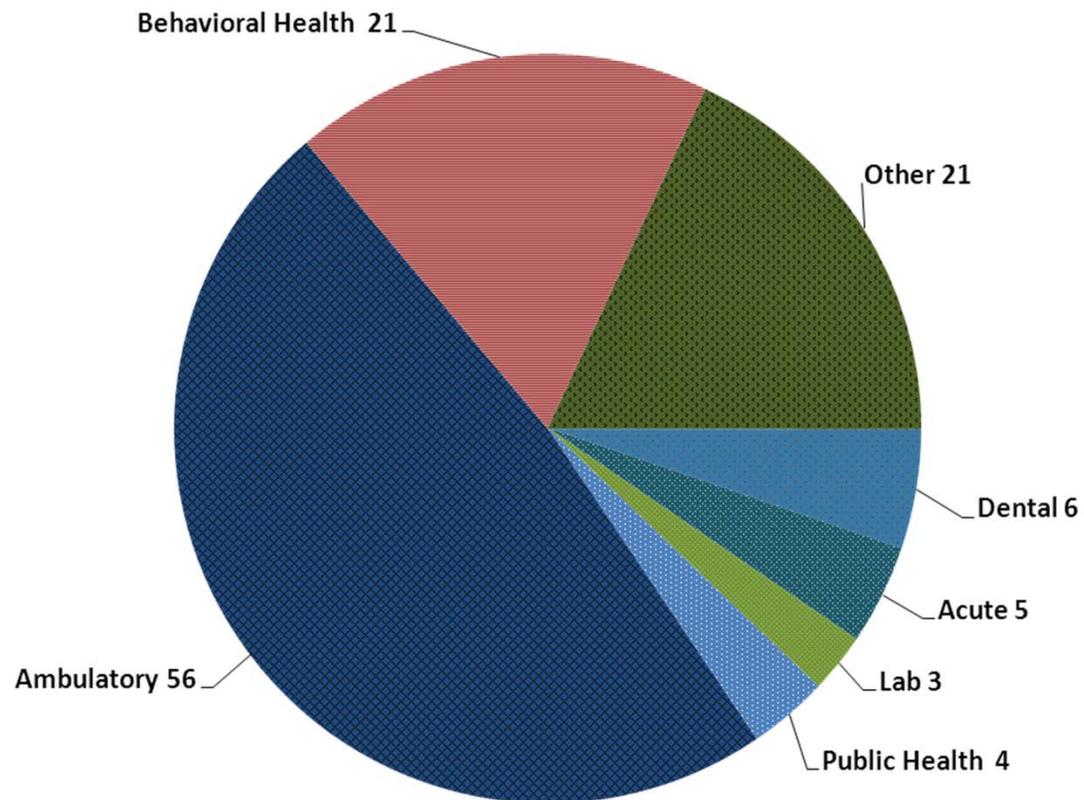


CareAccord Goals

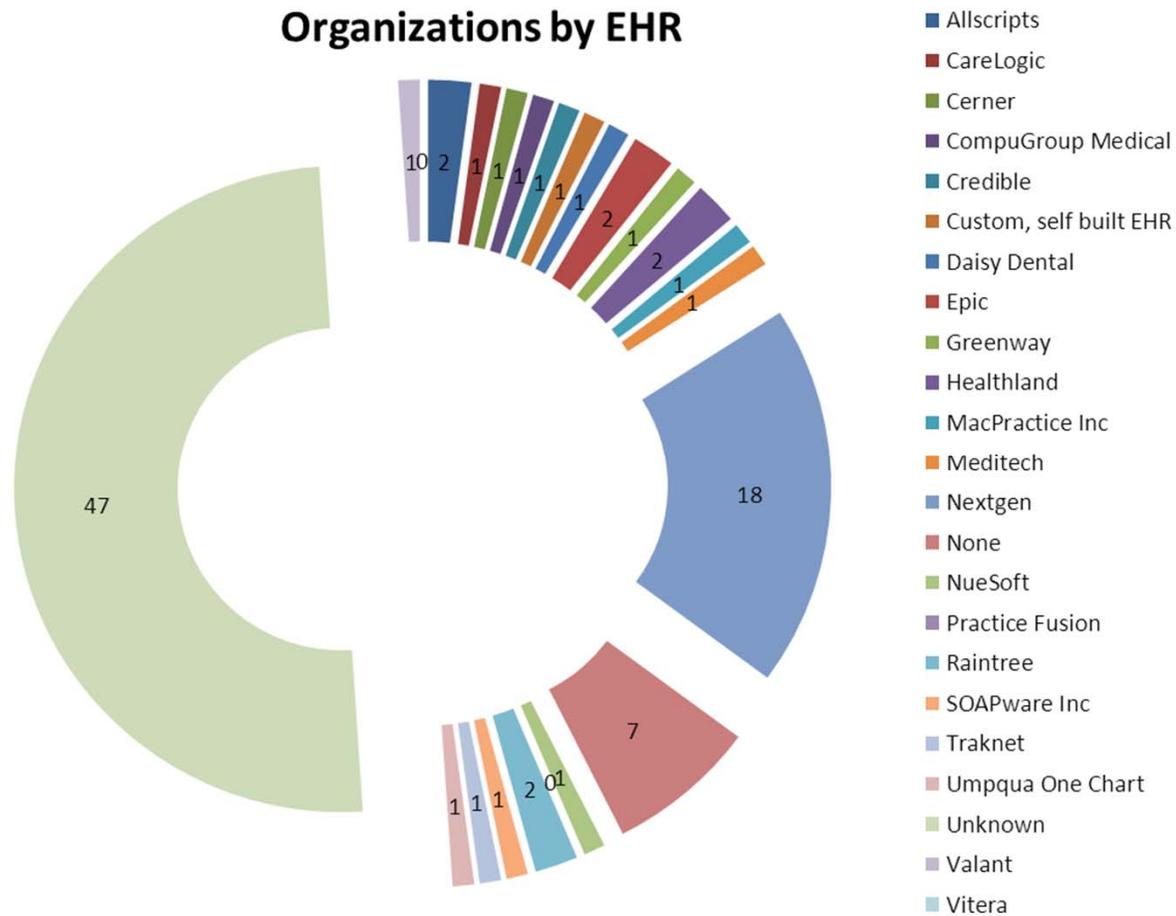




Organizations Served by CareAccord (April 2015)



EHRs in Use by Organizations Served





CareAccord Successes

- Bridging the Gap - Provide a no-cost solution to those facing barriers to implementing Direct secure messaging
- Enabling Statewide Direct - Have assisted Direct users through the Flat File Directory with Meaningful Use attestation and care coordination across organizational boundaries
- Convening Valuable Conversations - Organizing and participating in conversations regarding interoperability



CareAccord Challenges

- Issues related to EHR System Implementation of Direct
 - Limits related to messaging:
 - CCD-A format not supported by all systems - Example: .zip format (SMTP can't always handle .zip, XDR standard requirement)
 - Some EHRs require CCD-A attachment to deliver the message
 - Use different standards require one-by-one adjustments - Example: Flaws in translating between two standards (SMTP/SMIME and SOAP/XDR)
 - EHRs assigning Direct addresses to NPI credentialed clinicians only - Limits on care coordinating, work flow challenges
- Adoption and sustainability

**COMMUNITY
CONNECTED NETWORK**



May 19, 2015

What is the purpose of the Community Connected (C2) Network?

The C2 Network will provide an opportunity for social service and health care providers to change the way the community accesses and receives health care and social service support through information sharing.



What are the primary objectives of the Community Connected Network?

- To provide a mechanism to connect and share data between existing data systems.
- To simplify access to services for those in need.
- To enhance referrals and increase engagement by creating opportunities for warm hand offs and coordinated care between provider organizations.
- To address the CCO's triple aim to increase capacity, gain efficiencies and reduce costs associated with those families involved in multiple systems.

What components will be included in the C2 database?

- Centralized contact registry
- Centralized resource and referral module
- Customizable views and dashboard
- C2 Network new tenant onboarding tool
- Release of information module
- Inter-tenant record sharing capabilities
- Survey and assessment module
- Auto-populating of forms and summary sheets
- Integrated Network calendar and discussion forum
- Aggregate data reporting

Who will be a part of the C2 Network?

