

## Health Information Technology Oversight Council

January 7, 2010

10:00 am – 5:00 pm

Clackamas Community College  
Wilsonville Training Center Room  
Wilsonville, Oregon 97070

### Council Members Present:

Steve Gordon, MD, Rick Howard, Sharon Stanphill, Bridget Haggerty, Marie Laper, Greg Fraser, MD, Dave Widen, Bob Brown. Bill Hockett, Robert Rizk, and Brian Devore (via phone)

### Staff:

Carol Robinson, Dawn Bonder, Jeanene Smith MD, Susan Otter, Julie Harrelson, Chris Coughlin, John Hall, Mindy Montgomery, Dave Witter, Shaun Alfreds

**Starting in January, agendas include recording time marker information to help locate agenda items when listening to recordings. (Recording time marker - hh:mm:ss)**

### Review Agenda and Proposed Outcomes \*(00:03:00)

December minutes approved.

### New York State Health IT Strategy: Governance and Policy Framework by Rachel Block (00:05:30)

Rachel Block, Deputy Commissioner, New York State Dept of Health gave a presentation on Health IT Strategy used in New York. See presentation slides included in meeting materials.

### Discussion

- Question: Provider adoption/uptake challenges in NY phase 1 earlier work and other challenges?
  - Provider participation grown quite a bit – HEAL V program (in midst of implementing now). Takes time to get traction.
  - RHIO survey – half of hospitals and half of physicians actually engaged in RHIO efforts – higher than expected, given that just started in last couple of years.
  - Community adoption focus only way to drive effective changes needed in health care – however, this approach will take time and could result in variability between communities. Will assess HEAL V program next year to see if adoption goals achieved. Rely on each region to implement measures locally, so could end up with variability.
- Question: Clinical priorities process – documentation available?
  - State identified broad areas of activity (4 areas) – each project came in and proposed how they wanted to approach implementing in their community. Compared proposals and identified common elements, then each community had unique elements e.g. connectivity for EMS providers.
- Impact of Meaningful Use requirements?
  - Now that MU requirements released, we are trying to allow flexibility in contracts.

- Proposed MU regulations include preemption of states to propose any additional requirements to quality for MU payments – I don't think this is a good requirement. Also – if a hospital meets Medicare requirements could be deemed to meet Medicaid requirements – this undermines the role of the state Medicaid agency in terms of defining MU.
- Consent approach?
  - Patient has to give consent for a provider to access their info from the network, or can decline to give consent. Will have to evolve around federal requirements. Our policy is “all in” or “all out” – can select which providers get access, but not which information providers get access to. This is a statewide policy, which nearly all organizations across state currently implementing. All RHIOs implementing a federated model – so no central data repository, except for a central demographic data repository. A couple of organizations find that the act of accessing demographic data would require a disclosure.
- Do you have a patient identifier?
  - No patient identifier. RHIOs using data matching techniques through vendors to support MPI and patient matching within their RHIOs. Exploring whether this is something we will provide as a statewide service. Currently no cross over between RHIOs – this is next stage we are going to. Everyone is working from common architecture model and specifications, so it shouldn't be difficult technically.
- Consent policy development process?
  - Relied on Dept of Health legal policy opinion.
  - HISPC funding and process was key to support policy development for consent.
- \$250m in state funds invested in New York – other states don't have that level of funding. What will be challenges for us?
  - Our authority to have these organizations adopt and utilize common policies and standards derived from fact that the state had contractual agreements with these entities.
  - Don't underestimate the importance of 90 percent match for Medicaid HIT activities – can maximize the use of those dollars to support broader activities.
  - Clearly getting health plans engaged in process has been key for many RHIOs. At least in upstate NY we have small regional health plans have funding and support for their RHIOs. In NY City, have mostly national health plans, not as interested in supporting RHIOs.
  - Challenge – how to create an effective, collaborative governance structure when you don't have the financial or contractual link to require the policies to be adopted. Requires more collaboration. Leveraging existing community resources together will likely have broad support – as long as people recognize they are more effective working together than alone.
- How are you assuring statewide reach for community HIE in NY, given local RHIO activities?
  - Our funding approach – divided state into regions, grant criteria written to ensure every region got at least one award, then remaining dollars divided by objective scoring criteria.
  - RHIOs recognize that the more providers on board, the broader adoption they

could support. All have moved into larger communities. Partly driven by local market forces. Have about 90% potentially covered. ONC grant will have the goal of having all clinician have access statewide.

