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# Health Information Technology Oversight Council

February 4, 2016



# Agenda

- 1:00 pm Welcome, Introductions & Approve Minutes
- 1:15 pm Priority Policy Topics: Interoperability
- National Environment: Gary Ozanich, Health Tech Solutions
  - State Environment: Barriers to Interoperability in Oregon
  - State Levers and Potential Approaches
  - Interoperability SME Workgroup Discussion
- 2:40 pm Break
- 2:55 pm Priority Policy Topics: Behavioral Health Information
- Presentation by Gina Bianco, Jefferson HIE
  - Presentation by Veronica Guerra, OHA
- 3:55 pm HITOC Work Plan Discussion
- 4:05 pm Other HITOC Business
- Endorsement of PDAG and CCAG Charters
- 4:20 pm Public Comment
- 4:25 pm Conclusion and Next Steps

# Goals of HIT-Optimized Health Care

## 1. Sharing Patient Information Across the Care Team

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.

## 2. Using Aggregated Data for System Improvement

- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention.
- In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.

## 3. Patient Access to Their Own Health Information

- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

# Aims & Objectives for HIT-Optimized Care – Updated

## Overarching Aims & Objectives

1. Improved culture of HIT-optimized health care where providers and other stakeholders value and expect electronic access to shared information
2. Increased alignment of standards to promote interoperability
3. Improved distribution of financial burden for supporting HIT investments as payment models evolve

# Aims for HIT-Optimized Health Care Goals

**Goal 1 of “HIT-Optimized Health Care”:** Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care

1. Increased adoption of standards-based technology for data capture, use, and exchange
2. Improved ability to capture, produce and use interoperable standards-based data in formats that are structured to be integrated and automated within EHRs and workflows
3. Improved access to and sharing of meaningful patient information across organizational and technological boundaries
4. Ensured protection of privacy and security of patient information
5. Improved provider experience and workflows, reduced burden, and increased workforce capacity

# Aims & Objectives

**Goal 2 of “HIT-Optimized Health Care”:** Systems effectively and efficiently collect and use aggregated clinical data for quality improvement, population management, and incentivizing health and prevention

1. Improved use of HIT tools for data collection, analytics, and reporting
2. Increased use of aggregated data, including clinical data for population management, quality improvement, and alternative payment methods
3. Reduced reporting burden for data needed to support the coordinated care model across programs

# Aims & Objectives

**Goal 3 of “HIT-Optimized Health Care”:** Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers

1. Increased patient access to/use of their complete health records
2. Improved ability for individuals to provide relevant information into their health records
3. Increased capacity for individuals to facilitate care management by sharing information with their providers
4. Ensured confidence in the privacy and security of electronic health information

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# Priority Policy Topics: Interoperability

Gary Ozanich, PhD, Health Tech Solutions  
Susan Otter, OHA

**1. Sharing Patient  
Information Across  
the Care Team**

**2. Using Aggregated  
Data for System  
Improvement**

**3. Patient Access to  
Their Own Health  
Information**



**Health**  
Oregon  
Authority

# Goals for Today

- Come to a shared understanding of the national and state environments in which we are trying to achieve real-world interoperability
- Articulate significant barriers and opportunities that exist in this complex area
- Discuss the role of an Interoperability Subject Matter Expert (SME) Workgroup and provide input on scope and membership

# INTEROPERABILITY: HEALTH DATA EXCHANGE AND RE-USE

Gary Ozanich, PhD  
February 4, 2016

HealthTech Solutions, LLC.

# Interoperability Definitions

The capacity of different health information technology systems and software applications to communicate and exchange data and to make use of the data that has been exchanged.

~ Oregon Laws Chapter 243 (2015)

Ability of a system or a product to work with other systems or products *without special effort on the part of the customer*. Interoperability is made possible by the implementation of standards.

~ ONC (adopting the Institute of Electrical and Electronics Engineers (IEEE) definition)

# HIMSS Approach to Interoperability

**1 - “Foundational”** interoperability allows data exchange from one information technology system to be received by another and does not require the ability for the receiving information technology system to interpret the data.

**2 - “Structural”** interoperability is an intermediate level that defines the structure or format of data exchange (i.e., the message format standards) where there is uniform movement of healthcare data from one system to another such that the clinical or operational purpose and meaning of the data is preserved and unaltered.

- Structural interoperability defines the syntax of the data exchange. It ensures that data exchanges between information technology systems can be interpreted at the data field level.

**3 - “Semantic”** interoperability provides interoperability at the highest level, which is the ability of two or more systems or elements to exchange information and to use the information that has been exchanged.

- Semantic interoperability takes advantage of both the structuring of the data exchange and the codification of the data including vocabulary so that the receiving information technology systems can interpret the data.
- This level of interoperability supports the electronic exchange of patient summary information among caregivers and other authorized parties via potentially disparate electronic health record (EHR) systems and other systems to improve quality, safety, efficiency, and efficacy of healthcare delivery.

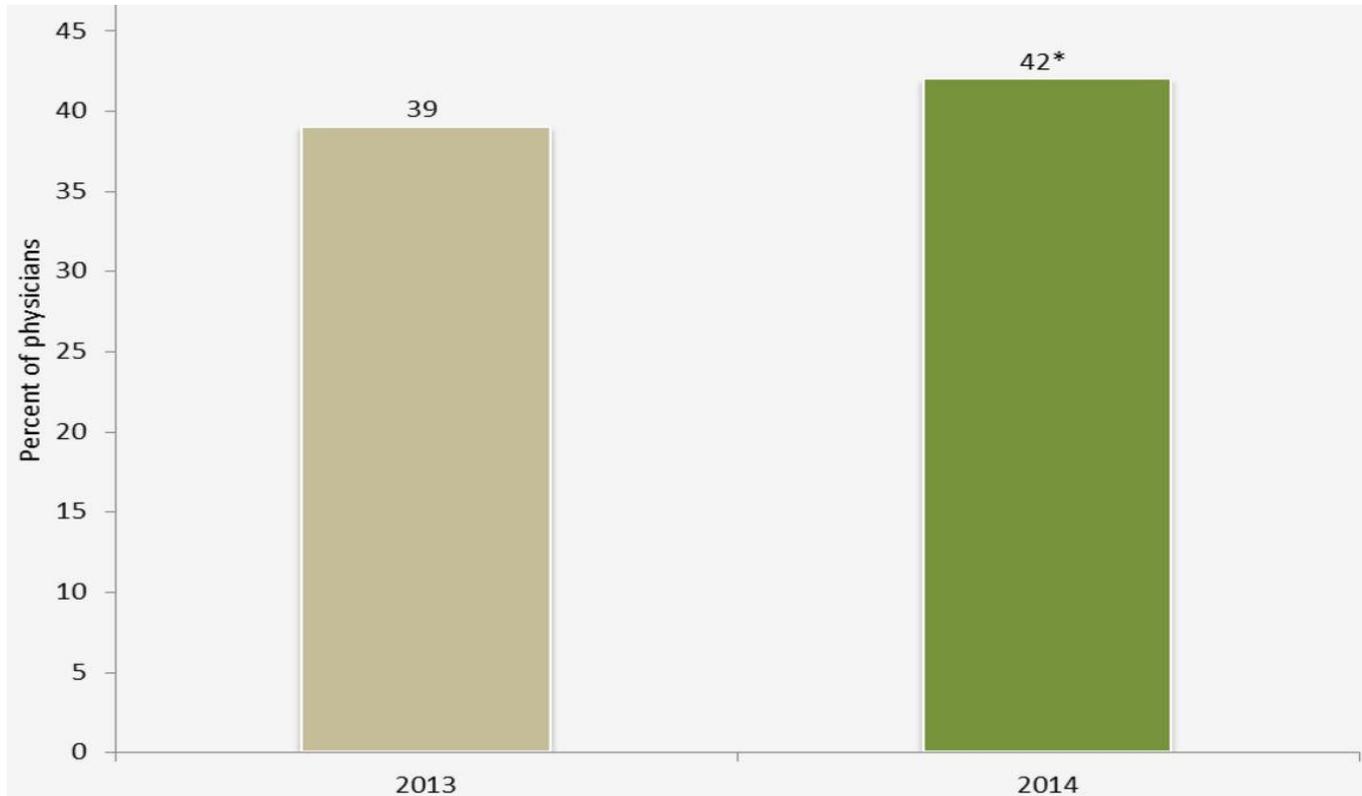
HIMSS: <http://www.himss.org/library/interoperability-standards/what-is-interoperability>

