

Health Information Technology Oversight Council

Thursday, November 3, 2011

1:00 p.m. - 5:00 p.m.

Council Members Present: Steve Gordon, Sharon Stanphill, Bill Hockett, Bob Brown, Brian Devore, Gregory Fraser, Robert Rizk

Council Members Participating by Phone:

Ex-officio Members Present: Mel Kohn

Council and Ex-officio Members Absent: Dave Widen, Judy Mohr-Peterson

Staff Present: Carol Robinson, Oliver Droppers, Kahreen Tebeau, Tom Wunderlich, Dave Witter, Mindy Montgomery, Luke Glowasky, Chris Coughlin, Steve Johnson, John Hall

Guests Present: Lisa Parker, Ellen Larsen, Carolyn Lawson

Welcome, Opening, and Approval of Minutes – Steve Gordon (Chair)

- Approval of minutes:
 - Bob Brown made a motion to approve both sets of minutes from Oct. 6 and Oct. 25; Greg Fraser seconded the motion; unanimous approval.

Meeting Objectives and Updates – Carol Robinson

- Meeting objectives:
 - See slide 3
- Technology RFP:
 - See slide 5
 - Announcement was posted for intent to award for core HIE services to Harris Corporation.
 - Office of Health IT on track to deliver Direct messaging services in quarter 1 of 2012.
- Staffing Updates:
 - See slide 6
 - The organizational chart and staffing model for the Office of Health IT (OHIT) is under development as new HIT planning, policy, and implementation needs are identified. The next phase of Medicaid HIE planning is closely aligned with the MITA (Medicaid Information Technology Architecture) State Self-Assessment and Strategic Plan, and OHIT will be coordinating closely with MITA staff and consultants.
- HITOC Appointments:
 - See slide 7
 - Carolyn Lawson and Ellen Larsen have been appointed by the Governor to serve on HITOC; their Senate confirmation is scheduled for Nov. 16.
- ONC Report & HIE Priority Areas:
 - See slide 8
 - ONC is very supportive of HITOC's decision to adopt clinical quality metrics as the fourth HIE priority area.

Medicaid EHR Incentive Program Update- Lisa Parker

- See slides 9-11
- With Medicare, we cannot disclose the exact numbers of eligible professionals (EPs) and hospitals that have received meaningful use (MU) payments; they have over 1000 EPs that have registered, over 400 have submitted applications, and around 50 have been paid. Only a couple hospitals have been processed by Medicare for their MU payments.
- For Medicaid, we have about 350 EPs that have registered with CMS; 124 have submitted

applications to Oregon; 16 have been processed and received their payments, and several are pending. We have 23 hospitals that have registered with CMS, 5 hospitals are in the middle of their applications, and 11 have submitted their applications; no hospitals have been approved for payment at this time. It takes 45 days to process the applications.

- We're refining the application review and processing process. More education is needed for providers about what they need to submit for validation of AIU (adopt, implement, upgrade)
- Steve Gordon, Chair: It will be pertinent when we discuss CCO criteria to remember that not all meaningful users of HIT are eligible to receive incentive payments. Also, some surveys indicate that many providers and hospitals will not be ready to meet MU stage 1 by 2013.
- It will be useful to figure out why many providers and hospitals won't be able to meet MU; the reasons vary and some of it may be tied to vendor readiness and capacity.

Regional Assessment of HIE in Oregon- Carol Robinson and Dave Witter

- See slides 12-22
- Providence, Legacy, OHSU, Salem Hospital, and Asante are moving to Epic EHR system. PeaceHealth has the Centricity enterprise version.
- Q: How does Epic relate to HIE? A: It's an integrated solution to HIE. Epic has developed a product called CareEverywhere that allows an organization to access the EHR data in another organization's EHR, if they're both using the same system. OHSU and OCHIN use CareEverywhere to access the records of the patients they have in common. One limitation of the Epic system is that you have to know where the records are in order to request to access them. A question that will have to be solved is how to move data between Epic and non-Epic users.
- In 2010 we did an assessment of the different regions in Oregon in terms of establishing and developing health information organizations (HIOs). In October 2011 we repeated an expanded survey of identified organizations moving toward the development of a regional HIO, or contemplating the need for expanded HIE services within a region.
- Suggestion to meet with the representatives from the 6-7 large health systems in the Portland Metropolitan area to discuss their HIE plans and development.
- Central Oregon region has made significant progress in terms of developing their HIE governance and financing plans. St. Charles has contracted with RelayHealth for HIE services that may be expanded throughout the broader community.
- Q: Why was Douglas County able to achieve widespread HIE adoption and coordination (90% of the region's providers are on a single EHR platform). A: The physicians association and the hospital have a different relationship in that region than in many regions- there was a higher financial incentive to perform HIE in that community.
- For organizations that have a high population of public payer patients (e.g. Medicaid) or uninsured/unpaid care, there is often a high incentive to coordinate care and share patient data. The opposite is often true in populations with a high percentage of commercial payers.
- The governance development process in the Gorge region developed consensus to move forward with HIE in their community.
- The federated approach - Oregon's fundamental strategy- is still evolving, given developments in the various regional HIE efforts.
- The role of the incentive program, MU, the CCOs, and the insurance exchange are all variables that could affect the development of regional efforts.
- The federated approach and the diversity of systems in use present challenges to the sharing of information across those systems.
- We may end up with a hybrid model of statewide HIE, where we have regional efforts, but also a statewide solution to connect the white spaces, and to connect those disparate HIE systems across the state.
- One barrier to HIE is that it requires process change and getting people to do their jobs and

businesses differently.