### **Governance Model– Recommendation, Discussion, Decision (01:05:00)**

Carol Robinson, Julie Harrelson, and Shaun Alfreds gave a presentation on Governance models, and led a discussion. Please refer to the presentation slides included in the meeting materials.

- Discussion

- Want to ensure list of policy and standards on slide 5 are complete.
- Important to build off existing structures, need to have adaptability to build sites that don't exist yet, and that we may not know that we need to build yet – need flexibility in model
- Consider NY model: Oregon will have to rely on collaboration without funding and maintain accountability.
- Question about which entity designs the evaluation tools and assesses progress and success.
- Financial sustainability – quality measures could be value added and offer value to potential funding source. Exchange could be the entity that assists providers to fulfill their quality reporting requirements related to MU, and could be a value that providers might be willing to pay a fee for. Could be other services that allow for value to funding sources.
- Accountability and governance roles:
- Question: Not clear from graphic on slide 6 – who is in charge?
- Role of state and private sector in setting standards: In other states, state blesses privately developed standards; there is incentive for everyone to comply.
- Role of Oregon's strategic plan to ensure that 3.5 million Oregonians will benefit. We need to support and help develop regional health information organizations. Since we don't have a pool of state funds, we run the risk of having sticks with no carrots that will end up with local efforts to wither and become confused.
- We need to develop a commodity-based architecture. These systems already in place could plug in as commodities; they may have to adjust a little.
- Huge need, economic constraint, mandates needed to met, and limited amount of time. It isn't a technology issue. It's a systems and change issue.
- Call for vote – this framework appears to meet the various goals (ONC, health reform, etc) including flexibility
- MOTION: Steve Gordon: After careful consideration of governance frameworks from around the country and in consideration of the objectives of the federal government as expressed through the ONC and in strong consideration of the health reform goals of the State of Oregon articulated by the triple aim for driving quality, efficiency and population public health, that the governance framework as proposed seems to achieve those goals and should stand as our initial framework as we move into a more detailed strategic planning process, recognizing that we expect it to evolve and to be refined over time. (See presentation slide #5, January 7, 2010 meeting for governance framework.)

Greg Fraser seconded the motion.

- Approved

### **Working Lunch with Presentation on Regional Extension Center (02:02:00)**

Abby Sears, OCHIN presented on OCHIN's application to the ONC to become a Regional Extension Center (REC). See presentation slides included in meeting materials.

#### Discussion:

- Key discussion points include:
  - Benefit to consumers? EHRs could include both patient portal and personal health record
  - OCHIN requests HITOC input on hiring a director for Oregon's REC.
  - OCHIN requests HITOC input on how to handle the different vendors in the state and the cost it will be to get them in Meaningful Use? We may eventually have to determine how many vendors we will and won't support. Not sure any one can afford to support 15 products.
  - Question about outreach efforts planned into different regional areas?
    - REC application proposes mapping regions of Independent Physician Associations (IPAs) and what systems they have, what areas are served, identify gaps. Look for organizations that want to extend their services.
    - Capitalize on OHSU's ORPIN infrastructure and their philosophy of putting folks in the field. Try to map where gaps are, and try to build field offices where there are gaps.
    - Partnering with critical access hospitals, OMA, Family Practice Association, and others.
  - Question about tracking what proportion of providers are achieving Meaningful Use (MU).
    - Part of REC services, level 3 – will include assessment of MU status, OHSU is creating database and assessment tool. Providers will be assessed and receive support to achieve MU.
  - Question related to purchasers of EHRs.
    - Think of the REC to be a tool to do what we want to do. The REC will have to negotiate with the vendors. The more collateral we have, the stronger our position will be. For example, HITOC could ask the REC staff to build a set of criteria that HITOC edits, REC could build RFP process. REC should not be the decider, because we have a conflict of interest. The OCHIN Network needs to compete with everyone else on an equal basis. To the degree that HITOC is willing to participate or create a governance structure to manage the REC – would be helpful.
  - Thoughts about privacy and security – potential HIPAA training certification, other services?
    - We are hiring people now in anticipation of that. We have an attorney on contract that is one of top 5 in country related to HIPAA.
  - Unit of consideration is the provider – we need to cycle back to ensure that those individuals are well represented and what needs are. This process is about primary care. Application process left out of critical access hospitals – they are in desperate need of support. Haven't seen anything for these hospitals. In Oregon,

