Health Information Technology Oversight Council
November 05, 2009
1:00 – 5:00 pm
NW Vitaculture Center, Salem

Council Members Present:
Steve Gordon, MD, Rick Howard, Bridget Haggerty, Marie Laper, Greg Fraser, MD, Robert Rizk, Dave Widen, Bob Brown. Bill Hockett; Brian Devore

Committee Members Absent:
Sharon Stanphill

Staff:
Carol Robinson, Dawn Bonder, Sean Kolmer

Welcome and Introductions

Steve Gordon welcomed HITOC members and staff.

HITOC members and staff introduced themselves.

Review of Agenda

Members discussed update and progress to date. October minutes corrected- Typo HER survey should be EHR survey and approved.

Application Update

Carol introduced ONC State HIE cooperative agreement application process, difficulties of drafting 4 year budget prior to planning process. Oregon will receive $8.58 million from ONC.

Shaun Alfreds introduced ONC application review and support process: ONC developing technical assistance program for all states. ONC developing process for cooperative agreements, more information may come forward from ONC in January that may impact our use of ONC funds.

Carol is reviewing assumptions we made for our application budget

- Spend significant resources for financial modeling, technical architecture support and other supports for the different domains required for Oregon's strategic and operational plan.
- Will need to see what ONC process is in terms of developing our RFP process.
- Fortunate to have Oregon's consulting team funded by legislature and in partnership with Northwest Health Foundation's HITOC fund.
- Budget is rough estimate, even initial planning period, since there will be ONC tech assistance that we would take advantage of first.
- Question: How was the budget determined? Answer: $8.58m will not be nearly enough to develop and implement statewide HIE – the $8.58m is federal seed money. Each state was given an allocation based on a formula – demographics, providers, other assumptions. REC (Regional Extension Centers) application is a separate pot of money, CMS incentive dollars is a separate pot of money. There are additional potential pots of money being developed.
- Question: What if application doesn't pass muster? Answer: process not defined. Conversations between ONC and HITOC staff to agree upon dollars for planning process. Once plans submitted, ONC will approve plans then implementation dollars will flow.

- Question: What are the expected dates for negotiation? Answer: expectation that December will be negotiation, planning dollars to flow Jan. 15.
- Question: What happens if plan not completed on time? Will we lose implementation dollars? Answer: We haven't heard what implications would be.

Communications Planning Update

Refer to handout. Chris Coughlin has been retained as a short term communications consultant. [Reviewing stakeholder outreach communication tools from handout:]

- She is drafting list of FAQs. Carol asks HITOC members to let us know FAQs you're getting
- Put out monthly newsletter
- Updating website
- Will ask HITOC members to write an article for website
- Bi-weekly teleconferences, invite HITOC members to participate
- Multi-media/traveling roadshows
- Using associations to develop key communicator groups who will communicate with their own constituents (e.g., provider champions)
- Trying to create communications processes that are 2-way
- Comment: Feet in the audience will be measure of success. Helpful to define nomenclature, pick a bellwether like Indiana to compare. Defining what we want to accomplish in layman's terms will be very helpful.
- Comment: It's important to recognize consumers have big role and pull. We can do what makes providers happy, but if we can get consumers to understand what we are doing and how it benefits them. Need to give equal weight to provider community and consumers.
- Budget includes money for communication process. Final 6 months of first year targeting provider adoption, and consumer education for year 2 – that is adjustable. As we see what provider issues are, we'll have a better sense of how to target money effectively.

Key Operating Considerations

Members reviewed, discussed and voted to modify suggestion #4, adopting principles as amended, and working principles.