# Historical Development: Locally Driven Solutions

- 1990s: Clinical Health Information Network (CHINs)
- 2000s: Regional Health Information Organizations (RHIOs)
- Problem: Governance
- Problem: Sustainability
- Problem: Absence of Standards
- Problem: Economic Incentives for Exchange
- Problem: De Facto Development of “Walled Gardens”



# Physicians Reporting Exchanging Data with Other Providers



\*Source: Health IT Dashboard <http://dashboard.healthit.gov/evaluations/data-briefs/physician-electronic-exchange-patient-health-information.php>

# What is the Status of Health Information Exchange Today?

- There is a mix of community/private HIEs/HIOs
  - Private HIEs: IDNs, ACOs, Vendor Networks, e-Prescribing
  - Pushing or publishing data on community HIEs is the exception
- Cooperative Agreement funding has ended
  - Community HIEs continue to struggle with sustainability
  - Some regions/states have embraced community HIEs
- Value propositions are linked to use cases
  - Hospital event (ADT) alerts
  - MU2/3 requirements

# The Effects of Exchange

- Randomized controlled studies in peer reviewed journals of community HIEs
  - Inconsistent results across studies
  - Some studies indicate evidence of reduced ED Use and Readmissions  
<http://s3.amazonaws.com/rdcms-himss/files/production/public/FileDownloads/Showing%20the%20Impact%20of%20HIE%20-%20Joshua%20Vest.pdf>
- There have been no published studies of private HIEs
  - Expectation that there would be greater impact
  - ACO performance is probably not a good proxy

# ONC Interoperability Roadmap

- Electronic health information sharing arrangements defined:
  - ▣ Shared decision-making
  - ▣ Rules of engagement
  - ▣ Accountability
- Complete milestones, calls to action and commitments documented with timelines in ONC Roadmap
- Ultimately driven by standards, policies and payment reform

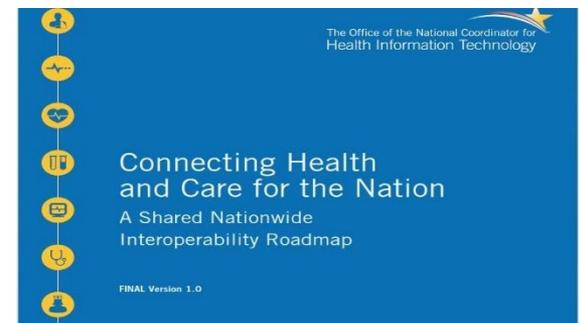
## *Milestones for Shared Decision-Making, Rules of Engagement and Accountability*



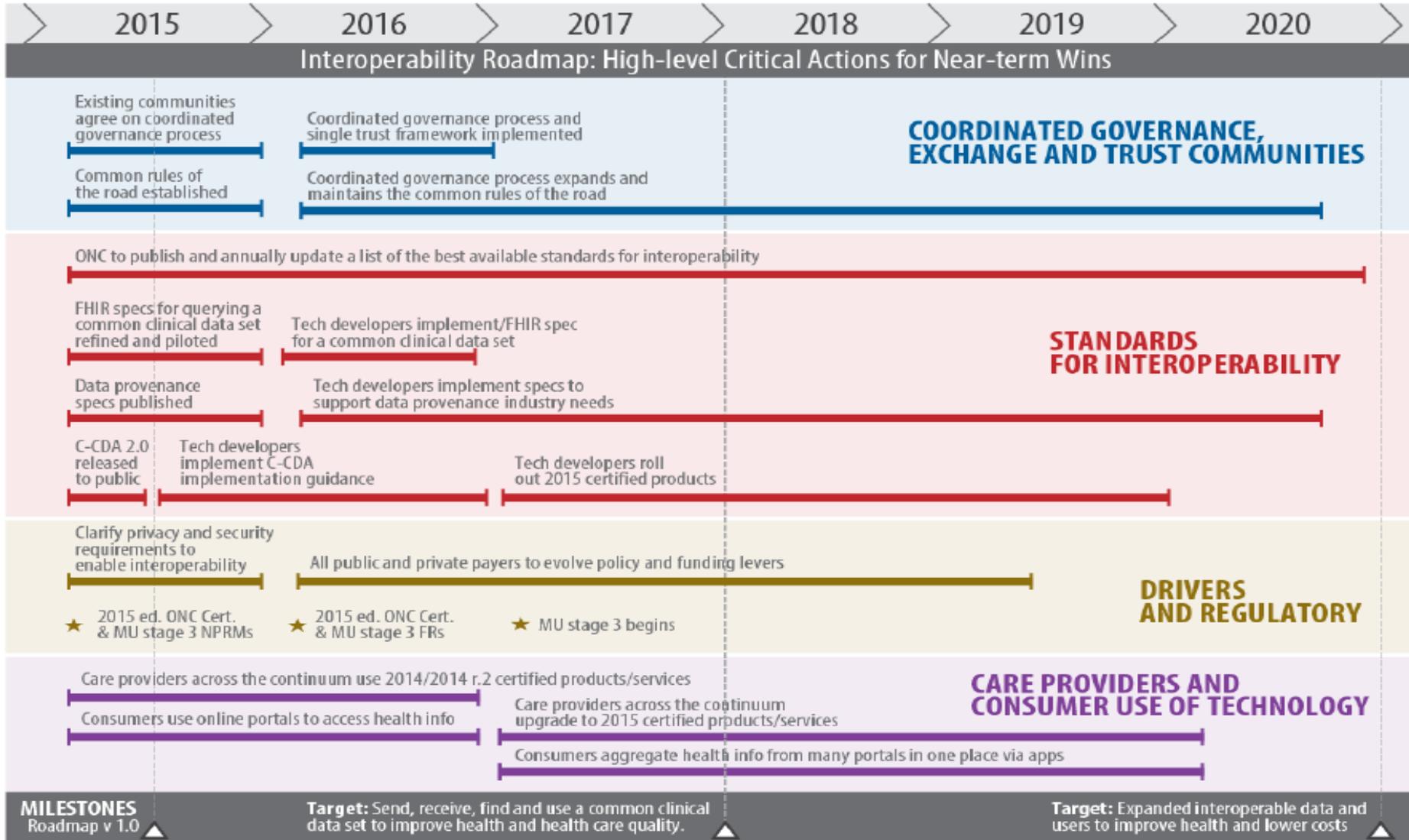
# ONC Shared Nationwide Interoperability Roadmap

- “It is not realistic to suggest that all electronic health information will be met with a single electronic health information sharing arrangement”
- “(A) variety of electronic health information sharing arrangements will continue to exist ... that meet the unique needs of many different communities”

*Connecting the Health Care of the Nation: A Shared Nationwide Interoperability Roadmap, Final Version 1.0. October, 2015. Page 7.*



# Timeline of Select High-Level Critical Actions for Near-Term Wins





# Governance

Standards and Interoperability

Drivers and Regulatory

Care Providers and Consumer Use of Technology

# ONC Initiatives Supporting Governance Models

- Supports existing governance initiatives and advances governance goals
  - Increase Interoperability
  - Increase Trust
  - Decrease cost and complexity
- Activities
  - Exemplar Cooperative Agreements
  - Forum Resources
  - Governance Framework

[www.healthit.gov/policy-researchers-implementers/health-information-exchange-governance](http://www.healthit.gov/policy-researchers-implementers/health-information-exchange-governance)

# Elements of the ONC Governance Framework

The Governance Framework reflects ONC's current thinking, as well as the recommendations of the Health IT Policy and Standards committees. It consists of four different types of principles. These include:

- "Trust principles," which guide HIE governance entities on patient privacy, meaningful choice and data management;
- "Business principles," which focus on responsible financial and operational policies for governance entities, with emphasis on transparency and HIE with the patient's best interests in mind;
- "Technical principles," which express priorities for the use of standards in order to support the Trust and Business Principles as well as interoperability; and
- "Organizational principles," which identify generally applicable approaches for good self-governance.

