

Oregon Health Information Technology Oversight Council

Thursday, October 8, 2009

2 pm – 5 pm

Portland State Office Building

800 NE Oregon Street Portland, Oregon

Room 918

Agenda

- 2:00- 2:20 Welcome and Introductions
- 2:20- 2:30 Review Agenda and Proposed Outcomes
- 2:30-3:00 Key Operating Considerations
 - 1. Bylaws and Policies
 - 2. Review Public Meeting Laws
 - 3. Guiding Principles
- 3:00- 3:15 HITOC Charter and Objectives
 - 1. House Bill 2009
 - 2. Federal Cooperative Agreement Program
- 3:15- 3:35 Progress to Date
 - 1. Letter of Intent
 - 2. Application for Cooperative Agreement Program
 - 3. Environmental Scan
- 3:35- 4:15 National Perspective of HIE
- 4:15- 4:45 Vision and Strategies for HITOC
 - 1. Working Principles
 - 2. Draft Work Plan with Timeline
- 4:45- 5:00 Next Steps, Questions

HITOC Consulting Team

Shaun T. Alfreds, MBA, HIT Program Manager at the National Academy for State Health Policy (NASHP) will serve as the project manager and team lead on this project. At NASHP, Mr. Alfreds conducts research and policy development in the areas of Health Information Technology (HIT) and Health Information Exchange (HIE) with particular emphasis on state and public sector roles. Prior to joining NASHP, Mr. Alfreds was a Senior Project Director at the University of Massachusetts Medical School, where he oversaw and supported a number of public sector HIT/HIE Projects for the National Governors Association State Alliance for eHealth, the Office of the National Coordinator for HIT, and the AHRQ National Resource Center for HIT. Mr. Alfreds currently serves as an adviser for a number of states, the Office of the National Coordinator for HIT and the State Level RHIO project on public involvement and financing of HIT/HIE initiatives. In addition to his HIT and HIE research, Mr. Alfreds has overseen health services research, program assessment, and policy analysis projects for state Medicaid agencies in Massachusetts, New Hampshire, and Maine. Mr. Alfreds holds a faculty appointment in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. He received an MBA from the University of Maine and a BS in Anthropology and Biology from the University of Massachusetts. Mr. Alfreds is also a Certified Professional in Health Information Technology.

Jay Himmelstein, MD, MPH will serve as a senior advisor and team member on this project. He is a Professor of Family Medicine and Community Health and Internal Medicine at UMass Medical School. He also serves as Chief Health Policy Strategist for UMass Medical School's Center for Health Policy and Research. Dr. Himmelstein also leads the Center for Health Policy and Research's Public Sector Health Information Technology Policy Group. He has been principal investigator on a number of funded projects focusing on the role of Medicaid and other human service programs can leverage investments in health information technology to improve outcomes and contain costs for those served by the public agencies. Professor Himmelstein was the founding Director of the Center for Health Policy and Research (CHPR) and led the Center's development from 1997 –2007. Professor Himmelstein is board certified in internal medicine and occupational and environmental health/preventive medicine. He received his bachelor's degree from Johns Hopkins University, his medical degree from the University of Maryland Medical School, and received Masters degrees in Public Health and Physiology from the Harvard School of Public Health.

Julie Harrelson will provide strategic counsel, communication development and facilitation support to the project, serving as the on-the-ground liaison between stakeholders in Oregon and the NASHP/UMASS team. Julie's career includes positions as CEO, Vice-President, Vice President of Sales and Marketing, Principal Business Consultant and Organizational Development executive. She has provided strategic counsel, executive counsel, business planning, operational and technical strategy development and leadership development to many regional organizations including Port of Portland, Providence, Portland Development Commission (PDC), Oregon Health Network (OHN), Women's Healthcare Associates, Starbucks, Nike, State of California,

United Way of New Orleans, Northwest Energy Efficiency Alliance. Julie has served as Executive Director for Women in Technology, on the Professional Committee at Oregon College of Arts and Crafts, the Executive Committee at TACS and currently is working with women leaders of the state to establish a Center for Women Politics and Policy at Portland State University providing leadership development for college women and teenage girls across the State through the New Leadership Oregon program and Teens Lead!