- Working principles
  - Staff will send materials electronically 7 days prior to meeting. We will bring printed/hole-punched packet for you at meeting.
  - Staff will provide meeting materials 7 days in advance of meeting, to the greatest extent possible. Council members should check for typos omissions, etc, and should request other supporting documentation, if needed. Meeting materials will be posted at least 24 hours prior to meeting date on HITOC website.
  - Motion to approve – Rob Rizk, seconded Brian DeVore, all approved
- Decision making agreement
  - <u>Relationship to Health Policy Board (Board)</u> –
  - In preparing strategic and operational plan, should be seen as a recommendation to the Board. We will be communicating with the Board on a regular basis. There won't be anything surprising to the Board in May. Ultimately the Board will need to approve the work that HITOC does. Work plan reflects this – includes time for Board to review and comment, while at the same time allowing for public process.
  - Comment: Don't want to be doing work different from Board's vision.
  - See Board really looking to HITOC for recommendations and direction on HIT.
  - With DHS and state environmental scan, we know what our assets are as we proceed with state Medicaid chapter of our book [will be in line with this planning process]. As we are completing our advance planning for Medicaid, divergence is not likely.

- Question: Is communication with Board two-way? Answer: Board updates will be delivered to HITOC and visa versa.
- Comment: HITOC dove immediately into work of the cooperative agreement; our work/role is slightly different now.
- Consensus decision-making:
- May be more beneficial to call out differences of opinion and allow minority reports than to spend a lot of time trying to come to consensus.
- Question: what is the outcome of this group – recommendations to Board? Answer: currently, but your role will depend on the outcomes of your planning process. As you consider governance models, HITOC's role for future is a decision that will have to be made in recommendations to Board.
- Comment: concern that recommendations could be ignored. AHIC – we sent recommendations up the line to HHS with no result. Struggling with how to give this group meat on the bone.
- Comment: Oregon won't receive implementation money if we don't have a plan approved by ONC. We're on a deadline. This makes it highly unlikely that another body in the state would slow this down.
- Comment: the HIIAC and Health Fund Board had similar process. The HIIAC recommendations were accepted by the Board unchanged. Part of our role is to make sure that Policy Board understands the importance of HIT and HIE and the HITECH Act money getting us where we want to go. All our incentives are aligned.
- Comment: if HITOC brings forth recommendations with a 7-4 vote or 9-2 vote, the Board will really want to know what the opposition felt. We are trying to anticipate something that might not occur, but we want to be transparent in our process and ensure that all voices are heard. Prepared to make complex decisions.
- Comment: Great care taken to select the HITOC membership to ensure representation of all views and perceptions about these issues. The fact that there are issues that the Council might not agree on needs to be recognized so we can deal with that.
- Comment: The public meeting law dictates that votes must be recorded documenting names opposed and documenting minority viewpoint.
- Comment: Whether minority report is issued or not, depends on those minority stakeholders.
- Comment: Burden is on minority voice to speak up, burden on the majority to listen and document.

Governance Engagement/ Workgroup/Stakeholder engagement

- Julie Harrelson – point out high level work plan w/meeting dates. Strategy for stakeholder engagement (review slide 8):
  - 2 –prong effort – conducting conversations with stakeholders around governance models, input on stakeholder process. Will develop survey broadly that asks the same type of questions – to go out early next week. Survey to cover demographic info, governance models, input on HIE and stakeholder feedback. Will give summary in December materials of the survey and conversations. Discussion in December HITOC meeting about governance model and stakeholder input.
  - Slide 9 – draft product in May.
- Question: "stakeholder" is vague word. How will we determine outreach to? Answer: key groups of people that represent different areas: consumer groups, former HIIAC members, payers, hospitals, associations, trade groups. Looking for representative diversity and geographic diversity. A bit of a conundrum because of compressed timeframe. Hope to talk about this more at end of meeting – where you think we can best target our efforts
- Comment: would suggest Northwest Health Foundation's group: the collaborative and OHAC's allied group. Would hope we outreach to those groups.
- Comment: 2 examples: California "if you build it they will come" model. Missing the objective/problem to solve. HIE could mean a thousand things to different people – in California it

was too broad – connected all the big guys but couldn't get further along. Other example: Tennessee – goal to reduce emergency room visits by getting HIE among the players; will be a community benefit, drove stakeholder engagement. May not need ambulatory providers at the table if it's a hospital problem – they got the costs down. Cart before horse problem – define the problem and the mechanics follow. Note that California won't be successful but they spent a lot of money. In Tennessee – hospitals chipped in because they understood investment.

