

Health Information Technology Oversight Committee
March 4, 2010
1 – 5 pm
Lane Community College

Council Members Present:

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

Council Members Absent:

Rick Howard

Strategic Workgroup Members Present:

Doug Ritchie (via phone)

Staff:

Carol Robinson, Susan Otter, Kahreen Tebeau, Oliver Droppers (via phone), Dave Witter, John Hall, Chris Coughlin, Julie Harrelson, Mindy Montgomery

Review Agenda and Proposed Outcomes - Steve Gordon (0:02:40.00)
Refer to agenda and presentation slides in meeting materials
Approve Minutes from Jan. 7 and Feb. 4 - Steve Gordon (0:03:50.00)
Marie Laper – motion to approve. Bob Brown – second. Approved without further discussion
Amended principles - Julie Harrelson (0:06:30.00)
Review of revisions – see slide <u>Discussion:</u> <ul style="list-style-type: none">• Question about the meaning of “flexible” in #3, does flexible meaning scalable – perhaps adaptive? Consensus to keep “flexible.”
State HIE Cooperative Agreement Award - Carol Robinson (0:08:43.00)
Refer to meeting materials: “State HIE Guidance for Reporting Expenditures” We just received news about changes from the ONC regarding Plan deadlines. The overall Plan is due in August, but the Financial section of the Plan is not due until February 2011. <u>Discussion:</u> <ul style="list-style-type: none">• How can you know what you will buy before you know how you will pay for it? May lead us to think about phasing.• Question: What is the implication of ONC approval of the state Plan? Answer: ONC approval of the state Plan will provide release of implementation funds.• Discussion of interstate requirements on ONC funding:<ul style="list-style-type: none">○ The biggest change has been that approximately 35% of the implementation funds are required to be used for inter-state HIE. We have to shift our planning focus to meet this new requirement. We need to talk with other states about how to address this. A big part of

the inter-state emphasis is on connecting to NHIN. We'll need to specifically address how consent and trust agreements are going to be managed across state lines, consider the legal and policy differences between states, and consider potential legal changes to manage this inter-state exchange. Another domain that may be affected is governance; for example, perhaps some governance body or council may have to be created to manage inter-state HIE. The Gorge Commission may serve as one model, whereby representatives from multiple states are assigned to a council.

- Question: Has the ONC increased planning funds to allow for interstate planning? Answer: No, our planning budget is capped at 10% of the total, but there is some flexibility to defer further planning into the implementation stage.

Update: Medicaid HIT Planning – Susan Otter (0:28:20.00)

See slide

Discussion:

- Oregon's Medicaid Planning Advanced Planning Document (PAPD) has been approved. Some Medicaid planning funds are to be used by HITOC for HIE Strategic and Operational planning purposes. The Medicaid PAPD also allows us to promote other programs to promote the adoption of EHRs (see slide, bullet 2).
- States are responsible for identifying meaningful users, providing the incentive payments, and doing auditing.
- The average state PAPD award is \$1.7million; Oregon's is \$3.5 million- on par with states like NY.

REC Award - Clayton Gillett, Chip Taylor, Abby Sears (0:47:40.00)

Welcome and congratulations- the REC award has been approved.

See presentation slides

Q&A during slides:

- Slide 6 Question: Why is Cerner not on the slide as an EHR product in Oregon? Answer: they are included in "Other".
- Slide 7 – The other thing to call out are the non-certified products. 12% (11 of 23 are certified) are not certified. Question: With the new certification proposed rules announced Tuesday morning, how much does that change things? Answer: Question referred to grant officer this morning, who is researching. She believes it must meet their certification standards. Look at CCHIT as a proxy for what the standards are going to be. The vendors who have gone through that certification process are more than likely to get through new certification process. Vendors are very focused on meeting federal requirements in order to sell products.
- Question: Any further information on the un-certified products? Answer: The survey included only products where there is a certified product line, so non-certified products used by 12% of providers are within a product line with no certified products
- Slide 8: question about benefit to consumers of EHRs. Answer: Tethered patient portal has a huge value to the consumer. Example of immunization record.
- Slide 9: question about objective to assist eligible providers to achieve meaningful use. Answer: The REC grant has the goal of assisting providers in accessing those incentives through achieving meaningful use. We split providers into these three categories to adjust our approach to providers at different levels of EHR adoption.
- Slide 12: Comment on possible changes to meaningful use standards- could be amended to