# Trust Communities Are Taking Leading Roles Including Rules, Specifications and Directories

- DirectTrust
- National Association for Trusted Exchange (NATE)
- Sequoia Project (evolved from NHIN/NWHIN/Healthway)
  - Carequality Interoperability Framework
- CommonWell Health Alliance (technology collaboration)
  - Vendor neutral platform
  - Leading work on APIs and FHIR



Governance

# Standards and Interoperability

Drivers and Regulatory

Care Providers and Consumer Use of Technology

# Key Exchange Issues to Overcome ...

- “Walled Garden” approaches by providers
  - Reluctance to share clinical data with non-affiliates
  - Patient control
  - Protection of referral network
  - A fee-for-service artifact?
  - ONC: “Current business environment ... often inhibits exchange”
- Information Blocking
  - Use of proprietary data formats to lock in customers
  - Requiring use of middleware (or other means of increasing costs)
  - Price discrimination

# Key Exchange Issues to Overcome....

- “Good Enough” Solutions
  - View-only portals are cost effective
  - Printing and scanning documents is not data re-use
- Liability of Exchanged Data
  - Trust in source of data
  - Medical errors
  - Risk of making part of the medical record
- Semantic Interoperability
  - Issues even when technical interoperability is present

# The Range of Standards

CATEGORIES OF STANDARDS	FUNCTIONS OF STANDARDS	EXAMPLES OF REAL WORLD USE OF THE STANDARDS
 <b>VOCABULARY &amp; CODE SETS (SEMANTICS)</b>	The information is universally understood	RxNorm Code for Ibuprofen is 5640
 <b>FORMAT, CONTENT &amp; STRUCTURE (SYNTAX)</b>	Information is in the appropriate format	C-CDA packages up data in the appropriate format
 <b>TRANSPORT</b>	The information moves from point A to point B	SMTP and S/MIME to send the C-CDA from one setting to another
 <b>SECURITY</b>	The information is securely accessed and moved	X.509: to ensure it is securely transmitted to the intended recipient
 <b>SERVICES</b>	Provides additional functionality so that information exchange can occur	DNS+LDAP: to find the recipient's X.509 certificate to encrypt a message

Source: *Connecting the Health Care of the Nation: A Shared Nationwide Interoperability Roadmap, Final Version 1.0.* October, 2015. Page 24

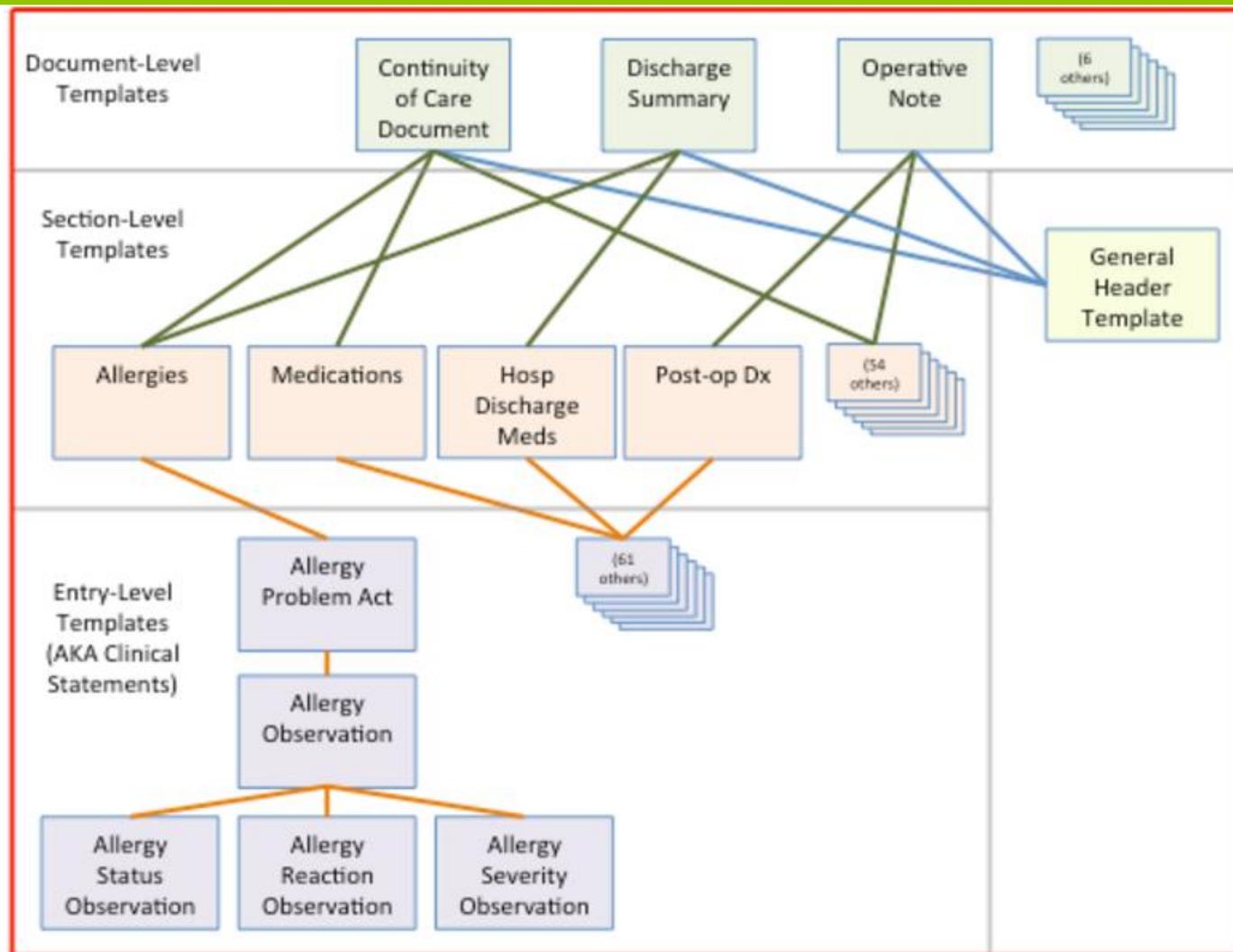
# Transport Solutions

- Provider Portal(Vendor Portal)
- HIE/HIO Portal
- Direct Secure Messaging
  - MU requires: Standards-based (C-CDA) attachments
  - Specialized Applications (e.g., Transform)
- Query-Based Exchange
  - HIEs/HIOs
  - Vendor
- APIs/ FHIR (Evolving)

# Direct Secure Messaging Appears the Principal Migration Path for Exchange

- Difficulties standing-up sustainable query-based exchanges
- Low-cost, flexible, and ubiquitous
- Directories are evolving
- Vendor neutral
- Supports solutions such as Direct on FHIR
- Problems with DSM are numerous, but well known

# Standards: 2.0 Consolidated Clinical Document Architecture



# Document Exchange vs. Requests/Access to Discrete Data

- Arguably, the “philosophy” of exchange is changing from the exchange of comprehensive (and lengthy) documents (e.g., CCD) to the exchange of smaller defined data elements (e.g., Medication List)
- C-CDA is designed to transfer entire documents not lists or discrete data
- ONC/CMS encouraging public application protocol interfaces (APIs)
- HL-7 is supporting the Fast Healthcare Interoperability Resources (FHIR)
- Models of HIEs managing API bundles as a value proposition

# CMS Leadership Touting Open APIs



**Andy Slavitt** @ASlavitt · Jan 12

(4/5) Level the tech playing field with open APIs to allow apps, analytic tools, plug ins and reduce EHR lock #healthIT



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[View other replies](#)

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# FHIR Is Creating A Lot of Heat

- Concept is straightforward
  - Defines specific “resources” that correspond to “granular clinical concepts”
  - Resources can be managed in isolation or aggregated
  - Designed for the web: based on XML or JSON structures
  - Based upon a RESTful protocol (e.g., HTTP-based)

<https://www.hl7.org/fhir/overview.html>

- SMART on FHIR is leading in application development

- Developed from Harvard initiative
- Vendors will have demos at HIMSS16





Governance

Standards and Interoperability

# Drivers and Regulatory

Care Providers and Consumer Use of Technology

# Meaningful Use Stage 3 and MACRA: What Comes Next

- Rewarding providers for outcomes the technology supports
- Flexibility to customize Health IT Solutions
  - Individual practice needs
  - User-centric and supports physicians
- Level the technology playing field
  - Promote innovation
  - Use of open APIs
- Prioritize interoperability
- Real-world focus

# Payment Reform Is Driving the Need for Interoperability

- MACRA is designed to link value-based payments to certified (interoperable) technology and care coordination
- 475 ACOs with 30,000 participating physicians
- CMS Targets
  - 85% of Medicare FFS payments tied to quality in 2016 and 90% in 2018
  - 30% of Medicare payments tied to alternative payment models by 2018 and 50% by 2020.
- Employers embracing value-based solutions and population health approaches



Governance

Standards and Interoperability

Drivers and Regulatory

# Care Providers and Consumer Use of Technology

# Consumer Engagement: The Biggest Challenge?

- MU Stage 2 Requirement: View/Download/Transmit
  - A great challenge for many providers
  - Unpopular requirement with “check the box” implementation
- Tethered portals
  - Patient control
  - Multiple sign-ons
  - Absence of aggregation strategies

# Developing Issues

- Mobile Health (1 65K health apps)
  - 36 apps = 50% downloads
  - 2% sync with providers
- FDA and device regulation
- Telehealth technologies and reimbursement issues

Healthcare IT News

Mobile

How many health apps actually matter?