- DHS
- Health & Human Services – Mental Health
- United Way
- Alcohol & Drug Providers
- Homeless Youth Service Providers/Shelters
- Early Learning Hub
- Courts
- Medical Providers
- Churches
- Community Action Agency
- School Districts
- Relief Nursery
- Goodwill/employment programs
- CCO's

What will the database provide to the users?

- Common messaging about what services are available, eligibility criteria for services and how to access those services.
- A centralized contact registry of participants that is updated in real time.
- The ability to see if a client engaged in the services they were referred to and which service providers are involved with them.
- Access to assessments/forms completed at other organizations
- Data reports that inform service provision and guide quality improvement efforts.

What will the database provide to the client?

- The ability to recognize that C2 network provider agencies are working together to support them.
- Referrals and appointments can be set from one location.
- A record of which organizations are working with them. The client doesn't have to remember who they visited at which organization.
- No need to share life story and traumatic events over and over again.
- Less trips to the wrong location for services that are no longer available.
- Assessments/forms only need to be completed once.

What successes have we had?

- Social service providers in Southern Oregon are willing to do the hard work it takes to collaborate to better serve our community.
- Our CCO's, Jackson Care Connect and Allcare support our efforts with staff time and financial contributions.
- Jefferson Health Information Exchange has partnered with us to create data sharing opportunities between medical and social service providers.

What challenges have we faced?

- Sharing a technology vision with those who are not tech savvy.
- Promoting the concept to an audience who hates databases.
- Developing contracts, quality assurance measures and payment schedules that ensure we get the product we pay for.
- Understanding and navigating HIPAA rules.
- Developing a cost structure that is scalable for smaller organizations to participate.

What is the timeline?

- Database Modules Built June - Dec, 2015
- End User Testing Begins
 Dec, 2015
- Release of System for
 Production Use Jan-March, 2016



For more information, please contact:
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Service Integration Manager
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Regional Health Information Collaborative (RHIC)



RHIC's Clinical Use Cases

- ▶ Health care providers want more information about their patient's total health history.
 - What other providers have been or are being seen by the patient?
 - What treatments or medications are currently prescribed?
 - What past treatments or medications had been prescribed?
 - What other medical or non-medical conditions exist for the patient?
- ▶ New Patients – RHIC provides access to previous health history when interacting with a new patient.
- ▶ ER Patients – RHIC provides access to health history for a patient who is unable to respond to health inquiries.
- ▶ Alerts – RHIC can notify PCP of emergency room visit, hospital admittance or discharge.
- ▶ Order Tracking – RHIC offers the opportunity for providers and support staff to track all orders to completion such as prescriptions and labs.
- ▶ Disaster and/or EHR backup – RHIC available for inquiry in the event that the an EHR is unavailable. Can be used in a disaster relief situation.





Care Team Link combines and shares patient data from public, private and non-profit partners within one system. *Care Team Link* delivers a more complete view of the patient, empowering practitioners and health care systems to deliver better care and better outcomes at lower cost.



COLLECT

GOAL 1: Create a whole-person view of the patient



SHARE

GOAL 2: Support patient-centered, coordinated care



ACT

GOAL 3: Achieve The Triple Aim:

- Enhance the quality, reliability and availability of care
- Improve the health of our communities
- Lower or contain the cost of care



IHN-CCO partners providing data (Phase 1)

- ▶ **Samaritan Health Services** – EPIC EHR – Hospital and Clinical visits
- ▶ **Benton County Health Services** – EPIC EHR (OCHIN) – Clinical visits including mental health
- ▶ **Linn County Health Services** – RainTree EHR – Clinical visits including mental health
- ▶ **The Corvallis Clinic** – AllScripts EHR – Clinical visits
- ▶ **Samaritan Health Plan Operations** – Facets – Claims data – Physical, Mental, Pharmacy, Dental, NEMT,
- ▶ **Lincoln County Health Services** – EPIC EHR – Clinical visits including mental health (Future Phase)



How will better outcomes be achieved?

- ▶ Health care providers will have access to patient information quickly and securely
- ▶ Health care coordination is improved
- ▶ Silos of information are removed

The right information is available to the right health care provider at the right time resulting in better clinical decision making.



The Children's Health Alliance
Population Health Management
Solution:

SMART

Care **M**anagement, **A**nalytics &
Reporting **T**ool

by **wellcentive**

Introducing CHA and CHF

Who we are:

An alliance of 100+ private pediatricians in Oregon and Washington

Our goal:

Lead clinical improvement innovations and deliver the highest quality of care to children and their families

CHILDREN'S HEALTH *alliance*



CHILDREN'S HEALTH *foundation*

The Alliance and the Foundation work together to:

- Develop and implement transformational quality improvement programs
- Drive quality care delivery, care experience and cost management
- Offer clinical and strategic expertise about meaningful pediatric measures and actionable workflow solutions

CHILDREN'S HEALTH *alliance*



CHILDREN'S HEALTH *foundation*

Why a Care Management, Analytics and Reporting Tool?

Areas of need and value:



Beyond the EMR... Adding Value through Provider-driven patient and population analytics

EMRs don't offer providers enough reporting and analytics power

- EMRs are not the source for all patient information. Data aggregation offers a broader view of patient care and needs
- Health Information Exchange (HIE) is driving exportability of EMR data
- HIE will be solved first at the payer level across national measures
- Blended payment models with pay-for-performance are imminent
- Provider groups need more meaningful and actionable data to manage and report quality and costs
- Niche “plug-in” solutions are connecting data across EMRs, claims, registries, etc. to offer more functions for Care Management, Population Management, etc.
- Provider-driven solutions can offer data aggregation AND point-of-care tool AND care management tools AND population analytics

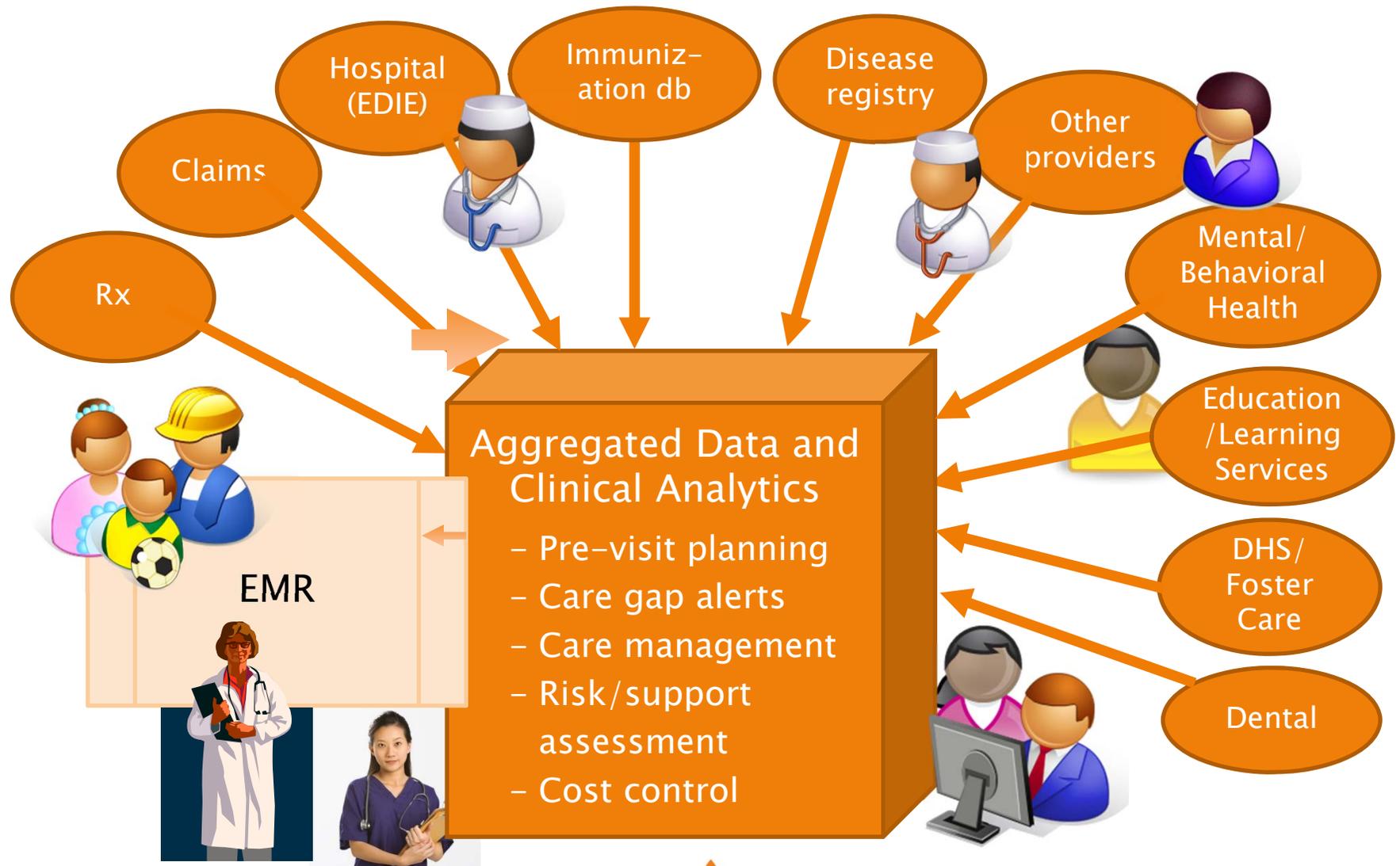
Why Another Clinical Tool?