- Comment: HIE not a thing, it's something we do. Worried about building this thing as opposed to actively exchanging information for a purpose.
- Comment: have to have end state for a strategy to work. We are leveraging work of HIIAC – may want to spend some time in January on this and how to reflect in stakeholder engagement.
- Comment: HIIAC was 12 month process, narrowed hundreds of recommendations to 4. HIIAC was limited by no money, no prospect of money – work came out of where can we go with very little money. Think HIIAC recommendations need to be reevaluated given we have money on the table and specific federal regulations now, which weren't in place during HIIAC process.
- Comment: Workgroups we might consider would be similar to HIIAC structure.
- Comment: Could save time to pick pieces of HIIAC work like consumer engagement.
- Comment: Want to really support suggestion about knowing the problem we're trying to solve. Would make life easier, makes this crisper.
- Comment: Spent last week reading 34 state grant applications. One state going for e-prescribing first, many states are pretty nebulous. Oregon's plan was one of most detailed.

Governance Models

- Shaun – presentation: slide show.
  - Purpose today – to set stage for HITOC conversation on governance model, vision, goal, Oregon's hopes to accomplish through HIE.
  - 5 domains for state plan include governance as one domain. Some questions you will need to answer:
    - How will state be involved in oversight and operations of HIE?
    - What entities oversee HIE activities and what services do they provide?
    - What rules govern entities participating in HIE and what entities enforce those rules?
    - Who is responsible for sustainability and allocating costs and collection of revenue?
  - [Review agenda slide]
  - Slide 3 – Many goals of HIE. Need data to: measure quality of care, outcomes, tie health care delivery to cost of care, etc.
  - Slide 4 – of 42 HIEs in country in 2008, all were different and none had a sustainable business model.
  - Slide 5 – 7 operating HIEs in country right now. They all look different and share different data – each has identified data that is valued to their state and focused around that. Today, we have nationally defined data set in the meaningful use data set – to be defined in December.
    - Question: – what would it look like if person was at center and not the system? People move between states. Answer: HITOC will need to address role of consumer in design of HIE. All 7 on slide were designed to be of value to provider – needed info at point of care. Having consumer involved is a different question – one has planned personal health record (PHR). At federal level and in our work (with NGA, State Alliance for eHealth and ONC) – making legal medical record that provider owns electronic and standardizing so that information is available at the point of care and one record follows the consumer throughout their engagement with health care system. A different perspective is that consumers need to be involved in their medical record – personal health records.
    - Question: Are there other countries with good HIE systems? Answer: Yes, but their health systems look very different
  - Slide 6 – EMRs need to be in place, Oregon is ahead of the curve here. But not all Oregon EMRs are standardized – how do we ensure that those vendors are playing fair? That's an oversight role we'll need to address. How are vendors going to be held accountable to meeting standards? ONC has

certification body but have said there may be other bodies.