"Without guidance patients may choose popular apps or try several in an effort to self-determine the best."

mobihealthnews

Scripps Wired for Health study results show no clinical or economic benefit from digital health monitoring

# Potential Solution



ONC's vision is one of consumers aggregating health information from many portals to one place

# Questions??

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# State Environment: Barriers and Opportunities for Interoperability

Susan Otter, OHA

1. Sharing Patient Information Across the Care Team

2. Using Aggregated Data for System Improvement

3. Patient Access to Their Own Health Information

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## Interoperability

- [Shared Nationwide Interoperability Roadmap Version 1.0](#)
- [Interoperability Standards Advisory](#)
- [ONC 2015 Certification Rule](#)

## Delivery System Reform

- [State Innovation Models Initiative](#)
- [HHS Delivery System Reform Goals](#)
- [Medicare Access & CHIP Reauthorization \(MACRA\)](#)



# Oregon and Roadmap Synergies

Component	Oregon Goals	National Roadmap
Provider	Providers have access to the right patient information to coordinate and deliver “whole person” care.	Evolving delivery models are not only driving appropriate data sharing, but dependent on it
Health System	Systems effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention.	Learning health system environment demands rapid actions and smarter spending
Patients	Individuals access their clinical information and use it as a tool to improve their health and engage with their providers.	Consumers increasingly expect and demand real-time access to their electronic health information

# State Call to Action/Oregon Alignment

Calls to Action	Oregon Progress
Interoperability roadmap articulated in health-related <u>strategic plans</u> . (2015-2017)	<ul style="list-style-type: none"><li>• Business Plan 2014-2017</li><li>• State Medicaid HIT Plan to CMS</li><li>• State Innovation Model grant</li><li>• Medicaid Waiver</li></ul>
Enact state-autonomous <u>policies</u> to advance interoperability. (2015-2020)	<ul style="list-style-type: none"><li>• HITOC</li><li>• Oregon HIT Program</li><li>• Partnerships (Emergency Department Information Exchange (EDIE) Utility)</li><li>• CCO CQMs</li></ul>
Take appropriate steps to implement policies in alignment to the national, multi-stakeholder approach to <u>coordinated governance</u> for interoperability. (2015-2017)	<ul style="list-style-type: none"><li>• Participation in DirectTrust (CareAccord)</li><li>• Member of NATE</li></ul>
Proposed and/or implemented strategies to <u>leverage Medicaid financial support</u> for interoperability and exchange. (2015-2020)	<ul style="list-style-type: none"><li>• Leveraged Medicaid funds for OHA provided services and partnerships (where applicable)</li></ul>

# State Call to Action/Oregon Alignment

Calls to Action	Oregon Progress
<p>Utilize health homes or other new models of care and payment to <u>integrate behavioral health with physical health</u> and incentivize health information exchange. (2015-2017)</p>	<ul style="list-style-type: none"><li>• Patient Centered Primary Care Homes (PCPCH)</li><li>• Behavioral Health in Coordinated Care Organizations (CCO)</li><li>• ONC Interoperability Grant (Jefferson HIE Common Consent Model)</li></ul>
<p>Implement models for <u>multi-payer payment and health care delivery system reform</u> (2018-2020) and use initiatives around value-based arrangements under Medicaid to <u>provide electronic tools to improve care coordination</u> and deliver quality improvement data to providers. (2021-2024)</p>	<ul style="list-style-type: none"><li>• Public Employees' Benefit Board, Oregon Educators' Benefit Board, CCO, PCPCH</li><li>• Oregon HIT Program (e.g. EDIE/PreManage, Provider Directory, Clinical Quality Metrics Registry, etc.)</li></ul>
<p>States with managed care contracts should routinely require provider networks to report performance on <u>measures of standards-based exchange</u> in required quality strategies, etc. (2018-2020)</p>	<ul style="list-style-type: none"><li>• For consideration</li></ul>

# Other Resources

- 2016 Interoperability Standards Advisory
  - Available here: <https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf>
  - ONC currently accepting public comments on the Standards Advisory for use in developing the 2017 advisory. Comments due Monday, March 21, 2016 5pm EDT
- State HIT Policy Levers Compendium
  - <https://www.healthit.gov/policy-researchers-implementers/health-it-legislation-and-regulations/state-hit-policy-levers-compendium>
  - A resource for states to identify potential policy levers to further progress on HIT

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# Interoperability Subject Matter Expert Workgroup

Justin Keller, OHA



# Barriers Identified by our Stakeholders

- Interoperability Panel (March 2015):
  - **Costs:** vendors pass costs along to their customers as they update and modify their products. While organizations experiment and learn what works within their network(s) and community, these costs can be considerable
  - **Value:** demonstrating value of health information exchange is difficult and tied directly to the scope of the solution.
    - Too Big = too complicated to launch
    - Too Small = not enough value
  - **Clinical Need:** standards need to be more closely aligned with the needs of clinicians. Existing standards (e.g. HL7, CCDA, etc.) not enough to cover all clinician needs

# Barriers identified by HCOP

- The HIT/HIE Community & Organizational Panel has identified the following opportunities and challenges in their initial meetings:

## Opportunities

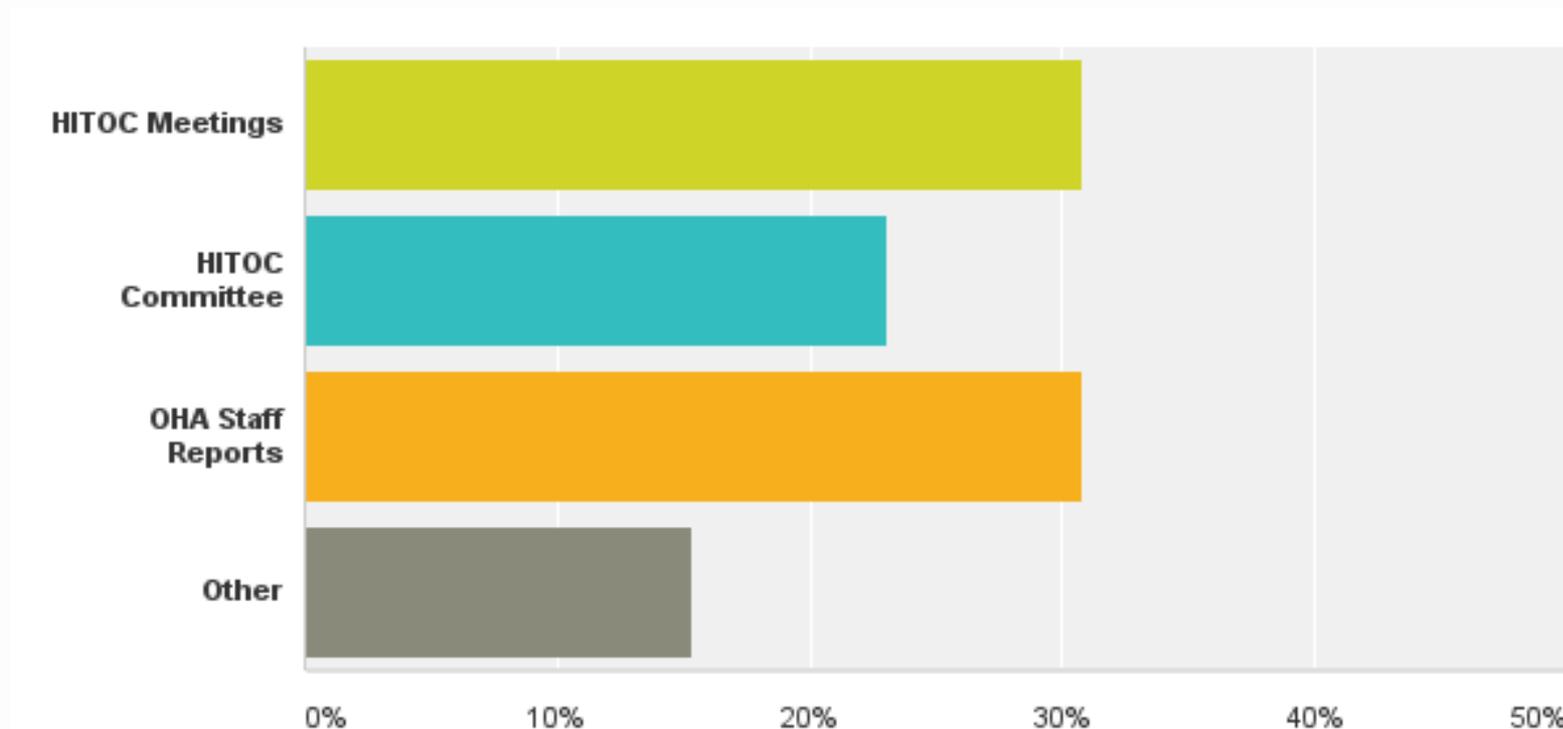
- Broad Stakeholder Support for health information exchange
- The multitude of use cases that are possible