Adding Value through PHM & Clinical Analytics

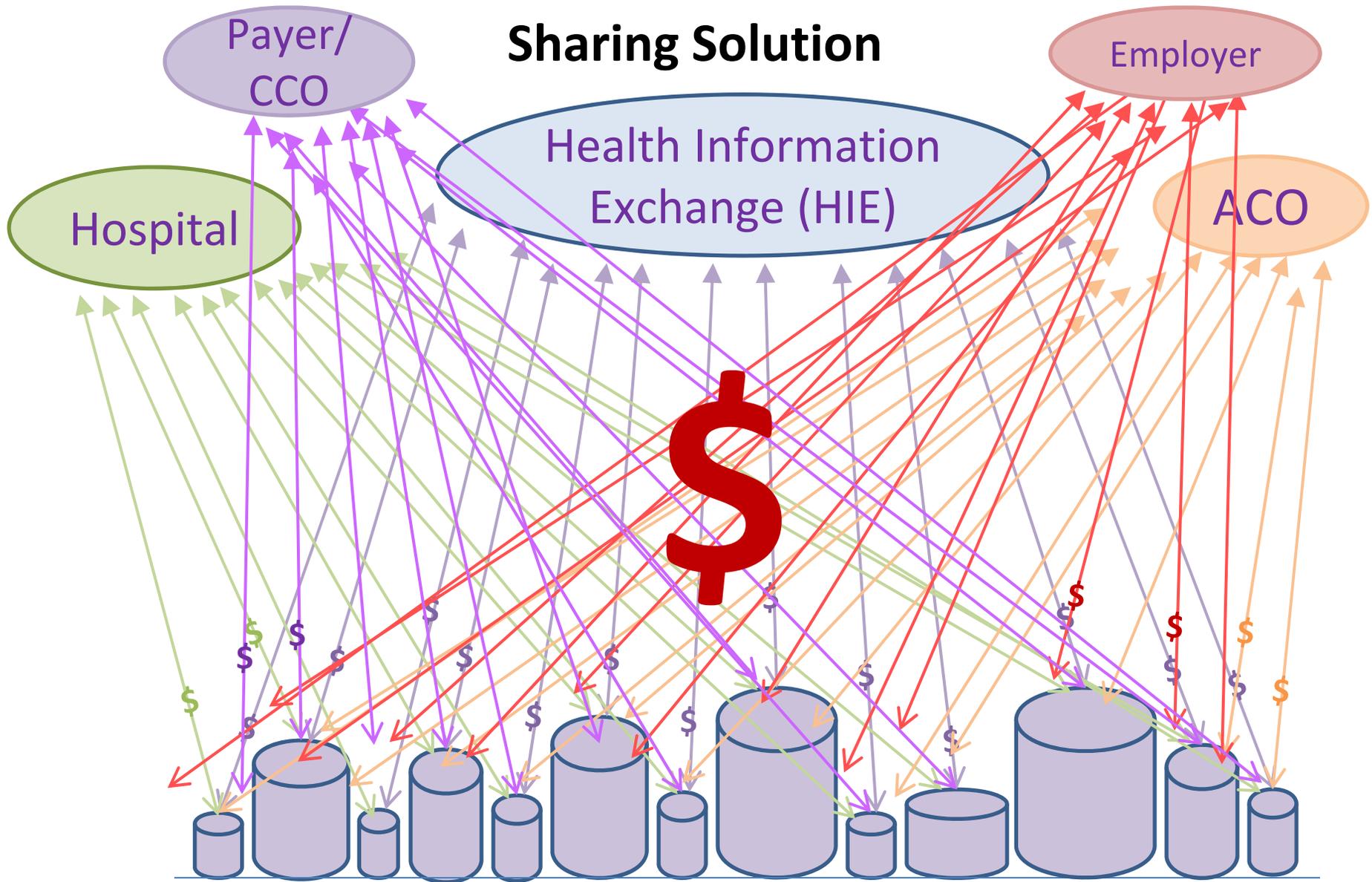
- **Desired goal:** One office-based clinical tool but EMRs cannot do it all effectively or economically
- **Practical solution:** Integrate a tool that links to the EMR & other clinical data sources and is as practical, economical and functional as possible
 - Aggregate patient info in one place
 - Support care management
 - Proactive population level and patient level planning
 - Offer analytics (more views of information)
 - Help communicate and share care plans



The Pediatricians' Vision for Meaningful Information in the Hands of the Pediatric Care Team