8 critical access hospitals have no EHRs, and some have questionable EHRs.

### **HITOC Updates and Recommendations (03:04:30)**

Subcommittee recommendations/process on letters of support for Beacon Community Grant applications: Rick Howard (See handout)

- Subcommittee members: Rick Howard, Dave Widen, Bob Brown
- Process described for HITOC subcommittee to review requests for letters of support for Oregon's communities applying for federal ARRA-funded under the Beacon Community Grant program. Subcommittee has developed a checklist based on the grant requirements and additional health reform goals specific to Oregon. Subcommittee will ensure letters of support are given only for applications that are credible grants that meet the majority of checklist items, and then will consider which level of support to provide.
- HITOC staff are aware of 5 potential applicants in Oregon. Nationally, ONC will select 15 total grants.

Discussion:

- Subcommittee should consider expanding the 2-page limit on the letter requesting support as applicants may not be able to address all criteria in those few pages. Due to the potential conflict of interest for many HITOC members involved in Beacon applications, it is more appropriate for HITOC to support the subcommittee to conclude the process as they see fit.
- Subcommittee will amend page length and conclude process, finalize process document, and post to website.

Presentation on other grants: Dawn Bonder

See presentation slide: Current ARRA HIT Funding Opportunities

- Curriculum Development Centers: OHSU is actively applying for this funding opportunity. Also one of the centers will provide a national coordination role – OHSU will apply for that too.
- Community College Consortia: Oregon is in region with many other states. Portland Community College is lead applicant for Oregon. Bellevue, WA would be regional coordinator.
- SHARP: No Oregon applicants identified yet.
- University based training: OHSU applying on their own – will fund their current informatics program.
- Competency exam development for community college curriculum: No Oregon applicants expected.
- State HIE Cooperative Agreement update: Carol Robinson spoke with ONC. ONC assured us that we would hear next week.

Electronic Health Records Survey Report - Executive Summary: Dave Witter (see handout: Draft Highlights of EHR Survey Report)

- Question – larger report coming out – where will it be published? Answer: On HITOC website – hopefully in next week or so.
- Question: barriers for practices with no EHRs – any concern about productivity loss? Answer: Productivity impact was an issue. Biggest barrier was cost of purchase, then

cost of implementation, then productivity. Narrative comments support concern about productivity impact.

- Question: How similar was our methodology to national efforts? Answer: We used the criteria in NEJM 2008 for “basic” and “fully functional” – so these were the same criteria as the national report.

### **HITOC Strategic Planning (04:00:00)**

#### HIE Strategic Planning Workgroup confirmation

- Carol introduced application process, had more than 35 applicants. Subgroup reviewed applications and put forth 12-member slate for HITOC consideration.
- Steve Gordon: submitting motion: slate for approval, Rob Rizk: second motion
- Discussion:
  - Question about geographic diversity
  - Rob Rizk: Felt this was a great cross mix from informatics, HIT, counsel, hospital and general administration, information management.
- Approved by unanimous vote