## Challenges

- The costs that vendors charge for turning on certain capabilities vary significantly
- Vendors are inconsistent in how they implement standards and requirements (e.g. Direct)
- Organizational privacy/security policies and other data sharing policies are inconsistent—in part due to federal policy questions
- Standards are often based on specific use cases—we have to build our own data specifications for unique uses

# HITOC Approach to Interoperability

- A majority of HITOC members wanted to address these issues themselves during our meetings (with OHA staff organizing)
- An interoperability Subject Matter Expert (“SME”) workgroup was suggested to help OHA staff keep the discussion moving



# Interoperability SME Workgroup

- SME Workgroup is proposed as an advisory group to OHA
- SMEs would advise OHA on the relevance of various topics related to interoperability and health information exchange so they can be presented to HITOC
- Role would include:
  - Feedback to OHA on how policies hit the ground—the distinction between interoperability and “real-world interoperability”
  - Input on our approach to staff work for HITOC meetings
  - Input on existing federal and state resources
  - Potential reviewers for OHA-developed guidance or other documents

# SME Membership

- As a group reporting to OHA, membership will be less formal than a HITOC committee
- Goals for membership:
  - HITOC Members as you have time/interest
  - One or more representatives from the HCOP as relevant
  - Broader technical and policy experts that can inform OHA about barriers at various levels of interoperability (not just health information exchange) and across different sectors

# Discussion and Next Steps

- Initial reactions and impressions on the material
- Does anything stick out to you as the most timely?
- Potential topics for educational webinars
- Thoughts on a potential prioritization process
  
- Next steps: Recruit Interoperability SME Workgroup with the goal of meeting prior to next HITOC meeting (May at the latest)

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# Priority Policy Topics: Behavioral Health Information Sharing

Gina Bianco, Jefferson Health Information Exchange  
Veronica Guerra, OHA

**1. Sharing Patient Information Across the Care Team**

**2. Using Aggregated Data for System Improvement**

**3. Patient Access to Their Own Health Information**



**Oregon Health Authority**

# Context for Behavioral Health Information Sharing

- Consistently comes up as a major barrier to comprehensive health information exchange (CCOs, HCOP, etc.) and integration of physical and behavioral health
- Major concerns include the inconsistency in how federal policies are interpreted and applied; lack of clear guidance in how to comply with these policies
- Major overhauls of behavioral health delivery systems (e.g. UNITY) will lead to further internal and external policy implications for sharing information
- OHA efforts to provide resources and information to support sharing information
- Local efforts, including but not limited to the work of Jefferson HIE on the ONC Interoperability Grant, are starting to address these issues directly



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# Connecting Health Care among Oregon Communities

Health Information Technology Oversight Council  
February 4, 2016

Gina E. Bianco, MPA  
Acting Director



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**What we do...**

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

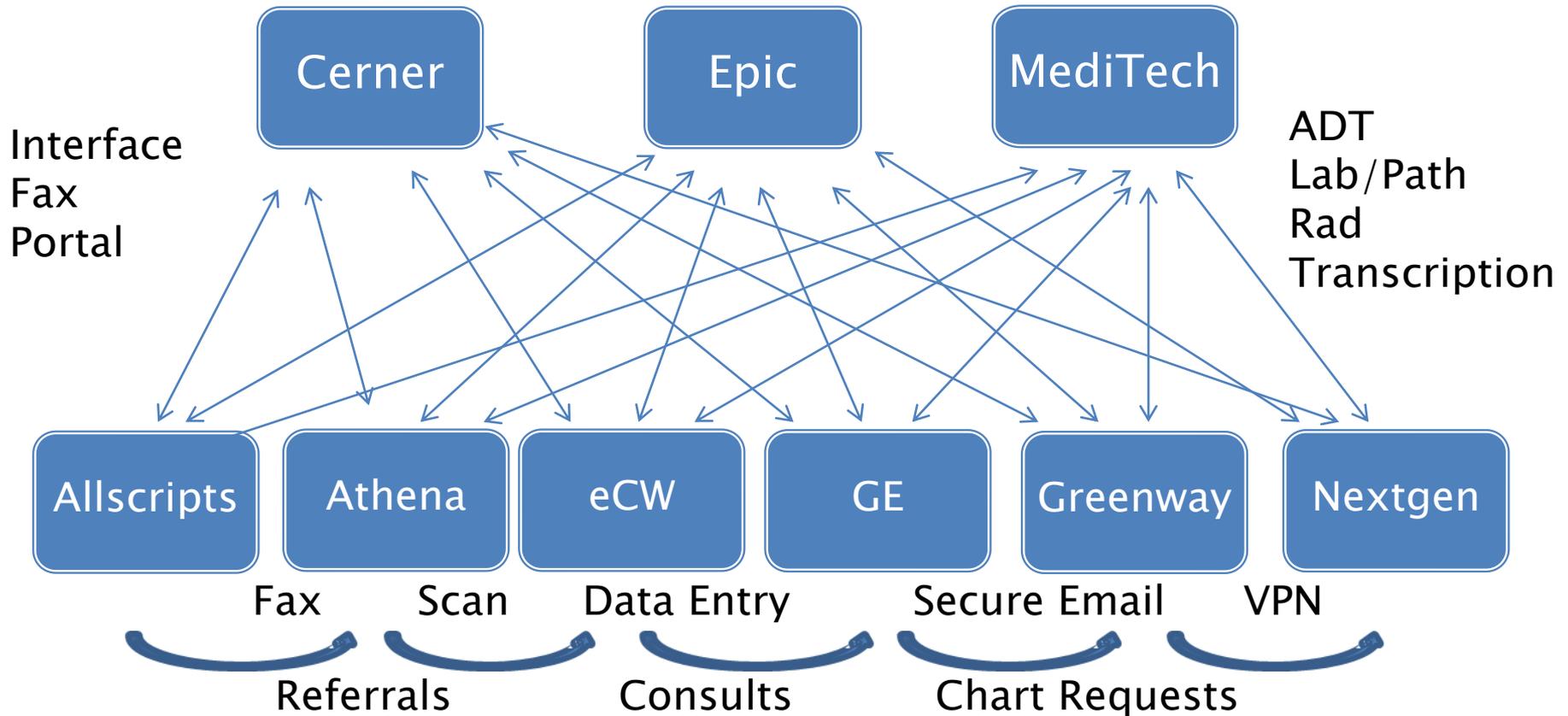
# The Overall Problem...

- ▶ 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)
- ▶ Outpatient clinical world is isolated and lacks access to data outside of the EHR
- ▶ Still requires significant amount of human interaction involved in obtaining records
  - Phone, fax, printer, scanner, etc...
- ▶ Payers are left out of the loop and must rely on claims to glean information about members health status
- ▶ State and Federal regulations limit options for sharing specially protected data, including substance abuse data and some mental health.



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# Why JHIE?



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Focus on patient centered care where information follows the patient

eReferrals  
 Secure Messaging  
 CCD Exchange  
 Query-Based Community Health Record  
 Results Delivery  
 Technology Agnostic  
 Standards Based



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# JHIE Governance

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



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# Past, Present and Future

2013

2015

2016

Point-to-Point  
Exchange

eReferrals &  
Direct Secure  
Messaging

Query-Based  
Exchange

Community  
Health Record  
(Patient Search)

EHR / CCD  
Integration

CCO Data  
Delivery

Analytics

Data for Care  
Management  
& Population  
Health



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# What JHIE Is and Is Not

## ▶ JHIE Is...

- Patient Centered – View one patient at a time
- An aggregator of community-wide health information
- A searchable repository of patient history from connected sources
- Clinically based using industry standards
- Growing!