Consent Implementation Subcommittee

- See slide 23
- See “Consent Implementation Subcommittee Charter” and “Consent Implementation Subcommittee Member List” in meeting materials
- HITOC had no suggested revisions to Charter; confirmed their earlier guidance that the Charter should not include re-evaluating the consent policy itself.
- Research will be performed by staff/consultants on consent management technology and solutions.

Discussion: Domains of Responsibility for CCOs and HIT/HIE- Carol Robinson and Sean Kolmer

- See slide 25
- See “Draft HIT CCO Considerations for HPB” and “Draft OHIT memo to HPB- Barriers to HIE and Care Coordination” in meeting materials.
- Staff has attended CCO workgroup meetings and worked with other internal state teams to strategize how HB 3650 will be implemented.
- The Health Policy Board (HPB) considered how to solicit input on health information technology (HIT) given the purviews of the four CCO workgroups. The HPB is interested in receiving input on the following: 1) should the HPB be prescriptive of expectations for CCOs, if so, then 2) what are appropriate baselines for initial HIT adoption rates, and 3) what is the appropriate staging going forward?
- The HPB will also need to know how to judge the adequacy of a CCO in terms of HIT based on the application they will submit.
- Question: A one-year time frame has very different “lynch pins” than a 5-year time frame. What time frame should HITOC be considering? Answer: Not all organizations will be ready to become CCOs immediately, but we expect change in delivery of services as quickly as possible with, improved outcomes over time.
- HITOC should be cautious not to be overly prescriptive, but should provide some framework to work within.
- HITOCs overall recommended approach is to get CCOs to come up to targets and improve over time.
- Question: Who will determine the values for the place-holder percentages? Answer: That has not yet been determined.
- Medicaid patients are receiving a variety of case management across the continuum of care including physical, mental, and oral health providers; we don’t have information on EHR systems with case management capability.
- We are not aware of any certified EHR systems for oral health providers.
- Federal ACO final rules have eliminated the requirement for 50% of providers to meet Meaningful Use of EHRs, and inserted reporting requirements.
- CCO criteria could focus on certain areas of HIE with known value, such as e-prescribing.
- A CCO should be able to evaluate its current capabilities and its improvement goals. Those goals should factor in state capabilities to leverage existing federal incentives.
- Setting the thresholds for adoption could be a negotiation with each CCO and a policy body. If a required percentage gets prescribed externally, it might not be appropriate for the unique conditions of the CCO.
- Question: What type of organizations will become CCOs? Answer: One example would be an organization that already has a financial risk-bearing structure, but other organizations might look very different. In any case the CCO will be responsible for increasing HIT use in their network and among individual providers.
- Criteria should be prescriptive of the data use, not the technology platforms. E.g. measuring

whether a clinical summary arrives at a referring physician's office within a certain amount of time might be appropriate, rather than measuring the technology used to get it there.

- Question: Will providers stop seeing Medicaid patients instead of complying with CCO HIT requirements? Answer: Some national studies have predicted a similar effect when Medicare penalties for not adopting EHRs begin in 2014.
- One way of achieving high performance in HIT is requiring outcomes, not processes, but some smaller practices will exit the system as a result of the requirements, similar to the way electronic banking affected the banking industry.
- Measuring where CCOs are today and an improvement plan are necessary. Waivers may be necessary once specific baseline criteria are set.
- Some CCOs will want to provide care in coverage areas that span different pockets of HIT adoption. There should be a provision for measuring difference within the same CCO network.
- One of the dangers of being overly prescriptive is creating another set of HIT mandates for providers (in addition to meaningful use, ICD-10, etc.) that could create additional challenges.
- CCOs should set their own bar for EHR adoption rates (or several bars within different pockets of the community) and the bar should be reviewed by a contracting agency.
- The proposed criteria for HIE requires CCOs to measure, set a baseline, and develop a plan for improvement. Staging for HIE seems appropriate, but the same number of years might not be appropriate for each CCO.
- If Oregon is going to meet the Governor's goals for cost savings, investments in some areas might have to be front-loaded.
- HITOC's recommendations for HIE should be consistent with the state strategic plan for HIE. Setting a requirement for every provider in a CCO to have a Direct e-mail address is consistent with Oregon's statewide HIE strategy and should be included in the recommendations to the HPB.
- It may be premature to be more prescriptive since we know so little about CCOs at this stage of their development. It will be appropriate to revisit requirements annually. CCOs should be partially responsible for developing the transformational requirements.
- For HIE the first level of criteria should be defined now (Direct email address for every CCO provider), but additional levels should be defined over time as CCOs develop.
- The HPB should be made aware of the challenges and issues with oral and behavioral health; we should help identify the risks for sharing information.

Public Comment

- Dr. Mike Saslow: We are making considerable progress, but not as fast as political and economic developments necessitate. Public testimony dated 10/24/11 contains descriptions of CCOs that provide an important framework for these discussions. HITOC ought to provide figures on the cost of using Direct messaging in a way that is relevant to different providers, such as per-hospital bed/mental health provider/provider for long-term care, etc. These figures would likely be minimal. OHA should require CCOs to be Direct functional from their first day of operations. HITOC should require vendors to become Direct capable in order to operate in Oregon.

Closing Comments

- Thanks for the staff work, already performed and continuing, on the CCO work.