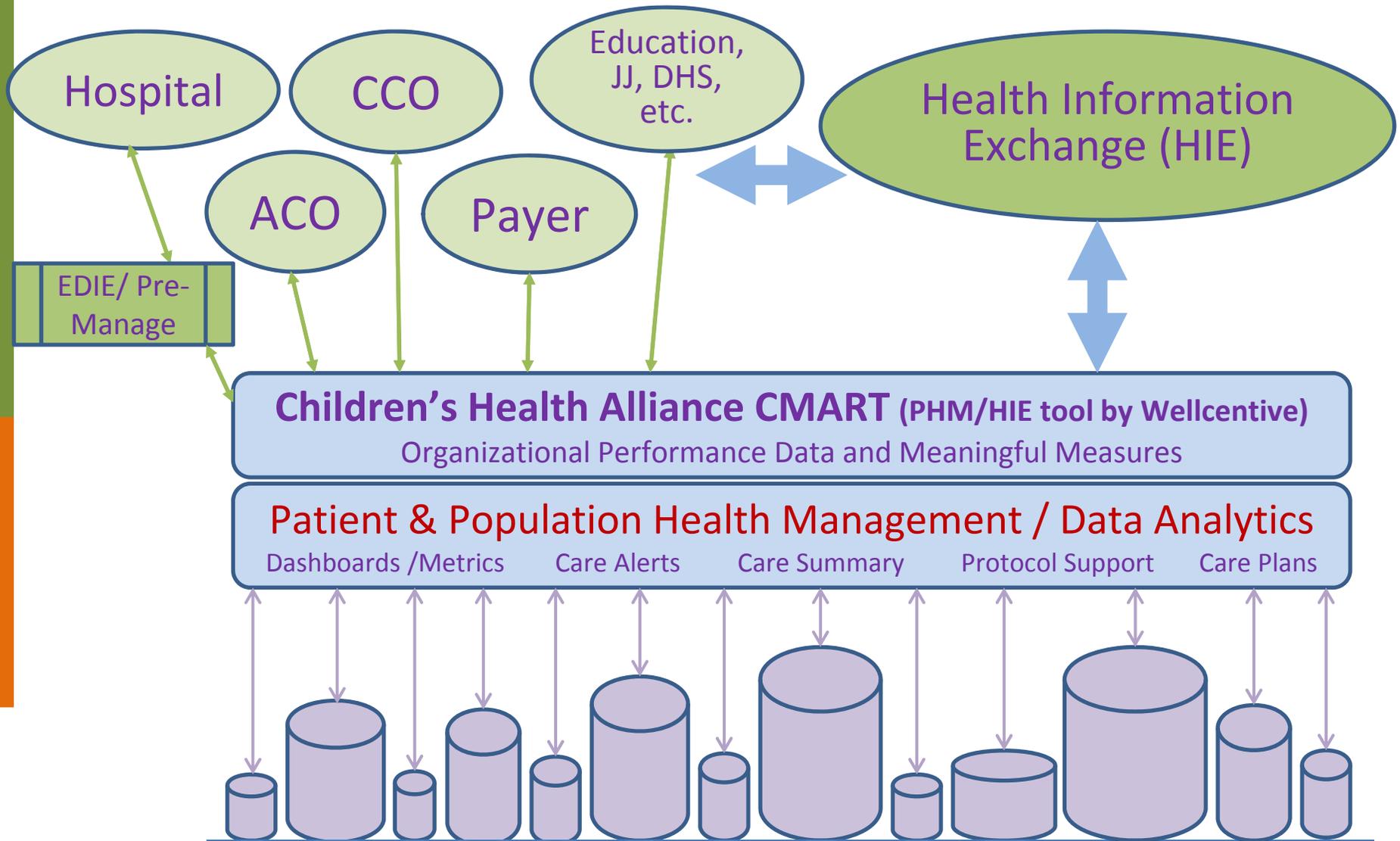


Absence of an Alliance level Practice-based Health Info Sharing Solution



Provider Practices – Multiple systems in place with varying levels of data exchange and reporting capabilities

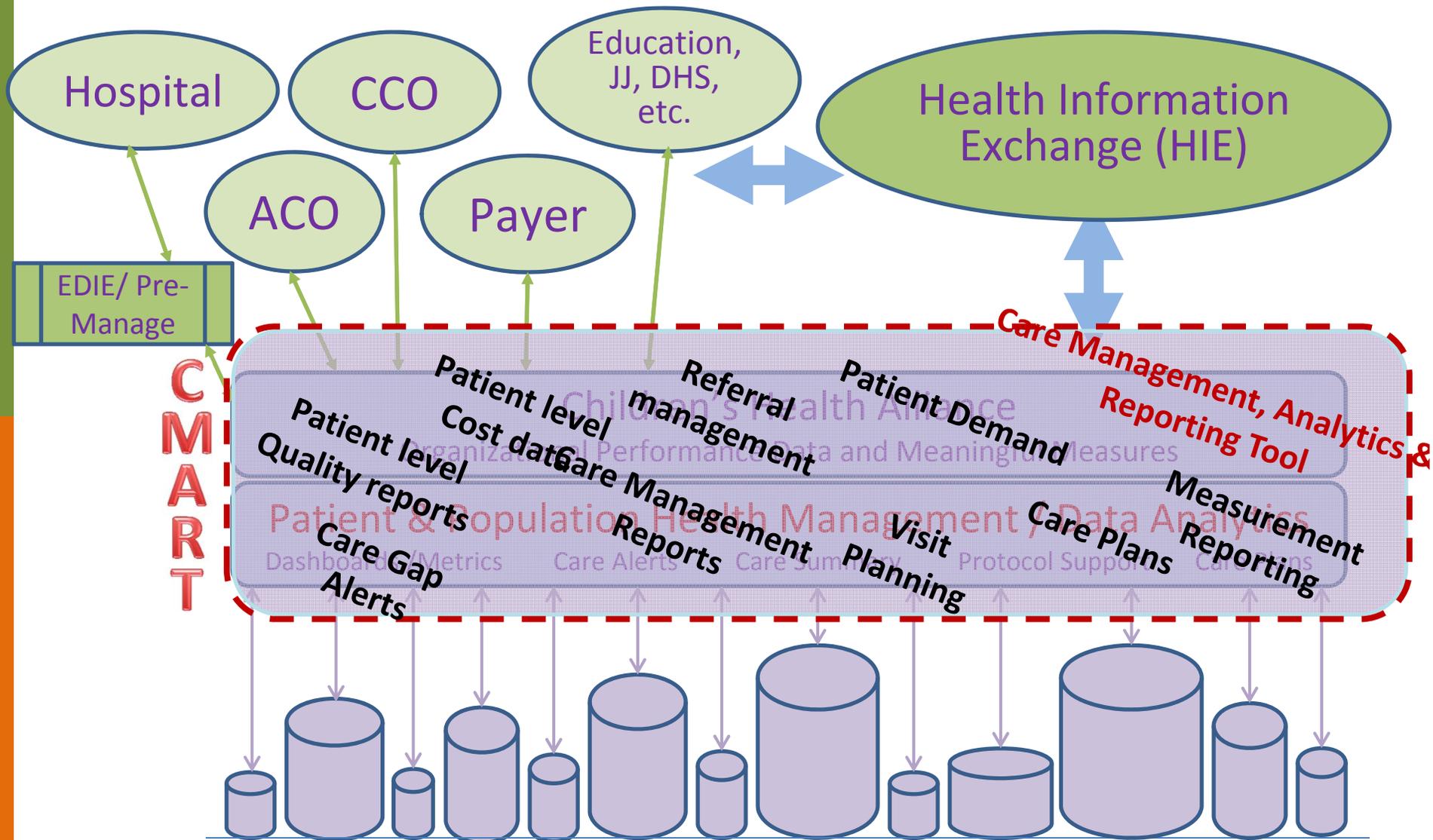
Inserting a Practice-based Solution for Common Data Exchange to **Minimize Redundancy** and Add Clinical Value



~100 Pediatricians at 20 practice sites using 8 EMRs with varying levels of data exchange and reporting capabilities



Inserting a Provider-based HIT Solution for Common Data Exchange to Minimize Redundancy and **Add Clinical Value**



~100 Pediatricians at 20 practice sites using 8 EMRs with varying levels of data exchange and reporting capabilities



Functional Priorities of Population Health Management Analytics for Provider Groups

- 1) Seamless connection with EMRs – to pull data and push alerts
- 2) Reliable import, normalization and aggregation of data from EHRs, claims, pharmacy, lab, registries, etc.
- 3) Care gap alerts and guidance for clinical care approaches at the patient level
- 4) Care management reports, workflow tools, care gap alerts
- 5) Care plan documentation and sharing capabilities
- 6) Robust data analytics – with ability for user queries
- 7) Measurement reporting – for standard pediatric measures and custom measures
- 8) Clinical practices guidelines
- 9) Pay-for-performance analytics and risk management modeling
- 10) Secure messaging with other providers