Dave Witter, MA conducts economic research to support decision making for this and other projects relating to health information technology and the exchange of health information between entities. Dave has over thirty years experience in the leadership, operations and finances of health care organizations. Mr. Witter spent six years at the Association of American Medical Colleges (Washington, DC) serving as Vice President of Enterprise (business) Development, Vice President of Information Resources (CIO) and Director of the Clinical - Administrative Data Service. Mr. Witter spent six years as president and CEO of the Academic Medical Center Consortium (Rochester, NY), an organization created by twelve major teaching hospital CEOs to conduct major health services research-based initiatives to improve quality and operations. Mr. Witter spent seventeen years at the Oregon Health Sciences University serving as, Interim University President, Vice President for Administration, Director of the Biomedical Information and Communication Center, University Hospital CEO, COO and CFO . Mr. Witter holds bachelor and master degrees in economics.

Oregon Health Information Technology (HIT) Glossary

DRAFT VERSION (JULY 2009)

CONTACT (FOR UPDATES): PAUL.ANEJA@STATE.OR.US (HEALTH IT ARCHITECT)

Ambulatory Care - Medical care provided on an outpatient basis.

Application Service Provider (ASP) - a third-party entity that manages and distributes software-based services and solutions to customers.

Case Management - A process of identifying individuals at high risk for problems associated with complex health care needs and assessing opportunities to coordinate care to optimize the outcome.

CCHIT - Certification Commission for Health Information Technology formed by three leading healthcare organizations to create an efficient, impartial and trusted mechanism to certify ambulatory electronic health records and other healthcare information technology (IT) products.

CDE - Clinical Data Exchange

CHI - Consolidated Health Informatics

Computerized Provider Order Entry (CPOE) - A computer application that allows a provider's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the provider about potential problems.

Consolidated Health Informatics (CHI) Initiative - One of the 24 Presidential eGovernment initiatives with the goal of adopting vocabulary and messaging standards to facilitate communication of clinical information across the federal health enterprise. CHI now falls under FHA.

Decision-Support System (DSS) - Computer tools or applications to assist in clinical decisions by providing evidence-based knowledge in the context of patient-specific data. Examples include drug interaction alerts at the time medication is prescribed and reminders for specific guideline-based interventions during the care of patients with chronic disease. Information should be presented in a patient-centric view of individual care and also in a population or aggregate view to support population management and quality improvement.

Demographics: Information about name, address, age, gender, and role used to link patient records from multiple sources in the absence of a unique patient identifier.

DICOM - Digital Imaging and Communications in Medicine - the industry standard for transferal of radiologic images and other medical information between computers. DICOM enables digital communication between diagnostic and therapeutic equipment and systems from various manufacturers.

Electronic Health Record (EHR) - An electronic repository of information regarding the

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health of an individual. A real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting.

Electronic Medical Record (EMR) - An EMR is computer-based patient medical record. An EMR facilitates access of patient data by clinical staff at any given location; accurate and complete claims processing by insurance companies; building automated checks for drug and allergy interactions; clinical notes; prescriptions; scheduling; sending to and viewing by labs; The term has become expanded to include systems which keep track of other relevant medical information. The practice management system is the medical office functions which support and surround the electronic medical record.

Electronic Prescribing (eRx) - A type of computer technology whereby physicians use handheld or personal computer devices to review drug and formulary coverage and to transmit prescriptions to a printer or to a local pharmacy. E-prescribing software can be integrated into existing clinical information systems to allow provider access to patient-specific information to screen for drug interactions and allergies.

Enterprise Architecture - A strategic resource that aligns business and technology, leverages shared assets, builds internal and external partnerships, and optimizes the value of information technology services.