#### Work plan outline and timeline: Julie Harrelson (see handout)

- Review of HITOC workplan and timeline

#### HITOC Communication: Stakeholder Identification and Communications Plan: Chris Coughlin

- Presentation and discussion of stakeholder matrix handout
- Presentation and discussion of draft communication plan (draft plan available upon request)

#### Strategic Outcomes (see Strategic Intent slide): Julie Harrelson

- Presentation of goals and strategic intent
- Discussion: Privacy and security should be mentioned under imperatives

#### Meaningful use measures, released on Dec. 30, 2009: Susan Otter

- Presentation on proposed Meaningful Use measures (see handouts)
- HITOC staff had sent homework to members ahead of meeting to assess the extent to which proposed measures met Oregon’s goals (see HIT capacities worksheet in handouts)

#### Brief survey to local/regional HIEs (both operational and not): Susan Otter

- Presentation of preliminary findings of survey on the capacity of Oregon’s local HIEs (see handout)
- Still waiting on responses from other HIEs.
- Most of the high priority items map to Meaningful Use criteria

#### Strategic Outcomes Discussion:

- Key discussion points raised include:
  - Consider chart presenting value and feasibility and time of the different

Meaningful Use criteria. Note, Meaningful Use criteria are mostly inherent to EHR systems in stage 1, but exchange itself is later stage.

- Statewide exchange may focus on moving information as opposed to making transactions (like ordering a lab test). Electronic transactions can occur without an organized statewide HIE.
- Discussion to help define the scope of “exchange” the noun and verb:
  - Consider the exchange to be a web of transactions informed by the market without creating a thing;
  - Consider a box – that includes a summary of critical components that can be used to understand how health care is meeting the needs of Oregonians;
  - Need the ability to aggregate data which won’t happen in an open market;
- New York doesn’t have state wide exchange, but has uniform standards so that exchange would be possible. That standard setting is the work of the HITOC.
- Tribal perspective: Consider value to community, our current system isn’t able to report back to consumers or for public health purposes.
- Health plans – benefit from healthier community. If everyone was healthier, we’d make money this year, but the next year, all our negotiated contracts/rates would go down.
- Consumer/individual perspective – I’d like my provider to have all info they need to see for my appointment, then after my appointment, the info goes away and goes back to where it came from. If that happens, then the quality of care and patient health goes up.
- Consider security and privacy of information we are collecting and the role of a patient health record.
- Data resides at point of care. Record locator set up through the exchange. Some pieces won’t be virtualized at point of care – dentist doesn’t need access to chronic condition information. Data is assembled based on context of the encounter. Your index then becomes quite important. Providence has a good model for that.
- Consider stewardship – who controls information?
- Privacy different than security, consider penalties for breaches. Will need to consider whether national CMS and HIPAA protections are sufficient.
- ONC Director’s letter indicated need to exchange across organizational, political, geographical boundaries.
- Federal health reform doesn’t include delivery system reform, to make these reforms will need data to show quality and other improvements

State HIE Toolkit: see website: [statehieresources.org](http://statehieresources.org). Shaun Alfreds

- Demonstration of ONC HIE Toolkit website.

**Public Comment (05:34:00)**

Bob Thorne, Democratic Party:

- Found last two hours’ discussion very interesting. Suggest HITOC staff mark recordings to allow stakeholders to advance to certain segments. Staff discussed how to do this.

Chris Apgar, consumer with chronic conditions and as person working in this area for a decade:

- Privacy is not the same as confidentiality from legal and public perception standpoint. Greatest threat to security is people on the business side of an organization being careless.
- Concern about statistics used, particularly the HITOC stakeholder survey, the adoption of EHR survey may not reflect how EHRs are being used, which impacts quality of data in the system. Recommend measuring utilization.
- Providence is not an HIE, two vendors within the same organization that don't talk to each other. HIE is between organizations.
- Stakeholder matrix misses financial community and employers. These entities have been exchanging information. HISPC project defined some specific stakeholder groups. Recommend reviewing those stakeholders.
- Appointments to workgroup do not include consumers. This is not a patient centered health system. Recommend you involve consumers in your strategic planning process.