Empowering Providers with Broader Patient Data and Analytics

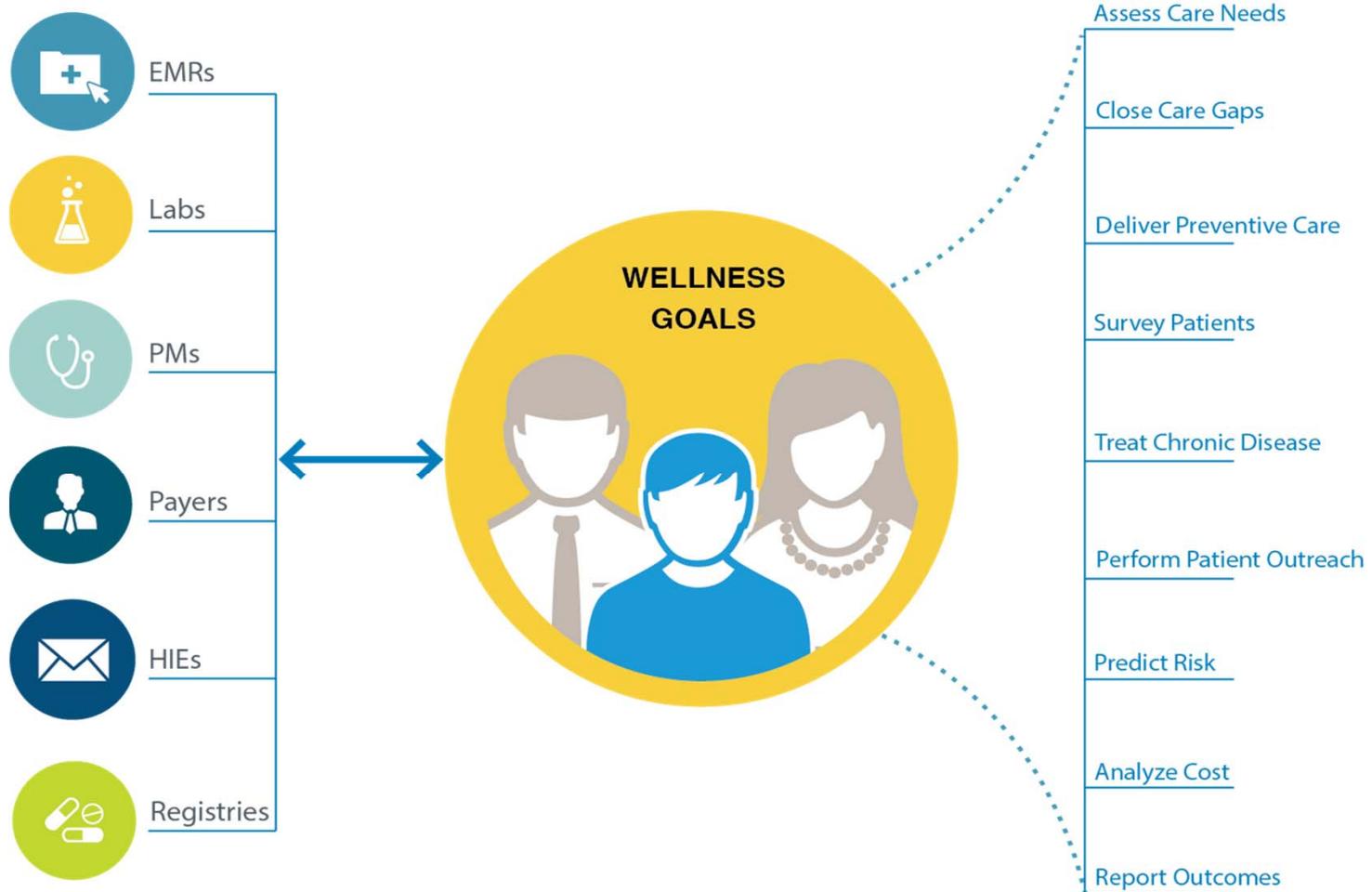
Meaningful and actionable organization of patient data from EMR:

- Preventative and chronic care alerts
- Care gap alerts
- Performance reports
- Care management forms, ticklers, calendars, lists
- Patient and population analytics
- Community care plans
- Replaces disease registries

When aggregating practice data with claims and payer data:

- Presents a broader view of patient utilization, care and costs
- Supports proactive care management and connection to other care & services
- Enables risk assessment modeling
- Informs pay-for-performance and other payment models

The SMART Solution



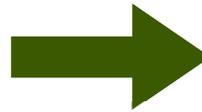
Pediatric Clinical Protocols Developed by CHA for CMART

1. Asthma
2. ADHD
3. Autism
4. Cerebral Palsy
5. Dermatology
6. Developmental Disorders
7. Diabetes - Type I & Type II
8. Down Syndrome
9. Foster Care
10. Pediatric BMI (Obesity)
11. Pediatric Dental
12. Pediatric Mental /Behavioral Health
13. Well Care and Screenings for Adolescents
14. Well Care and Screenings for Infants and Children



Asthma Care Management using CMART

Data Inputs



Action Outputs



EMRs

- Asthma Dx
- Asthma Rx
- Office Visit
- Spirometry Procedure



Payer

- Specialty Visits
- Med Fills
- Other Services



Rx

- Med Fills



Hospital

- ED Visits
- Admits/Discharge



Registries

- Severity Classification
- Control Level
- Action Plan Date
- Trigger Assessment Date

AGGREGATION



Clinical Staff

Outreach

- Daily Alert on ED / hosp. admits
- List of high risk patients due for maintenance visit
- List of patients due for annual asthma status check

Visit Planning

- Patients due for Spirometry
- Patients due for action plan
- Patients due for trigger assessment



Care Manager

Education

- Med follow up outreach
- Environmental triggers education
- Shared care planning
- High risk patient outreach



Practice Manager

Performance Monitoring

- Practice Care Goals
- Health Plan performance reports
- Operations reports



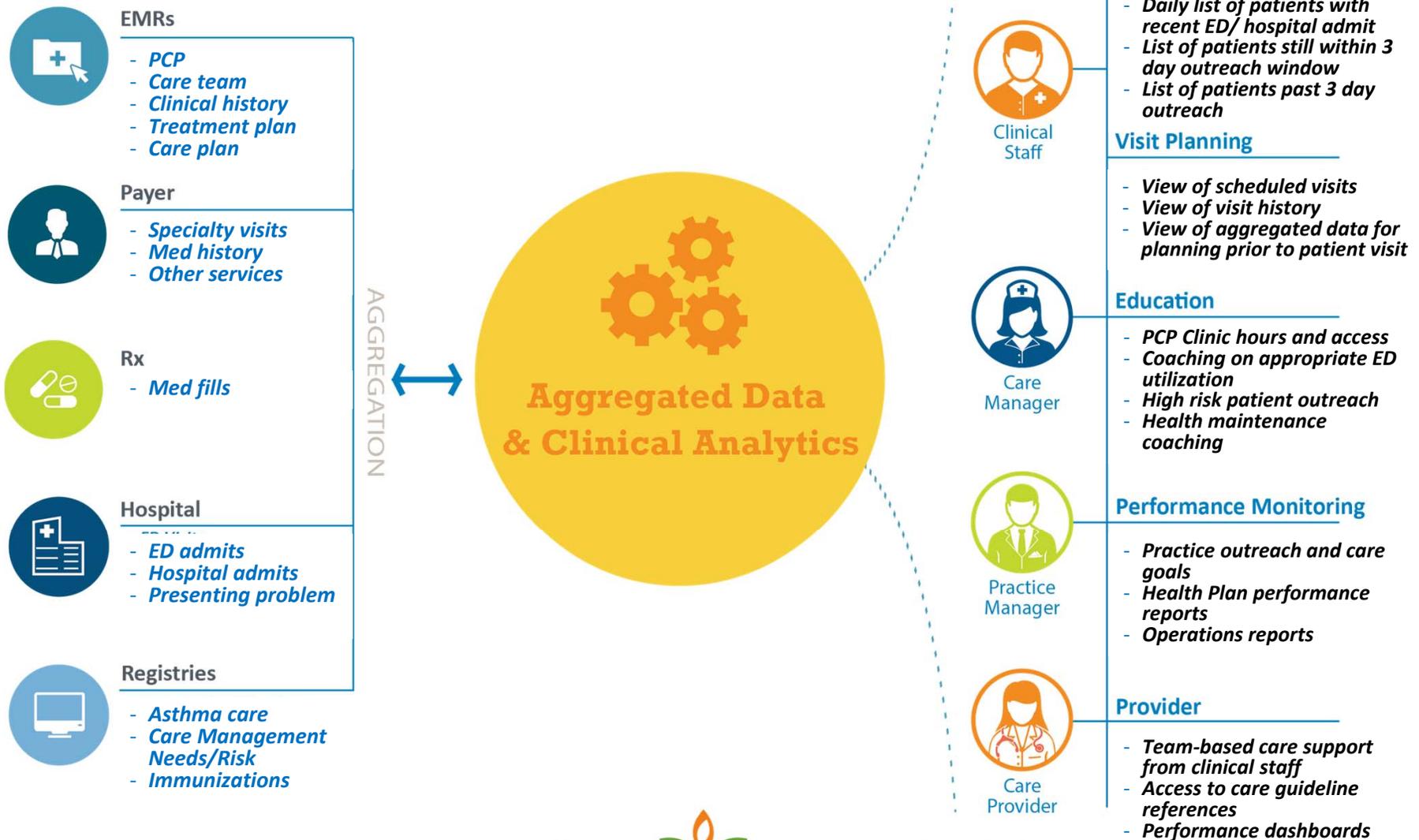
Care Provider

Provider

- Care guidelines
- Performance Dashboards

ED/Hospitalization Follow-up by PCP using CMART

Data Inputs → *Action Outputs*



Example Care Goals and Measures

- Asthma Care Goals
- Support Level Assessment Goals
- Bright Futures Well Visits
- Annual Well Visits (including Adolescents)
- Outreach every 6 months Tier 1 patients
- ED Follow up in 3 days
- Developmental Screenings
- Depression Screenings
- SBIRT Screenings