## ▶ JHIE Is Not:

- A complete medical record
- Population centered – View group of patients at a time
- A care management system
- Claims based



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# JHIE By the Numbers

As of December 31, 2015

**4** Hospital Systems; 7 Locations

**5** Coordinated Care Organizations

**752** Providers (since February '13)

**202** Clinics (since February '13)

**507,000** Patients in the Community Health Record

**3,951** Average # of Direct Messages Received Per Month

**14,732** Monthly Avg Queries to Community Health Record

**2,020,000** Avg. Monthly Transactions Processed (since August '14)

**9,414,944** Total Messages Delivered to Inboxes (since April '15)

**7,730,326** Total Messages Delivered to CCO Inboxes (since June '15)



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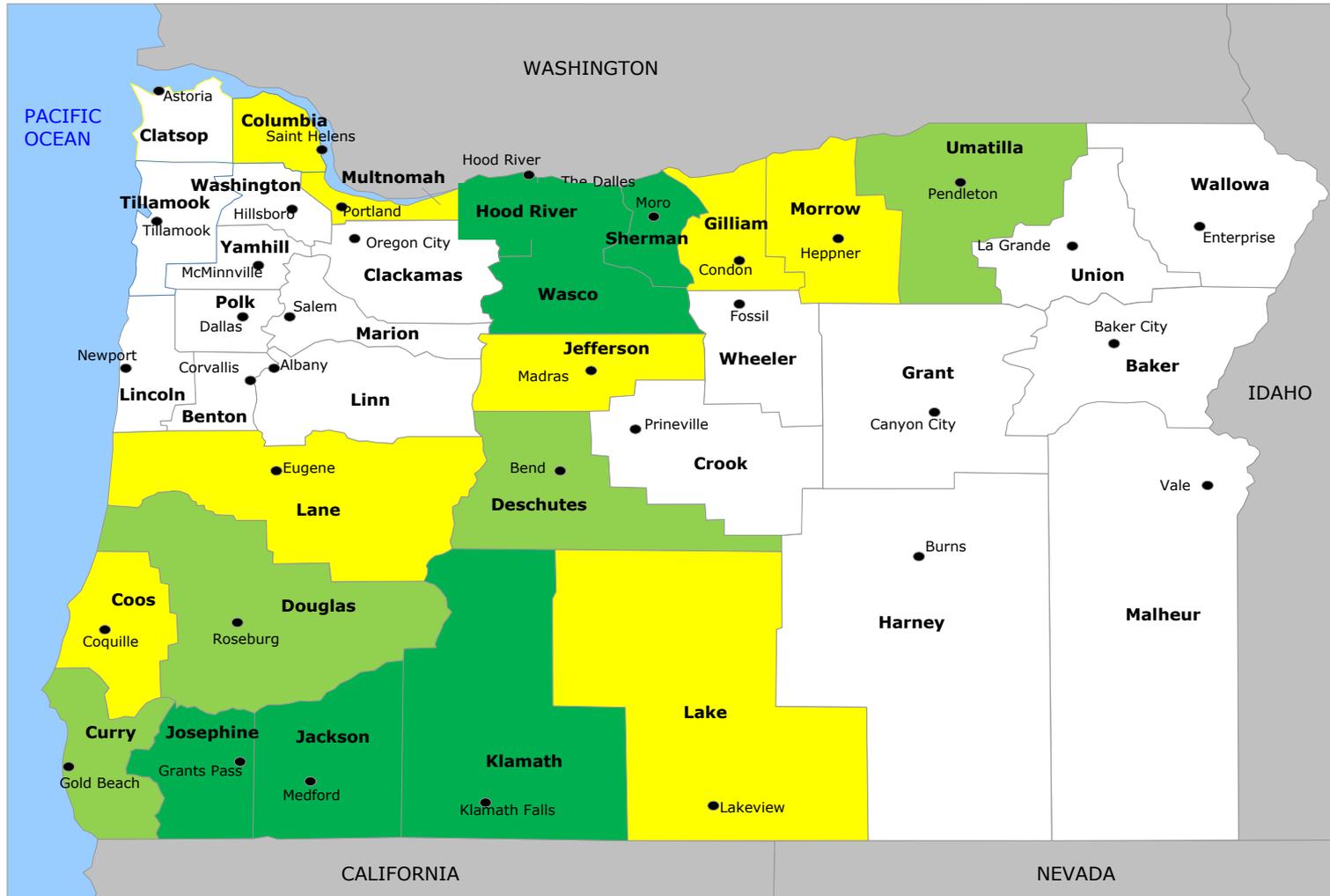
# Promoting Adoption and Use

- ▶ Assess practice workflow and opportunities to create efficiencies/improve processes
  - Identify “pain” points
  - Identify champions
  - Train users (role based for providers & staff)
- ▶ Follow up with practice 2 & 4 weeks out
  - Retrain as needed
- ▶ Periodic usage checks
  - Follow up as needed
- ▶ *Provide EXCELLENT customer service*
- ▶ *Change is hard and requires hand holding!*



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# JHIE Coverage Area



- Enrolled hospitals & clinics
- Enrolled clinics
- Some Interest in participating
- Currently no activity



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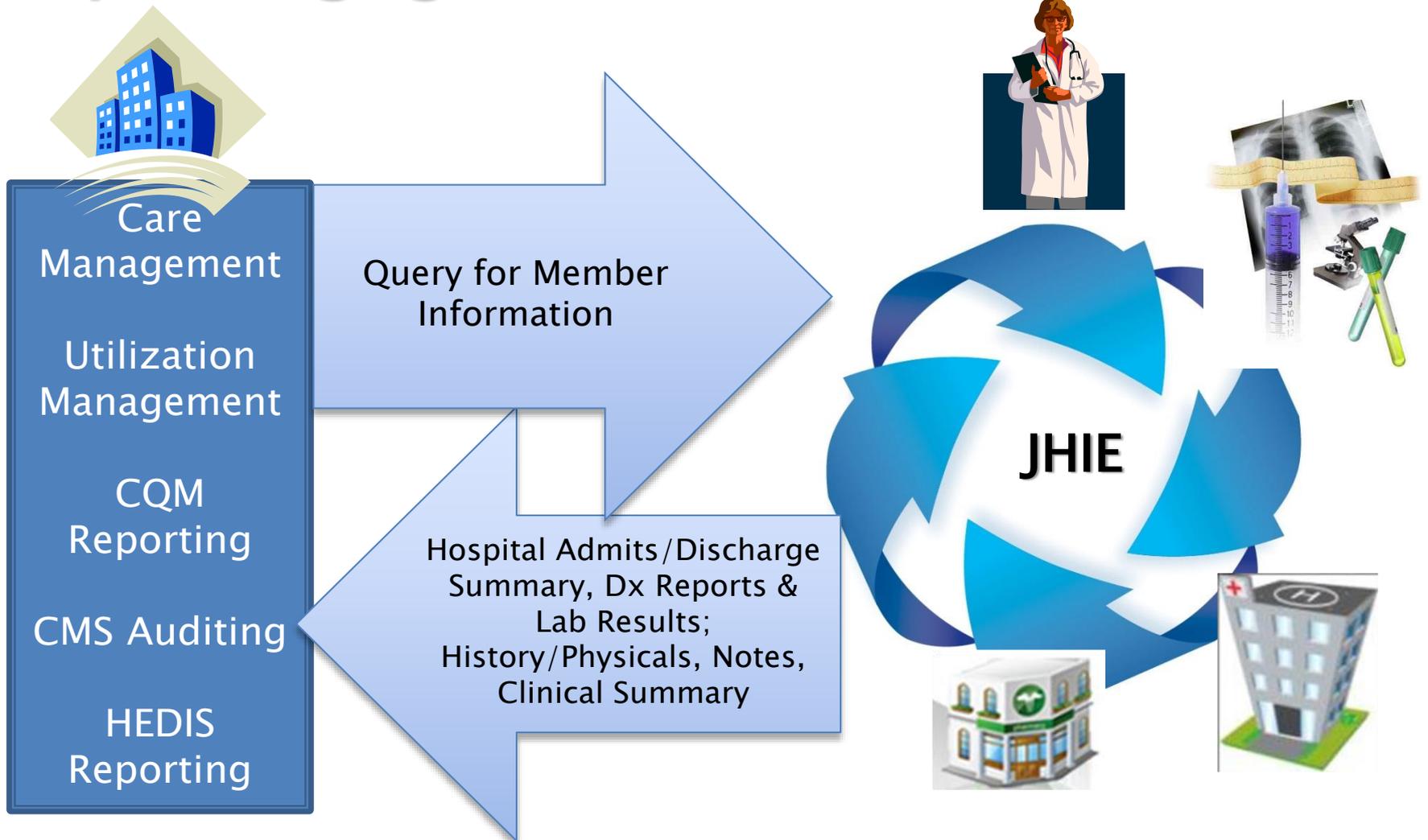
# How we support CCOs/Payers

