

Health Information Technology Oversight Council

October 8, 2009

2:00 – 5:00 pm

Portland State Office Building Room 918

Council Members Present:

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

Committee Members Absent:

None

Staff:

Carol Robinson, Dawn Bonder, Jeanene Smith, MD, Sean Kolmer, Jeannette Nguyen-Johnson

Welcome and Introductions
Steve Gordon Welcomed HITOC members and staff HITOC members and staff introduced themselves.
Review of Agenda
Members discussed key operating Considerations, HITOC Charter and Objectives, Progress made to date, National Perspectives of HIE, Vision and Strategies for HITOC, Next Steps, and questions
Key Operating Considerations
Members reviewed, discussed and adopted bylaws, passed. Members reviewed and adopted, and passed conflict of interest policy. Synopsis of Public Meeting Law was provided; meetings must be recorded and agenda posted 7-10 days prior to meeting, stakeholder and public input/comments should be accepted on a regular basis. If more than 6 HITOC members meeting to discuss matters related to HITOC's duties, must call a public meeting.
Guiding Principles for HITOC (DRAFT)
Members referred to handout. Will wait to adopt until further discussion at November meeting. Drawn from guiding principles of HIIAC and Meeting two weeks ago in DC with the National Governor's Association and the National Coordinator. Focus on transparency throughout the entire process. Comments: Rick Howard: HIE is a public good to be used to improve the quality of life for Oregonians. #5 change individuals to mean consumers and providers explicitly #4 Add security of information Q: Nothing in HB 2009 about assisting consumers in making informed health decisions. How closely do we adhere to the language of the bill? A: Jeanene Smith says that the bill language outlining objectives should serve as a guide, but subject to interpretation.
HB 2009 Sections 1167-1171
Duties of HITOC: Set goals and develop a strategic plan; monitor progress; maximize the distribution of resources; create a mechanism to help with adoption of technology; identify and select the industry standards; enlist and leverage community resources; educate the public and health care providers, coordinate health care sector activities, support and oversee efforts to implement a personal health record bank for medical assistance recipients; determine a fair; appropriate method to reimburse providers for their use of electronic health records, determine whether to establish a HIT loan program. Carol: ARRA did not exist during the initial phases of HB 2009. Now the expectations within ARRA funding is a major focus

for the HITOC.
ARRA, HITECH and State Responsibilities
Refer to handout, OCHIN Application for the Regional Extension Center will be turned in by November (check website for application)
Progress to Date
Refer to Handout
Environmental Scan: Oregon Readiness for HIT
<p>Well positioned: Health Systems—Legacy does not have a contemporary EHR in place but is in the middle of a major installation. Mid to large practices; More urbanized areas; Federally Qualified Health Centers – many get EHR/PRM support from OCHIN</p> <p>In need of the most help; Small and Rural Practices; Local Public Health Departments; Corrections (there are clinics within each of the correctional facilities in the state, but none have an EHR and are just in the beginning stages); 32% of Critical Access Hospitals do not have an EHR; Freestanding Public Sector Applications—Ex. MMIS, Immunization Registry, State Lab Systems, Communicable Disease Reporting System—All Freestanding need to figure out how to integrate into meaningful HIE</p> <p>Some of what is already established has required a lot of resources. Is there anyway to connect the nodes of these systems rather than completely restructure into a fully integrated HIE?</p> <p>Other important technologies include Imaging Systems</p> <p>Other beneficial functionalities within HIE—Ex. MRSA alert when a patient enters a facility</p> <p>PHR-OHSU and Kaiser have forms of PHR</p> <p>OR HIE Grant—8.58 million for the next 4 years; \$1-2 million for planning; \$6+ million for beginning stages of implementation</p>
Introduction of Consultants—Dave Witter, OHPR 2009 EHR Survey—Expansion of 2006 Survey
<p>Analyzed cost of EHR adoption and utilization by ambulatory clinics within states; Draws on functionalities; Oregon compared to National; 70% of Oregon Clinicians work in practices that have installed EHR (not to say that 70% of physicians are using EHR)</p> <p>Some systems are not fully functioning systems, home grown, not CCHIT, not running the latest version that is CCHIT certified</p> <p>35% of clinicians work in a practice without an EPM system</p> <p>Major drawbacks are: cost, return on investment and time to implement the system due to workflow interference</p> <p>Hospitals: 47 of Oregon’s hospitals are using some form of EHR</p> <p>8/25 (32%) Critical Access Hospitals are not using an EHR</p> <p>Hospitals that do not have a plan right now will not be well positioned to qualify for meaningful use</p> <p>Hospital Survey—Nearly 100% response rate</p> <p>IPA Survey-- IPA’s working with doctors towards EHR adoption</p> <p>Health Plan Survey</p> <p>DHS Environmental HIT Scan</p> <p>HIE Activities</p>
Introduction – Nationwide Transformation –Shaun Alfreds
<p>Office of National Coordinator created in 2004 under Bush Administration</p> <p>Disincentives to adopt EHR—the sharing of information reduces some of the competitive advantages of the health care market</p> <p>Incentives to adopt HIT—To produce better quality of care by measuring and accessing information to produce</p>