- Slide 7 – Question on #3, didn't NGA change exchange of real-time info between providers etc – to add the consumer? Answer: No.
- Question: Is there one standard? Answer: There are lots of standards, that's part of the problem. The ONC has standards committee. Will have standards for EMR, exchange, etc. Can expect a core set of standards that EMRs and HIEs will need to abide by to be standards.
- Question: Do you expect one standard for each of those items? Answer: Yes, expect one set of standards.
- Comment: That's what AHIC was supposed to do, didn't get very far. There will have to be translator – for example look at HIMSS – it's technologically complex but it can be done. CCHIT certifies on functionality.
- Audience member requests we clarify acronyms for audience.
- Slide 8 – federal $8.58 million ARRA dollars has significant requirements to account for these funds, which will be resource intensive. Regional Extension Center (REC) grants – will primarily support safety net providers.
- Slide 9 – challenge is identifying who do the public benefits of HIE accrue to, and how does that inform sustainability plan.
- Slide 11 – Discussion: current federal funding of federal programs really constrain states in how they purchase information systems, must be tied to programs which lead to siloed information systems that cannot exchange data, states must write expensive translators to give illusion of interoperability. Attempting to reform at federal level the funding of services that allows for purchasing of shared services that all programs can use to meet their objectives. Would require change in funding allocations methods for federal programs. Right now, Medicaid program funding systems that have same or similar functionality as children and family programs. Need to change this at federal level so programs can exchange data within and even across states. Working with NGA, other federal and industry partners to support interoperability between these systems and move into a shared services architecture.
- Slide 12 – discussion: broadband isn't in a lot of state plans, health care delivery is focus of Oregon Health Network (OHN), state pulling together broadband committee with representatives from each sector that relies on broadband including health care. Won't necessarily be written in this state plan. May want broadband presentation for HITOC. Plans need to be aligned. It should not be ignored in strategic plan – federal government concerned about capacity for sharing very large files. Don't want to disadvantage rural providers from access to meaningful use incentives.
- Slide 13 – collaboration will be critical, mistakes will be made – plan needs to address mistakes and move forward.
- Slide 14 – Convening, coordination, operations.
- Slide 15 – strategic plan is not static, it is a living document that will change over time. Average implementation of EMR is 12-16 months.
- Slide 18 –Question: how well is Delaware doing? Answer: doing well, created firewalls to alleviate disadvantages, financing based on subscription fees. However, discussions about changing into a public-private 501c3 non-profit due to slowness of political and contracting process.
- Slide 19 – state government coordinates and/or partners with private on coordination and convening, with private led operations. RHIOs (Regional Health Information Organizations – local HIEs) state coordinates RHIOs and ensures they all abide by standards and report on public health measures, addressing needs of public. A lot of states trying to figure out public utility aspects – look different in different states. Will discuss NY as example.
- Slide 21 – this was preferred model by HIEs, providers, etc., but question of how to get there.
- Slide 22 – requires private and public sectors to agree on sustainable business models – this is difficult.
- Discussion –What are current HIEs in Oregon? Answer: private-led, basically been built by delivery systems: OCHIN, Samaritan Health – evolved from interests of local business systems. These models were developed before ARRA requirements for state role.