- ▶ Access to clinical data to support care management teams
- ▶ Access to clinical data to support quality improvement efforts
- ▶ Clinical data feeds to support quality metric reporting, analytics, feed native systems, etc.
- ▶ Access to members' clinical history to see what's not known in claims system
- ▶ Notification of when the member has a health event of interest requiring care coordination



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# Payer Engagement Services



**Employs National Interoperability Standards  
and is Technology Neutral**



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# EHR Vendors–Live or In Process

- ▶ Allscripts
- ▶ Athena Health
- ▶ eClinical Works
- ▶ Epic
- ▶ GE Centricity
- ▶ GEMMS
- ▶ Greenway
- ▶ Mosaiq
- ▶ NetHealth Agility
- ▶ NextGen
- ▶ OCHIN Epic

**102 Clinics/Practices**



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# Project Roadmap

- ▶ New Data Sources
  - Hospitals, Ambulatory Providers, Reference Lab, Diagnostic Facilities
- ▶ eHealth Exchange Certification
  - Connectivity with VA and SSA
- ▶ PDMP Connectivity
  - *Dependent upon legislative change (House Bill 4124)*
- ▶ Clinical Event Notifications
  - Integrated with Community Health Record
  - Connectivity with CMT
- ▶ Enhanced CCO/Payer Services
- ▶ Data for Population Health and Analytics
- ▶ Behavioral Health Information Exchange



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# What Works Today for BH Data Exchange

- ▶ eReferrals and Direct Secure Messaging
  - Point to point exchange for BH providers to communicate with one another and other healthcare and social service providers
- ▶ Query Patient/Client Health History
  - Many behavioral health clients have several health care co-morbidities.
  - Allows users to understand the physical health needs of their patients/clients
- ▶ Receive clinical results directly into your EHR and send summaries of care to the community (mental health)
  - Reduces paper, is more efficient and improves productivity and workflow



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# BH Information Exchange Project

- ▶ Lawfully Integrate Physical and Behavioral Health Information Exchange
- ▶ Develop universal interpretation of law for the exchange, disclosure, and re-disclosure of drug, alcohol and mental health data
- ▶ Develop common consent management model (CMM)
  - Common Release of Information form
  - Requirements for electronic data exchange
- ▶ Implement CMM within JHIE technology to enable robust exchange
- ▶ Connect with behavioral health EHRs



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# Findings: Managing Consent to Share

- ▶ Qualified Service Organization Agreement
  - Required between JHIE and data contributors
- ▶ Consent must be captured for disclosure of:
  - Addictions information (Part 2)
  - Psychotherapy notes
- ▶ Re-disclosure is not allowed without explicit patient consent



# Findings: When Consent is Not Required

- ▶ Emergency Setting
  - Must document reason for querying
- ▶ CCOs
  - For TPO, including care coordination and audit/evaluation



# Next Steps

- ▶ Behavioral Health Survey
  - EHR adoption and capabilities
- ▶ Develop Common Consent Form
  - For use on paper and electronically
- ▶ Document Technical Requirements
- ▶ Behavioral Health Exchange Summit
  - *April 12, 2016 (tentative) in Eugene*
- ▶ Implement Comment Consent Model and Build EHR Interfaces



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# Overall 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





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Questions?

Comments...

Ideas!





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# Contact:

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[Gina.Bianco@jhie.org](mailto:Gina.Bianco@jhie.org)

Visit: [www.JHIE.org](http://www.JHIE.org)

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# Behavioral Health Information Sharing Advisory Group

Veronica Guerra, Policy Lead



# Agenda Goals

- Overview of the Behavioral Health Information Sharing Workgroup
- Advisory Group work plan and timeline
- Overview of webinars
- Next steps and resources

# Overview of the Advisory Group

- **Need:** Lack of understanding of Part 2 and state laws impacted CCOs' care coordination ability
- **Goal:** To develop solutions to support integrated care and enable sharing of behavioral health information between behavioral and physical health providers
- **Members/Partners:** Internal staff from across the agency

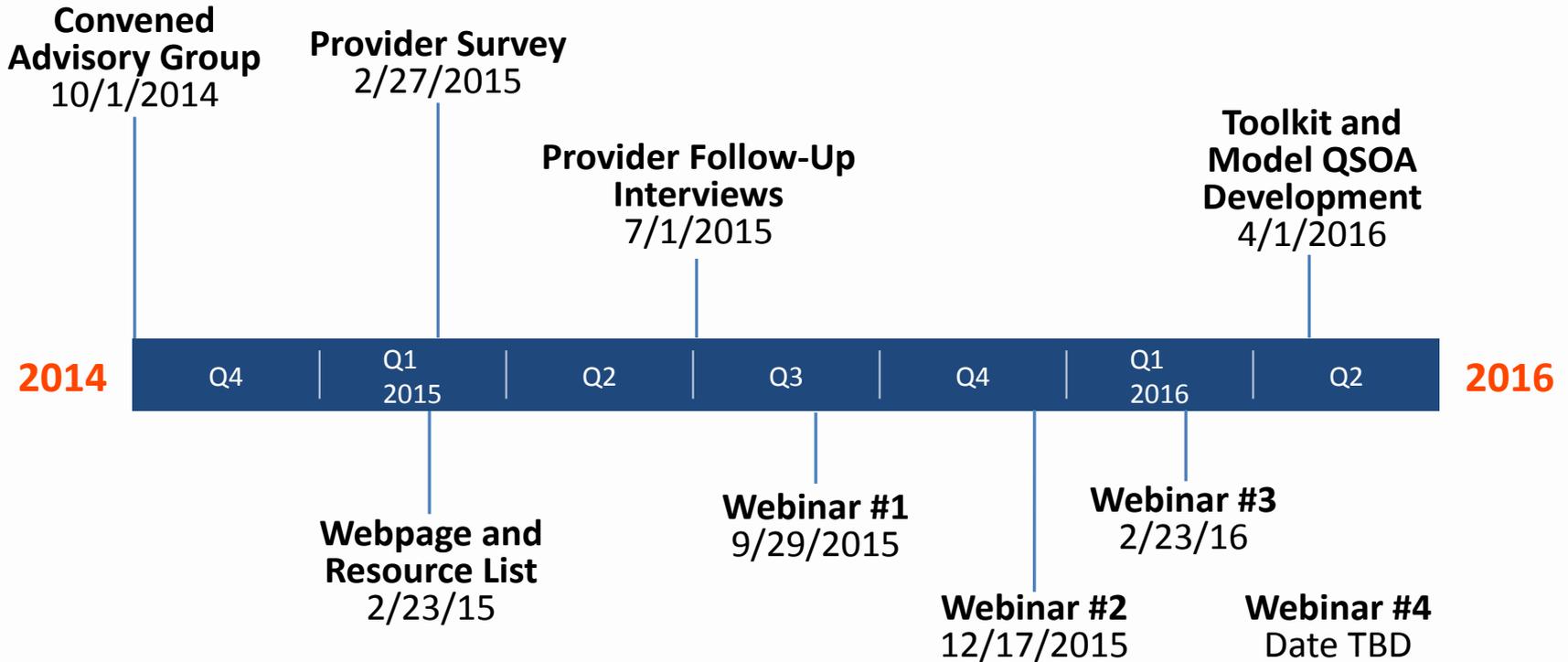
## Priorities:

- Outreach to stakeholders
- Education
- Leverage existing IT solutions
- Develop tools to facilitate information sharing

# Advisory Group Work Plan

- Conduct provider survey to understand barriers to sharing behavioral health information
- Develop a webpage with resources for providers
- Conduct a series of webinars
- Develop a model Qualified Service Organization Agreement (QSOA)
- Develop a toolkit covering privacy laws, case studies of allowable sharing, model forms (consent and QSOA), and FAQs
- Engage federal partners in discussions about modifications to Part 2

# Timeline



# Webinars

- **Webinar #1: September 29, 2015**
  - Topic: Overview of state and federal privacy laws
  - Presenters: SAMHSA, Oregon Health Authority, and the Oregon Department of Justice
  - Attendees: 300
- **Webinar #2: December 17, 2015**
  - Topic: Deeper dive into federal privacy laws with use case examples from providers
  - Presenter: Robert Belfort, Manatt, Phelps & Phillips, LLP
  - Attendees: 275
- **Webinar #3: February 2016**
  - Topic: Overview of Oregon's HIT/HIE infrastructure and current work on behavioral health information sharing
  - Presenters: Susan Otter, OHA Office of Health Information Technology, Gina Bianco, Jefferson HIE, and OCHIN representative
- **Webinar #4: April/May 2016**
  - Topic: Overview of provider toolkit on behavioral health information sharing and intended uses