<p>meaningful reports; Coding system that exists was made for payment not for quality reporting purposes</p> <p>Federal HIT Market-Infusion—Refer to handout</p>
<p>Goal: Move the HIT Tipping Point- Refer to handout; Obama Administration is hoping to push the adoption curve for HIT with various stimulus incentives</p>
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<p>CMS Incentives for HIT Adoption</p>
<p>Refer to handout; 44.7B to incentivize Medicare and Medicaid providers to adopt EHR at levels of meaningful use; \$44000 for Medicare , but must already have an EHR; \$63750 for Medicaid, which may be enough to provide incentives, as these groups do not have to have an EHR to qualify for incentive monies and thus could use towards purchasing an EHR –These incentives will certainly shift market forces, potentially creating more affordable EHR systems; a lot of specialty centers will not qualify for incentives, nor will laboratory and radiology centers, or long term providers; must adhere to specified metrics, which will become increasingly stringent over time, in order to receive incentives; 5100 of 10000 practicing physicians could qualify for Medicaid/Medicare physicians, but these physicians would need to be in a practice operating with and EHR (ultimately about 1/3 of Oregon’s physicians could qualify); Ambulatory physicians can only qualify for Medicaid OR Medicare, whereas hospital physicians can qualify for both; ; Incentives are for providers to be at levels of meaningful use and adhere to the respective quality reporting metrics, etc.; Physicians assistants, family nurses practitioners, and dentists can also get these incentives</p>
<p>State HIE Cooperative Agreement Program</p>
<p>State’s Critical Role; (Refer to handout); Funded by ONC; \$8.58 million for Oregon; align stakeholders and promote HIT adoption across providers; intent by the Feds for states to do cross-border planning, but this is very difficult; this should set up providers can qualify for the 2011 CMS incentives</p>
<p>Regional Extension Center Program</p>
<p>Refer to handout; in Oregon there will be a partnership between OCHIN and OHSU</p>
<p>How does Oregon use the Federal stimulus monies/incentives to build a sustainable HIE?</p>
<p>Vision and Strategies for HITOC</p>
<p>Oregon’s Triple Aim Goal: Improved Patient Experience; Improved Population Health; Lower per Capita Costs</p>
<p>Building on Oregon Health Fund Board’s Goals</p>
<p>Referred to handout</p>
<p>Building on HIIAC Recommendations</p>
<p>Referred to handout</p>
<p>HITOC Working Principles</p>
<p>Benefit of the doubt; Start/end on time; Homework; Meeting attendance—be here physically; Respect the agenda and timelines; Dialogue and consensus; Documentation for conflict and divergence of opinion; Disagree and commit; Process of making decisions & role of decision-making vs. recommendation to the health board; evaluation of process; Conflict of interest; Serve the public interest and not personal interest.</p>
<p>HITOC Working Principles Staff</p>
<p>Meeting materials out a week in advance, meetings begin and end on time</p>
<p>HITOC Working Principles Consultants</p>
<p>Define the governance roles of the state for HIT—Based on the environmental scan and what other states have done; Meaningful use guidelines will be coming out; Keep us up to date with what is going on nationally</p>
<p>Next Steps</p>
<p>Standing meetings in 2010, first Thursday of each month from 1-5pm, with some potentially longer; continue to engage HIIAC members</p>