meeting 50% of meaningful use requirements would be eligible for 50% of the incentive payment. Federal approval of meaningful use expected June 22, 2010.

- Slide 13: Most dentists do not have 30% Medicaid patients. There are no Medicare dental benefits so they wouldn't be eligible for those incentives.
- Slide 15: System selection process – interested in getting proposals from outside contractors and end users in designing that process, trying to figure out how to do this in a 60-90 days window. Expect to start that process in the next month. The goal is to narrow down vendor support for new adopters, but will support the systems already in place.
- Last slide: Next steps – OCHIN Board want to put together an advisory committee in lieu of the OCHIN board being the advisory committee to the REC. This should include representation of small practices across the state. They will ask for HITOC input in selecting members.
- ONC requirement for 10% of provider incentives going into the REC as their subscription fee, perhaps because of the 10% match requirement. Want to try to use some of OCHIN's operating money for the 10% match and be more creative about how a provider would buy in to the REC.

Discussion:

- Scott Zaks, public question: how many providers in Oregon will be eligible? Answer: Medicare physician has to bill about \$24,000/year Medicare services to get maximum Medicare payment. About 70% of Oregon physicians (in the provider types eligible) will qualify for either Medicare or Medicaid incentives, varying by specialty type.
- John Booker, Democratic Caucus public question: will incentives help doctor's recoup payments quickly? Answer: EHRs can help get the information to the state if that is the problem. Eligibility interfaces may still be problematic.
- Dennis Shafer, Willamette Family Treatment Services: We are about to purchase a system, what assistance can we get from HITOC or REC? Answer: suggest you contact Clayton at the REC, we can share some resources such as KLAS reports. Perhaps HITOC can post some of these documents on our website.

Break (3pm)

Updates (2:03:40.00)

HIMSS Conference - Carol Robinson

- Lots of information
- Learning about opportunities to bring money into the state

Beacon - Carol Robinson

- Award announcements have not been made yet.

HITOC Strategic Workgroup Meeting Synopsis (2:06:15.00)

Naming Conventions- Chris Coughlin

See naming conventions slide

Governance Models and decision points – Shaun Alfreds (3:25pm)

See slide presentation and reference meeting materials: "HITOC Strategic Workgroup Meeting Summary, Feb 11, 2010, Topic: Governance"

Q&A during slides:

- Slide 13-16: Model 1:
 - Question: Where would regulation/requirements for how regional HIOs would interact with each other be in Model 1? Answer: Could be part of a contract or could be a certification process.
 - Question: What authority would HITOC have? Answer: Could need additional legislation to adjust legislative authority, or may want to change the stakeholder mix on HITOC.
 - Question: What were the most important pros/cons? Answer: The top two pros were that model 1 is not very disruptive because HITOC structure is in place; and is less expensive. The biggest cons: how to get the regional HIOs to play together and set standards and who does that, and how do you ensure statewide coverage.
- Slides 17-20: Model 2:
 - Question: Was interstate requirement for ONC funding known when these models were discussed? Answer: No. Question: Would the recommendation change considering that requirement? Answer: Either model could connect to NHIN and create standards and policies that could govern privacy and security agreements.
 - Question: Would non-profit statewide HIO be able to have more financing flexibility than a state entity? Answer: This was brought up as a potential pro of model 2.