# OHA's Next Steps

- Legal Action Center Actionline services
- Conduct two additional webinars
- Develop a model Qualified Service Organization Agreement and provider toolkit
- Collaborate on OHIT and Jefferson HIE ONC grant
- Engage federal and state partners in discussions about modifications to Part 2
- Continue to consult with other states

# Resources

For more information about the Behavioral Health Information Sharing Advisory Group and access to webinar recordings and other resources, please visit:

<http://www.oregon.gov/oha/bhp/Pages/Behavioral-Health-Info.aspx>

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# HITOC Work Plan Discussion

Susan Otter, OHA  
Justin Keller, OHA

**1. Sharing Patient  
Information Across  
the Care Team**

**2. Using Aggregated  
Data for System  
Improvement**

**3. Patient Access to  
Their Own Health  
Information**



**Health**  
Oregon  
Authority

# Goals

- Project major deliverables for the upcoming year
- Reflect back on discussions from the first two HITOC Meetings in a draft work plan
- Continue to connect the dots—find alignment between strategic plan, federal calls to action, and HITOC work plan

# High Level Work Plan: Deliverables

2016

2017

<b>Policy Topics</b>	<ul style="list-style-type: none"> <li>• Interoperability:             <ul style="list-style-type: none"> <li>• <b>Guidance (to be defined)</b></li> </ul> </li> <li>• Behavioral Health Information Sharing:             <ul style="list-style-type: none"> <li>• <b>Jefferson HIE Common Consent Model;</b></li> <li>• <b>Behavioral Health Provider HIT Survey</b></li> </ul> </li> <li>• Other Policy Board or HITOC-identified Topics as needed</li> <li>• OHA Policy Work:             <ul style="list-style-type: none"> <li>• <b>Medicaid Policy changes (e.g., EHR Incentive Program);</b></li> </ul> </li> <li>• Chartered Committee Policy Work:             <ul style="list-style-type: none"> <li>• <b>HCOP continues to meet</b></li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Identifying new priorities for 2017-2019 biennium</li> </ul>
<b>Strategic Planning</b>	<ul style="list-style-type: none"> <li>• Rely on Existing Business Plan Framework</li> </ul>	<ul style="list-style-type: none"> <li>• Process to develop next HIT strategic plan:             <ul style="list-style-type: none"> <li>• <b>Stakeholder engagement process;</b></li> <li>• <b>Development of strategic plan</b></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Release of next strategic plan</li> </ul>
<b>Oversight</b>	<ul style="list-style-type: none"> <li>• Consideration of pressing issues as <u>Oregon HIT Program</u> develops:             <ul style="list-style-type: none"> <li>• <b>Fee structure for Provider Directory and Common Credentialing;</b></li> <li>• <b>CareAccord Business Plan;</b></li> </ul> </li> <li>• Regular staff updates             <ul style="list-style-type: none"> <li>• Wrap up of telehealth and patient engagement initiatives (Open Notes)</li> </ul> </li> </ul>		

# High Level Work Plan Continued

2016

2017

<b>HIT Environment and Reporting</b>	<ul style="list-style-type: none"> <li>• Define scope of environmental scan</li> <li>• Define format and scope of HITOC Reporting to Board</li> <li>• <b>First Report to the Policy Board due June 2016</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>First Report to the Legislature on Oregon HIT Program released July 2016</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Second Report to the Board due June 2017</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Second Report to Legislature on OR HIT Program released July 2017</b></li> </ul>
<b>Federal Policy</b>	<ul style="list-style-type: none"> <li>• Federal Law/Policy Considerations:             <ul style="list-style-type: none"> <li>• Stage 2 Modified rule;</li> <li>• Stage 3 Meaningful Use;</li> <li>• ONC standards advisory,</li> <li>• Medicare Access &amp; CHIP Reauthorization Act (MACRA);</li> <li>• Privacy and security requirements (42 CFR part 2, etc.)</li> </ul> </li> </ul>			

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# Other HITOC Business

Justin Keller, OHA

1. Sharing Patient  
Information Across  
the Care Team

2. Using Aggregated  
Data for System  
Improvement

3. Patient Access to  
Their Own Health  
Information



Oregon  
Health  
Authority

# Provider Directory Advisory Group (PDAG) Overview

- **Formed: April 2015**
- **Objective:** Advise the Oregon Health Authority on a broad range of topics relating to technology, policies, and programmatic aspects of the provider directory
- **Roles and Affiliations:** Comprised of 15 external stakeholders representing a wide range of roles and affiliation
  - Roles – providers (including mental and dental), IT, data and analytics, billing, compliance, CIO, HIE leadership
  - Affiliations - CCOs, health plans, hospitals and health systems, HIEs, Independent Physician Association (IPA), Oregon Medical Association (OMA)
- **Meeting materials are posted to our website:**  
<http://www.oregon.gov/oha/OHIT/Pages/Provider-Directory-Advisory.aspx>

# PDAG Roles and Responsibilities

**1. Input and guidance:** Policy, program, and technical considerations, as Oregon moves forward to implement statewide provider directory services

- 2015 – focus on functionality, uses, and value of a provider directory service
- 2016 - Fees and fee structure\*, phasing roadmap, governance, program planning (including communication planning)

**2. Share PDAG information broadly**

- Represent/survey users in PDAG member's organization
- Make connections to related health IT committees, such as Administrative Simplification Workgroup, Oregon Health Leadership Council (OHLC), Common Credentialing Advisory Group (CCAG), etc.

\*Fees will be flagged for HITOC participation

# Common Credentialing Authority

- Legislative mandate from 2013 for OHA to establish a program and database to provide credentialing organizations (COs) access to information necessary to credential or recredential health care practitioners

## Legislative Requirements

### SB 604 (2013)

- Establish a program and database to centralize credentialing information
- Convene an advisory group to advise OHA
- Develop rules on submittals, verifications, and fees

### SB 594 (2015)

- OHA to establish implementation date by rule, with six months' notice

# Common Credentialing Advisory Group Overview

**Formed: September 2013**

## **Objective:**

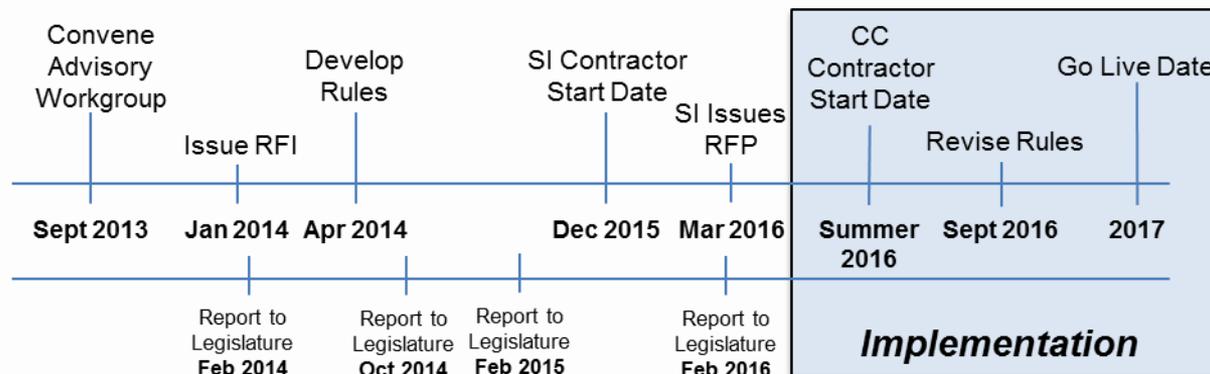
- Advise OHA on program and database to provide credentialing organizations (COs) access to information necessary to credential or re-credential health care practitioners

## **Roles and Affiliations:**

- Comprised of external stakeholders representing a wide range of roles and affiliation
  - Roles – Practitioners, credentialing organizations, and health care regulatory boards
  - Affiliations - CCOs, health plans, hospitals and health systems, Independent Physician Associations, Ambulatory Surgical Centers, dental care organizations

# Common Credentialing Advisory Group (CCAG) Membership and Scope

- Advise OHA on the implementation of common credentialing which includes:
  - Credentialing application and submittal requirements,
  - The process by which credential organizations access the system,
  - Standards for the process of verifying credentialing information,
  - The imposition of fees



# Next Meeting

April 7, 2016, 1:00 – 4:30 pm

Transformation Center Training Room  
Lincoln Building, Suite 775  
421 SW Oak Street  
Portland, OR

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# Public Comment