EPI - Enterprise Patient Index

Evidence-based practice - Evidence-based practice is the integration of best research evidence with clinical expertise to aid in the diagnosis and management of patients.

Federated Architecture - allows a collection of database systems (components) to unite into a loosely coupled federation in order to share and exchange information. The term federation refers to the collection of constituent databases participating in a federated database.

Federal Health Architecture (FHA) - A collaborative body composed of several federal departments and agencies, including the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), the Department of Veterans Affairs (VA), the Environmental Protection Agency (EPA), the United States Department of Agriculture (USDA), the Department of Defense (DoD), and the Department of Energy (DOE). FHA provides a framework for linking health business processes to technology solutions and standards, and for demonstrating how these solutions achieve improved health performance outcomes.

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HIE - Health Information Exchange. The electronic movement of health-related information among organizations according to nationally recognized standards. The mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care.

HIPAA - Health Insurance Portability and Accountability Act

HL7 - Health Level 7 (Refers to the seven layer network model popularized by ISO): Message format standards used for exchange of data between healthcare systems.

HL7 RIM - HL7 Reference Information Model: Object model used in deriving new HL7 (Version 3) message formats.

Health Information Technology (HIT) – HIT provides the umbrella framework to describe the comprehensive management of health information and its secure exchange between consumers, providers, government and quality entities, and insurers. Health information technology (HIT) in general are increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of the health delivery system. Broad and consistent utilization of HIT will:

- Improve health care quality;
- Prevent medical errors;
- Reduce health care costs;
- Increase administrative efficiencies;
- Decrease paperwork; and
- Expand access to affordable care.

Interoperability - The ability of two or more systems (or components) to exchange information and to use the information that has been exchanged.

LOINC-Logical Observation Identifiers Names and Codes - Standard code set covering medical terms, procedures and diagnoses maintained by Regenstrief. Adopted by the largest commercial laboratories and most Federal agencies.

MPI-Master Patient Index (also called Master Person Index by some vendors): An electronic index that enables lookup of patient data distributed across multiple systems, to provide an aggregated view of patient's EHR.

NCDCP-National Council for Prescription Drug Programs - creates and promotes standards for the transfer of data to and from the pharmacy services sector of the healthcare industry. NCDCP standards are focused on prescription drug messages and the activities involved in billing pharmacy claims and services, rebates, pharmacy ID cards and standardized business transaction between pharmacies and the professionals

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who prescribe medications. Participating organizations include chain and independent pharmacies, pharmacists, database management companies, insurers, pharmaceutical manufacturers, IT system vendors and wholesale drug distributors.

NHIN – National Health Information Network

ONCHIT – (on kit) Office of the National Coordinator for Health Information Technology

Personal Health Record (PHR) - An electronic application through which individuals can maintain and manage their health information (and that of others for whom they are authorized) in a private, secure, and confidential environment.

PMS - Practice Management System

Population Health: Population health is an approach to health that aims to improve the health of an entire population. One major step in achieving this aim is to reduce health inequities among population groups. Population health seeks to step beyond the individual-level focus of mainstream medicine and public health by addressing a broad range of factors that impact health on a population level, such as environment, social structure, resource distribution, etc. An important theme in population health is importance of social determinants of health and the relatively minor impact that medicine and healthcare have on improving health overall.

Public Health: Public health is concerned with threats to the overall health of a community based on population health analysis. Governmental public health agencies provide the backbone to the public health infrastructure, but this infrastructure is also dependent on other entities such as the health care delivery system, the public health and health sciences academia, and other sectors that are heavily engaged and more clearly identified with health activities. Public health also plays a legal regulatory role (e.g., conducting restaurant inspections).

Record Locator Service (RLS) – Indexing software (still in development) designed to enable authenticated users at each sub-network organization to access EHRs from any location. The final model will most likely include several data fields including: patient demographics, record location, local medical record number and the date of last update to the record.