SMART Implementation Progress

- 112 providers across 8 EMRs licensed for SMART (March, 2014)
- Comprehensive asthma protocols, care alerts & measures (August, 2014)
- Pediatric needs assessment/care management segmentation methods, documentation, alerts and measures (August, 2014)
- Bright Futures™ Pediatric Preventative Care protocols and alerts (October, 2014)
- Pediatric protocols, QI measures and alerts in development (March, 2015)
- Pediatric care management and community care plan workflows in development (March, 2015)
- EMR and other interfaces completed



Results to Date



- ★ Pediatric care management measures will begin in 2015
 - ✓ Tier 1 patients with a care management outreach in the past 6 months
 - ✓ Tier 1 patients with a current care plan
 - ✓ Children and adolescents current on well care and screening schedules
 - ✓ Emergency visit follow-up

Emergency Dept. Visit Rates per 10,000 Asthma Patients				
	2009	2010	2011	2012
CHA Peds	54.2	56.9	40.9	46.2
Comparison Providers	86.2	79.9	64.7	71.6

Inpatient Admission Rates per 10,000 Asthma Patients				
	2009	2010	2011	2012
CHA Peds	10.7	10.9	5.5	7.7
Comparison Providers	14.6	12.9	9.0	10.0

Engaging Collaborators

- **Data partners – gaining the whole view of the person/patient:**
 - Admissions and clinical data from hospitals and providers
 - In OR and WA (and other states):
Emergency Data Information Exchange
 - Claims data from health plans and CCOs
 - Rx data from Payers and PBMs
 - Immunization data from state registries
 - Information from disease-based registries
- **Clinical partners – sharing care information and care plans**
- **Evolving to community-wide Systems of Care and support**



Recent Recognition

Health Data Management

2014 Analytics All Stars

Population Health Management Project of the Year



Healthcare Informatics

2015 Innovator Award – Second Place

Dorland Health

2015 Case In Point Platinum Awards Finalist

Best in Case Management and Care Coordination

Pediatric Care Management

Winner to be announced May 7



State Environment Overview and the Role of HITOC

Susan Otter

Director and State Coordinator for
Health Information Technology

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Oregon's Coordinated Care Model



How does Health IT support CCOs and the coordinated care model?

Selected characteristics of the coordinated care model:

- Care coordination, population management throughout the system
- Integration of physical, behavioral, oral health
- Accountability, quality improvement and metrics
- Alternative payment methodologies
- Patient engagement

Coordinated care model relies on access to patient information and the Health IT infrastructure to share and analyze data

Vision of an “HIT-optimized” health care system

The vision for the State is a transformed health system where HIT/HIE efforts ensures that all Oregonians have access to “HIT-optimized” health care.

Oregon HIT Business Plan Framework (2013-2017):
http://healthit.oregon.gov/Initiatives/Documents/HIT_Final_BusinessPlanFramework_2014-05-30.pdf

Goals for HIT-optimized health care:

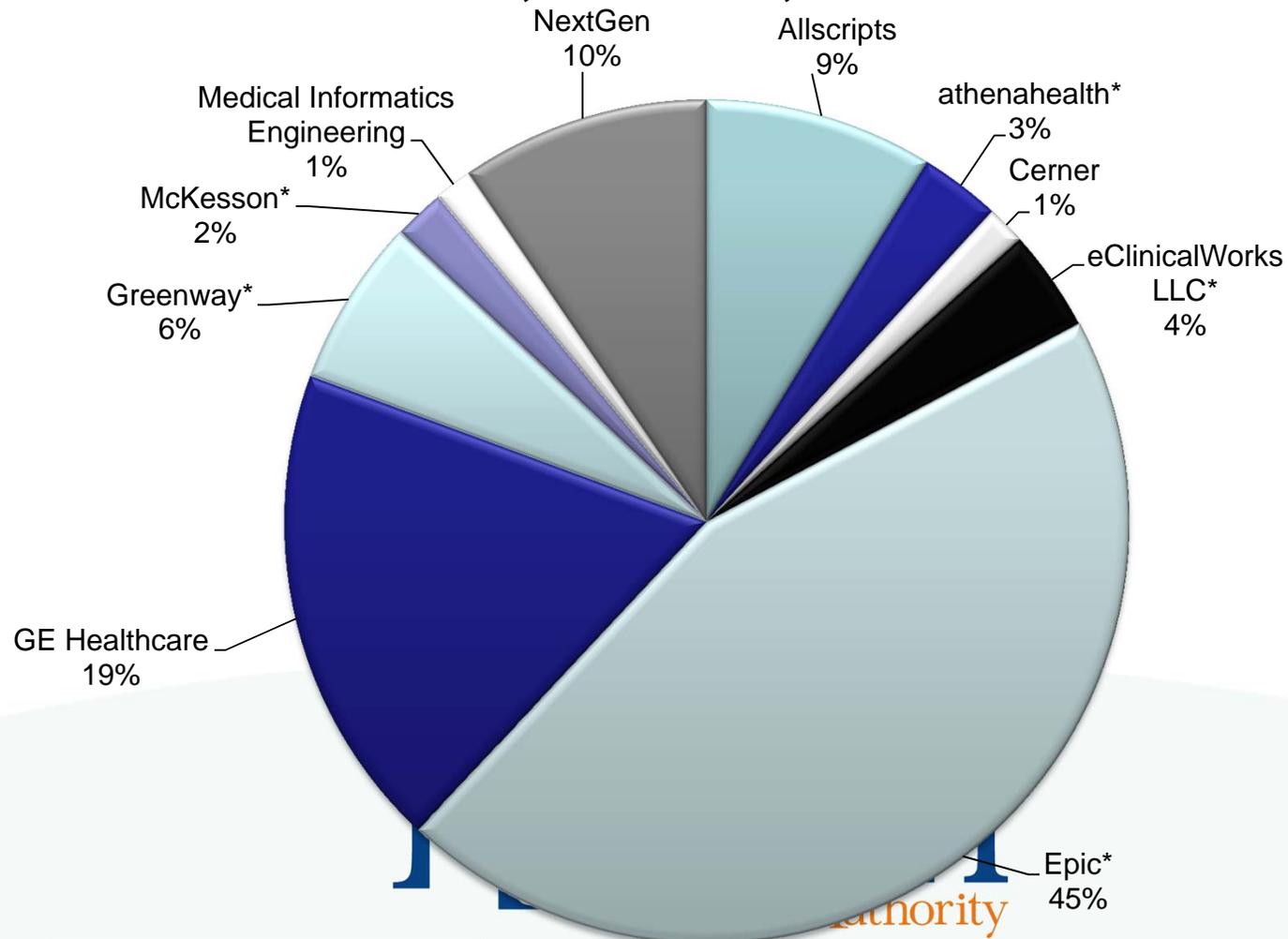
- Providers have access to meaningful, timely, relevant and actionable patient information at the point of care.
 - Information is about the whole person – including physical, behavioral, social and other needs
- Systems (Health plans, CCOs, health systems and providers) have the ability to effectively and efficiently use aggregated clinical data for
 - quality improvement,
 - population management and
 - to incentivize value and outcomes.
- Individuals, and their families, have access to their clinical information and are able to use it as a tool to improve their health and engage with their providers.