Workgroup recommendations- Shaun Alfreds

See slide 22

- SWG governance input: governance as a phased process with phases 1, 2, and 3
- No consensus was determined for timing of phases due to additional information being needed that will be generated from future domain discussions

Stakeholder input – Chris Coughlin

See slide 23

- Overview and brief assessment of the Feb. 26, 2010, Stakeholder Webinar
- Audience input and process for two-way communication

Discussion

- Question: Any sense of why 49 of the people who registered did not attend? Answer: No. We can follow-up to see if there were any technical reasons.

Technology-John Hall (3:03:55.00)

John presented on technology introductory meeting with the Strategic Workgroup (slides 24-30)

Discussion (3:12:30.00)

HITOC Process:

- Question about how will the HITOC discuss the governance model recommendation? Answer: HITOC should respond and provide guidance to Workgroup on their proposed governance model.
- Question: How would we provide input on these models? Answer: We are committed to getting you materials the Friday before the meeting, so it is helpful to come in prepared.
- Comment: HITOC group needs more time to discuss, in addition to the presentations.

- Comments on how we can be more effective in discussion: put larger topics at front of agenda.
- Recommend HITOC members attend workgroup meetings, if interested in in-depth discussion.

Discussion of governance models

- Comment on both models – dotted lines should be bi-directional.
- Comments on model recommended by workgroup (slide 22):
 - HITOC make-up would have to change.
 - Phase 2, bullet 2: “if necessary, develop light operational capacities” – Question: If these are necessary, wouldn’t they be necessary in phase 1? Answer: phase 1 would get standards in place, and down the road, could have a model like NHIN, that doesn’t include centralized services under a statewide operational function (e.g., master patient index). Question: Have any states followed that model? Answer: MN may end up there.
 - State HIO is recommended as a non-profit, non-governmental entity.
 - There was no specification on timing, but some idea that phase 1 may be very short (1-2 years) while national standards get developed, and we’ll know then whether there will be a need for light operations.
 - Until we examined where the value proposition is in financing and what kind of willingness we’ll see to sustain a statewide operation, it’s responsible to plan for phasing to allow time for HIOs to mature and develop. Phasing also gives a chance for us to learn from other states.
 - Should look at which model we really want in place in the end, and then make sure we phase to achieve that model.
 - We can’t make governance decisions in isolation from other domains.
 - State now has \$4.7m for intrastate exchange – this restricts us in our exchange efforts within Oregon.
 - The ONC requires 7 functions be covered. We are addressing these 7 functions over the course of several meetings.

Public Comment Opportunity (3:54:30.00)

Robin Moody, OAHHS –

- Medicaid incentives planning. Appreciate efforts to move quickly, understand incentives will flow around January 2011, congratulations on \$3.5m grant. Hospitals want Medicaid incentive program to mirror Medicare’s process to keep it simple.
- Under current statutes, believe Critical Access Hospitals will not be eligible – we know 8 critical access hospitals have no EHRs. Would be great to look for state support in this area.
- Believe many providers will be rendered ineligible because of location of practice – including hospital owned outpatient facility.

Bob Adams, Bay Area Hospital

- How can we provide input and questions to HITOC? Answer: Use HITOC.Info@state.or.us – all testimony will be presented to HITOC, questions will be sent to the appropriate person to respond. Also, monthly stakeholder webinars are good places for input. Lastly, we are planning a meeting to get input from operational and developing regional HIOs. We are also planning a consumer meeting later in the spring. Once we have a draft state plan, we will hold meetings around the state to have discussions.

Written public comment received from Chris Apgar. Testimony is publically available upon request to HITOC Staff.

Next steps – Carol Robinson/Julie Harrelson (3:59:00.00)

- Stakeholder meeting will be held on April 15 to get direct input and feedback from HIOs. It will be open to the public.
- Once there is a draft plan, there will be several meetings across the state to get feedback and input from the public.
- Encourage HITOC members to review workgroup materials thoroughly prior to next meeting.