- ONC categorizing states by progress toward state HIE – 5 states (ME, VT, DE, NY, UT) are operational HIE, 21 states in middle-planning process (includes Oregon), 20 states are early on in planning.
- Slide 23 – Maine developed model 3 style private led operations – sharing data with more than 50% of providers. Board is public/private 501c3 non profit. This year, $1.7m state funds allocated. Question: how many hospital systems? Answer: 3 major hospital systems cover 80% of lives.
- Slide 25 – Maine technical and operational model: Original project was HealthInfoNet linking to medium/large hospitals, labs, imaging, small hospitals.
    - Question: what was problem they set out to solve? Answer: wanted to improve quality, exchange between 2 of large hospital systems, multiple EMR vendors – saw value in developing exchange to develop the interfaces between the hospital system's constituents.
    - Aggregating data across multiple providers for single patient – goal is one patient one record no matter where they were seen or who they were covered by. Central record repository – retains copy of entire record. Using Google health to model personal health record interface. Maine has all-payer claims data base. Administrative data is not in the HIE, going through a process to aggregate data and planning to add this data.
    - Pharmacies – claim information was being exchanged – state wanted to ensure that individual's paying cash would have data captured. Maine has state law to report all class 2-5 drugs are reported to state – legislature is changing this to report on all drugs. Right now have to contract out aggregating – changing this requirement will help.
    - Comment: Patient not represented here. Answer: there is no direct patient access, they are working on this through Google health.
- Slide 26 – Maine oversight model: includes executive steering committee – HealthInfoNet, state Departments, associations, etc.; and 5 standing committees including HIT/HIE adoption/implementation committee with Medicaid representation. Broad representative consumer committee – was long-standing committee just directly adopted into this.
    - This implies there was value in this consumer committee. Addressed consent, etc. Question: is there an assessment of consumer input for various HIE activities? Comment: consumers probably believe exchange is already happening.
    - Sharing info: Board membership/participation by coordinator
- Slide 27 – HealthInfoNet is applying to be REC.
- Discussion: how are Maine and New Hampshire collaborating? NH has no HIE on the ground.
- Slide 29 – NY is public utility model. NY had $250 million to spend through bonds and taxes.
- Slide 35 – Delaware
- Slide 41 – Conclusions – 3 models aren't only way to go, there are various hybrids. Consent process is difficult – need consumer engagement.
- Discussion: ONC requires a public/private governance model. Do all 3 models meet that ONC requirement? Yes. Good info, a lot to think about as we move forward, too much to discuss in 10-15 minutes. We need to get well-versed in health reform goals of state so we can incorporate that when we report back to the Board. Triple aim is underpinning – [improve population health, control costs, increase access] – end game goal are these 3 aims. Need to prioritize goals for HIE – how do we get there. This group can be helpful to prioritize where does HIE lend most value to making pieces of health care reform
- Matrix will be created to cross walk HB 2009 and initiatives within that to tool of HIE – what HIE can do for each of HB 2009 initiatives.
- Policy Board will be looking at draft workplan for next 12-18 months when they meet on Tuesday. Looking at what decisions need to be informed by this group can help define that process.
- Need to include in matrix what motivates the users of data
- Need to reflect input – data being collected by OHPR and others.
- We saw many models here. At end – we have patient with chronic condition that ends up in ER, they need to have the information and not put them through the battery of test and can treat them according to cause. That's the end result. That's what Tennessee did – keep costs down. That is all

by-products, what we have to deliver is that information when it's needed.

Workgroups and stakeholder engagement

- Time in December and January to come to conclusions. There is a charter for HITOC, now we're talking about how to get there.
- Difficult to have many workgroups over our compressed time. We can decide this model in December after survey.
  - Expert workgroup would have 10 members – a public and a private member with expertise on each of the 5 domains. Meet regularly over 4 months. They provide input on topics.
  - Team would collect thoughts/input.
  - Goes to HITOC for further input.
  - Team further refines.
  - Goes to stakeholder groups.
  - Cycle 3-4 times, roughly once a month, leads to draft plan by Spring or end of April.
  - These domain discussions should be happening at one time, need input from critical stakeholder groups. Who does the work? The team serves as the engine to convert the thinking into something that's actionable.
- Question: output is what? Answer: the strategic and operational plan.
- Some states are hiring large firms that would develop the plan for the state. Another option is having multiple workgroups, this is difficult for time considerations. Tried to create a hybrid of these two options – to have experts feed content expertise to you. Want to create a variety of mechanisms to communicate with stakeholders – webinar, etc.

Next Steps, questions

- Any additional input staff need? If you have strong concerns about this approach that we hear about it quickly.
- Standing meetings in 2010, first Thursday of each month from 1-5pm, with some potentially longer; continue to engage HIIAC members.

Public Comment

Andrea Meyer, Legislative Director for ACLU – not an expert in this area, involved in privacy issues. ACLU has broad involvement in civil liberties and civil rights, and gets involved in privacy issues. Disappointing that ACLU member not appointed to HIIAC, but I participated in meetings and small workgroup on privacy. Privacy is not the same as technology and security. Consumers have concerns in all sorts of areas. Privacy is different then confidentiality. Disappointed that principles don't invoke "privacy" but language in HB 2009, section 1179 mentions privacy. Technology and security is not privacy. A lot of discussion about public and private stakeholders – think public stakeholders are government and private is business, so not sure if consumers fall into these. Importance that consumers buy in at front end.