EHR Adoption and Meaningful Use in Oregon

- Oregon providers have been early adopters of EHR technology
- Currently, Oregon is in the top tier of states for providers receiving EHR incentive payments, with
 - more than \$366 million in federal funds coming to:
 - nearly all Oregon hospitals and
 - nearly 6,500 Oregon providers
- However, more than 100 different EHRs are in use in Oregon

EHR Vendor Systems purchased by Oregon Eligible Professionals (top 10)

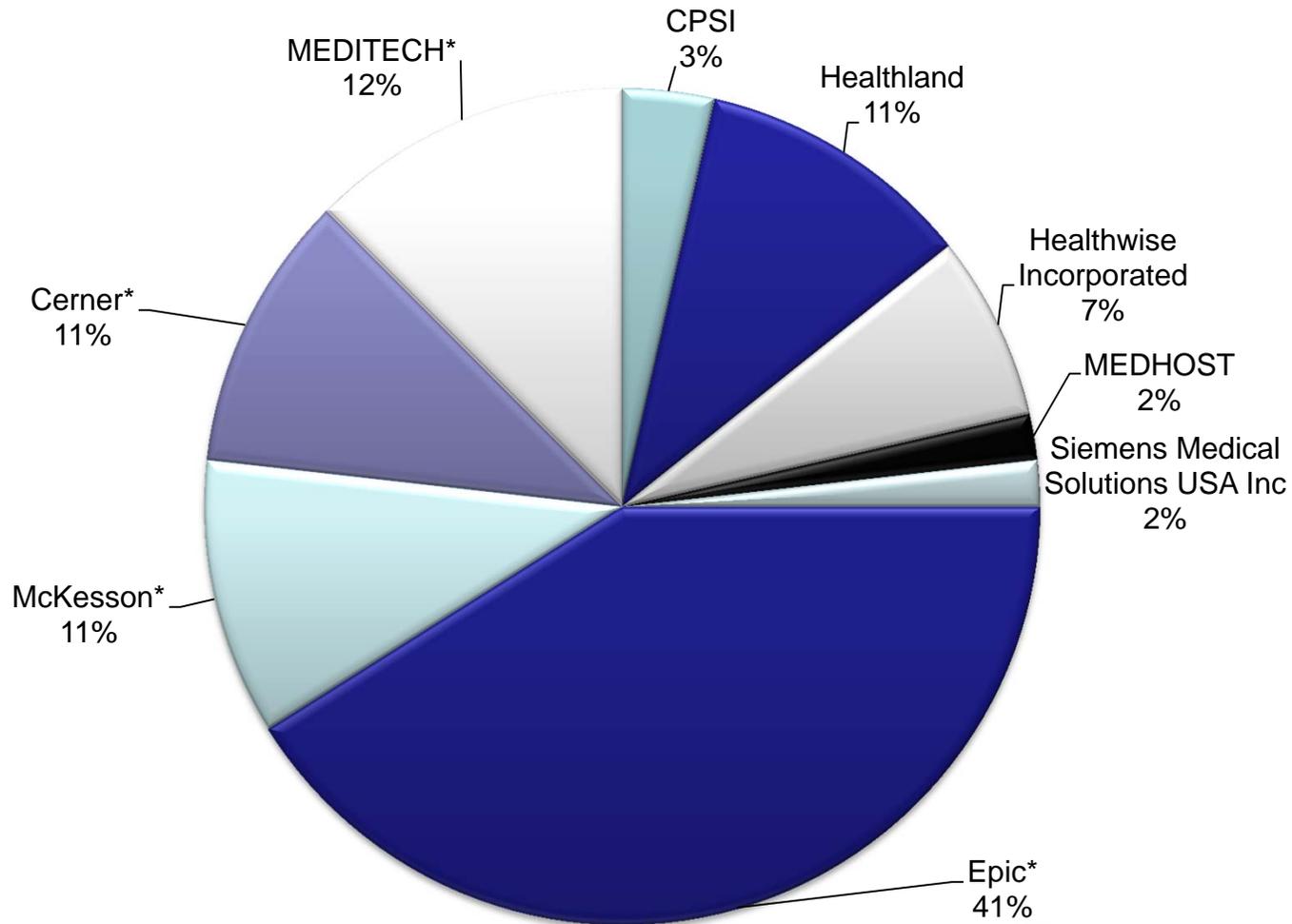
N=4,912 out of 6,007 total



* Denotes vendor also has 2014 CEHRT version in use

Count of unique providers that received a payment in either the Medicare or Medicaid EHR Incentive Programs from 2011 – August 2014.

EHR Vendor Systems in use by Oregon Hospitals (56 out of 59 total hospitals)



* Denotes vendor also has 2014
CEHRT version in use

Oregon
Health

Count of unique hospitals, that received a payment in either the Medicare or Medicaid EHR Incentive Programs from 2011 – Aug 2014

Health Information Exchange in Oregon

- Several community HIEs:
 - Jefferson HIE – Southern Oregon, mid-Columbia River Gorge region
 - Central Oregon Health Connect – Central Oregon
 - Coos Bay, Corvallis, others in development
- Direct secure messaging within EHRs is beginning
 - CareAccord, Oregon's statewide HIE
- Vendor-driven solutions:
 - Epic Care Everywhere, CommonWell
- Hospital events:
 - The Emergency Department Information Exchange
 - Statewide hospital event notifications
- Other organizational efforts by CCOs, health plans, health systems, independent physician associations, and others
 - including HIE and HIT tools, hosted EHRs, etc. that support sharing information across users

HIT/HIE exists in Oregon, but gaps remain

Many providers, plans, and patients do not have the HIT/HIE tools available to support a transformed health care system, including new expectations for care coordination, accountability, quality improvement, and new models of payment.

The Role of the State in Health IT

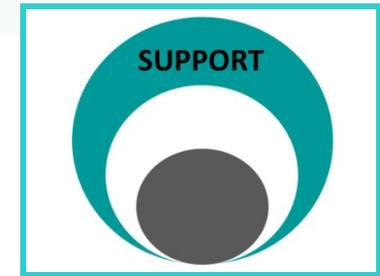
Community and
Organizational
HIT/HIE Efforts

SUPPORT

**STANDARDIZE
& ALIGN**

PROVIDE

State role: Supporting Community and Organizational HIT/HIE Efforts



- Promoting electronic health record (EHR) adoption and provider's ability to use EHRs in meaningful ways
- Promoting interoperability and statewide health information sharing
- Providing guidance, information, and assistance
- Monitoring the changing state and federal health IT environment
- Convening stakeholders to inform state HIT efforts, share best practices and identify challenges (HITOC)

State role: Standardizing and Aligning Efforts



- Adopt standards for organizations using state HIT services, to ensure safety, privacy, security, and interoperability
- Align state clinical metrics and reporting requirements

State role: Providing or Enabling New State-Level Services



- Services for sharing health information to support care coordination
- Foundational HIT services to support HIE and organizations using aggregated health data
- Medicaid-focused services including Technical Assistance with EHRs and meaningful use for Medicaid practices

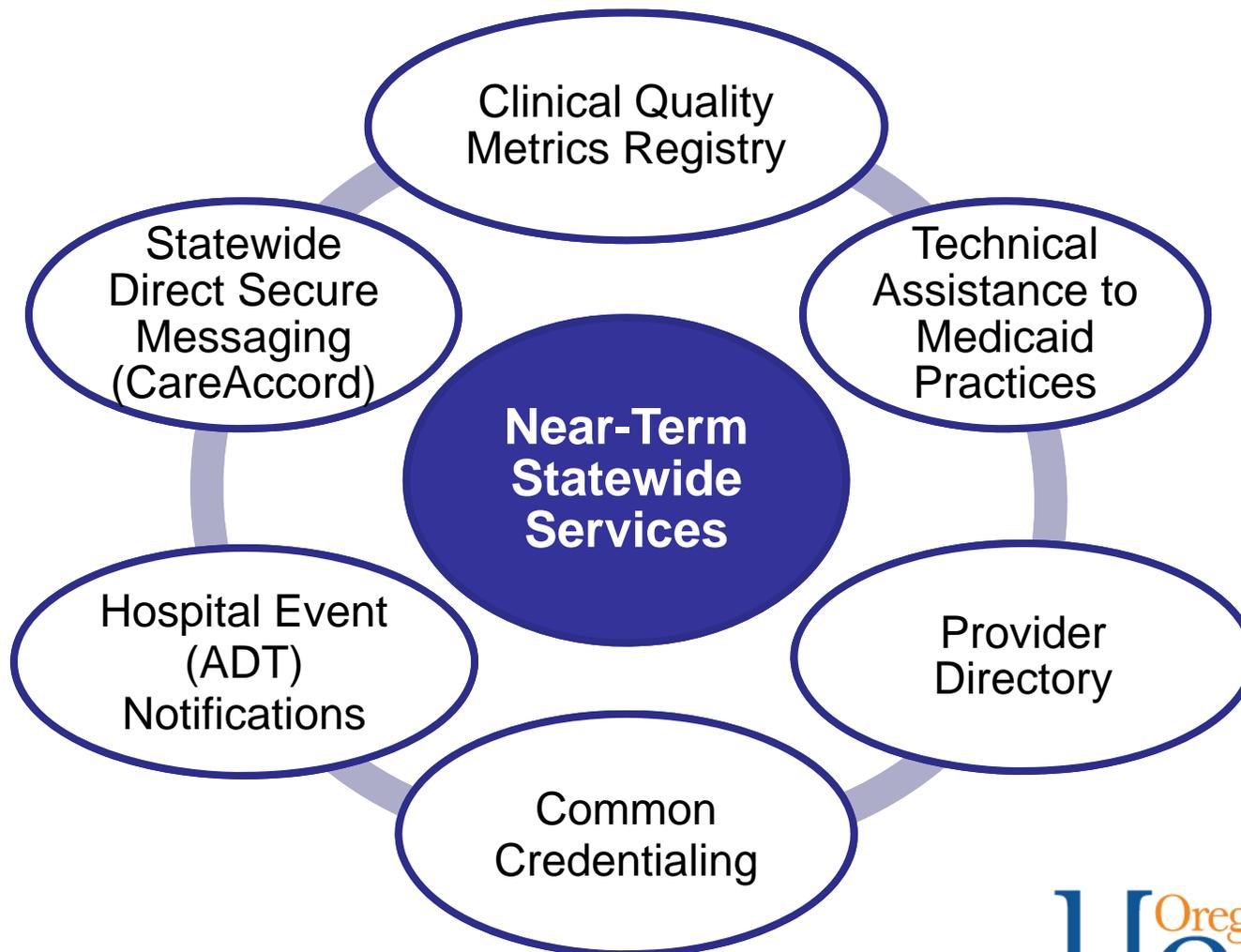
Principles for state-level HIT efforts

- Prioritize interoperability and avoid redundancy: Leverage existing resources and national standards, while anticipating changes
- Demonstrate incremental progress
- Support services with value that achieve common good
- Protect the security and privacy of health information of Oregonians

State-Level Health IT Services

- Why provide some health IT services at the state-level?
 - Connecting and supporting providers across the state
 - Administrative simplification and efficiencies where multiple systems would be duplicative and burdensome
 - Fill gaps where there are no services available
 - Bring significant federal Medicaid investment to state-level health IT services

Near-term statewide HIT services



2015 HIT Legislation – HB 2294

At a high level, the legislation seeks three things:

- 1) The authority for OHA to provide statewide health IT services beyond Medicaid/OHA programs, including charging fees to users
- 2) The authority to participate in partnerships or collaboratives to implement and provide statewide health IT services
- 3) To update and refine the role of the Health IT Oversight Council (HITOC)

Health Information Technology Oversight Council (HITOC) - 2009

- Governor-appointed, Senate-confirmed council established by HB 2009 (2009)
 - Tasked with setting goals and developing a strategic plan for health information technology in the state
 - Led extensive strategic planning effort for Oregon's 2010 plan to the Office of the National Coordinator for Health IT
- HITOC
 - monitors and evaluates the shifting HIT environment
 - makes policy and strategy recommendations
 - convenes committees as needed to collect and share information

Updating HITOC's Role – relationship to OHPB

HITOC would:

- Report to the Oregon Health Policy Board (OHPB), membership would be set by the OHPB
- Monitor and regularly report on progress of state and local HIT efforts in achieving goals of adopting/using HIT to support health system transformation
- Make recommendations to the OHPB on HIT efforts needed to achieve goals of health system transformation
 - Strategy, policy, planning, HIT priorities
 - Areas of concern, barriers
 - Respond to OHPB requests
 - Examples: Integration of behavioral health; patient engagement
- Advise Board on federal HIT law/policy changes

HITOC Panels and Work Groups

- HITOC charters panels and work groups when they are needed to focus on specific topics related to Health IT (like HCOP)
- Previous panels and work groups have included:
 - Finance Workgroup
 - HIO Executive Panel
 - Legal and Policy Workgroup
 - Consumer Advisory Panel
- Like HITOC, these panels meet publicly
- Panels and work groups provide HITOC with valuable recommendations on policy and strategy for health IT at the state level

HCOP Role and Charter

Marta Makarushka
Lead Policy Analyst, OHA



HCOP Charter

Objective

- Facilitate communication and coordination among CCOs, entities that provide health information exchange, and other healthcare organizations
- Provide strategic input to the Health Information Technology Oversight Committee (HITOC) and Oregon Health Authority (OHA) regarding ongoing HIT/HIE strategy, policy, and implementation efforts.

Membership

- Limited to organizations that are leading a HIT/HIE project with a cross-organizational focus
- Organizations based in Oregon
- Vendors are not eligible to be members

Role of HCOP

HCOP will serve in an advisory role (not a formal decision-making role). Activities will include:

- Sharing experiences with the group, particularly around:
 - Best practices
 - Barriers
 - Opportunities for collaboration
- Identifying opportunities for HITOC regarding guidance and/or developing policy to address barriers
- Provide insights to OHA regarding OHA's statewide HIT/HIE initiatives, concerns or implications for implementation, and opportunities for improvement and support

Role of OHA

OHA staff will

- Prepare meeting materials, convene meetings, and take meeting notes
- Post materials and meeting schedule to the healthit.oregon.gov website
- Report HCOP activities to the:
 - Health IT Oversight Council
 - CCO HIT Advisory Group
 - The Provider Directory Advisory Group (as necessary)

Guiding Principles and Expectations

- HCOP may make recommendations to HITOC on areas of focus
 - Not a formal decision-making body
 - Decisions by consensus where possible
- HCOP Meetings will be public
- HCOP members are encouraged to attend in person whenever possible
- Meeting materials will be distributed prior to each meeting - members are responsible for reviewing these materials prior to the meeting, if possible
- OHA and the HCOP should be vendor-neutral and refrain from any type of endorsement for particular vendors

Brainstorming Activity: HCOP priority topics



Identifying topics and issues of interests

- Best practices you want to learn from each other
 - Successes discussed during roundtable
- Pain points for which you would like support
 - Barriers/challenges discussed during roundtable
- Questions you would like answered
- Information you are in need of
- Suggestions/recommendations for OHA/HITOC

Topic Areas Identified on Interest Forms

- Implementation
- State Services/Goals
- Security/Privacy
- Fiscal
- Provider-centric
- Consumer-centric
- Telemedicine

Prioritizing Meeting Topics

- Group to decide now?
- OHA to decide and bring back to the next meeting?
- What factors to use as basis?
 - Most member interest?
 - Pertinent to most members?
 - Most relevant to HITOC
 - Most urgent?

Process Discussion

- How would you like OHA to staff the Panel/meetings?
- How would you like next meeting topics to be selected?
- How can we be a resource to you?
- This is an experiment!
 - Panel may be of greatest value to itself and secondly to make recommendations to HITOC
- Technology consultants to participate starting in November

Conclusions, Next Meeting, and Action Items

- Excited to be convening HCOP quarterly
 - You have an important role to play
 - Opportunity to impact future of HIT/HIE
- Great list of topics
- Future Meetings:

Tentative Date	Time	Location
May 21, 2015	1-4 pm	TBD
August 20, 2015	1-4 pm	TBD
November 19, 2015	1-4 pm	TBD
February 18, 2016	1-4 pm	TBD

Process Check

- What did you like about this meeting?
 - Format?
 - Activities?
 - Discussion?
 - Duration?
- What would you like to see us change?
 - What should we add?
 - What should we remove?

For more information on Oregon's HIT/HIE developments,
please visit us at <http://healthit.oregon.gov>

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