RHIN – Regional Health Information Network

RHIO – Regional Health Information Organization

RPI – Regional Patient Index

RxNorm - Clinical drug nomenclature produced by NLM, in consultation with FDA, VA, and the HL7 standards development organization. RxNorm provides standard names for clinical drugs and for dose forms as administered.

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SAML - Secure Assertion Markup Language - SAML provides an XML-based framework for exchanging authentication and authorization information, enabling single sign-on--the ability to use a variety of Internet resources without having to log in repeatedly. Provides a technology neutral way to exchange security information using XML to communicate authentication, authorization, and other user attribute information.

SNOMED - Systemized Nomenclature for Medicine: Clinical Terms - Standard code set covering medical terms, procedures and diagnoses maintained by College of American Pathologists. The federal government, through the National Library of Medicine, has signed a contract with CAP for a perpetual license for the core terminology set called SNOMED CT, which stands for Systemized Nomenclature for Medicine: Clinical Terms. The agreement makes SNOMED CT available to IT users in the U.S. at no cost.

OREGON PUBLIC MEETING LAWS

Guidelines for the Health Information Technology Oversight Council

History

The Oregon Public Meetings Law, ORS 192.610 to 192.690 was enacted in 1973 in an effort to ensure that deliberations and decisions of governing bodies are made openly.

Definitions

Since the Health Information Technology Oversight Council (HITOC) was created by statute, they are considered to be “*public bodies*.” A “*governing body*” is a group of members of a public body with the authority to make decisions for or recommendations to a public body on policy or administration, which in the case of the Council or any of its Committees is at least a quorum.

Statute defines “*decision*” as any determination, action, vote or final disposition upon a motion, proposal, resolution, order, ordinance or measure of which a vote of a governing body is required. “*Meeting*” is defined as the convening of a governing body or a public body in order to make a decision or deliberate toward a decision on any matter.

Meeting Requirements

Any time a quorum of the Council or one of its Committees meets to deliberate towards a decision, the meeting must be open to the public. Meetings cannot take place in locations which practice discrimination and must be accessible to disabled persons.

Public notices for all meetings must be provided to interested parties at least 48 hours prior to the start of the meeting. Meeting notices must include the time and location of the meeting, as well as a list of the principal subjects expected to be discussed.

A sound, video or digital recording or a set of written minutes must be taken at every meeting and must be made available to the public within a reasonable time after the meeting. The minutes must be a true reflection of the matters discussed at the meeting and the views of the participants and must include the following information: all members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the results of all votes and the vote of each member; the substance of any discussion; a reference to any document discussed at the meeting.

Notice rules still apply to meetings held by phone or other electronic means. In such cases, at least one place will be made available to the public where the public can listen to the meeting in real time.

Public Record

All documents distributed to the Council or its Committees, discussed at meetings or produced by the Council and its Committees will be considered public record. Documents will be made available at meetings and upon request from any member of the public. Correspondence, including but not limited to, letters, memoranda, notes and electronic messages that communicate formal approvals, direction for action and information about the Council and its Committees are considered part of administrative record and thus are subject to public record requirements.

Enforcement

Decisions made the Council or its Committees in violation of the Public Meeting Laws will be voided, unless it is reinstated while in compliance. A reinstated decision is effective from the date it was initially adopted.

Oregon Health Information Technology Environment Assessment, 2009

Health Information Exchange (HIE) Activities Inventory (a partial & evolving list – September 30, 2009)

PURPOSE: This report identifies HIE activities in Oregon that may be useful in the process of developing an HIT plan with strategies for health information exchange in Oregon that leverages existing resources and accelerates achievement of Oregon HIT goals.

DEFINITIONS:

Terminology developed in 2008 through a collaborative process by the National Alliance for Health Information Technology and authorized by the Office of the National Coordinator for Health IT.

www.nahit.org/images/pdfs/HITTermsFinalReport_051508.pdf.

- **Health Information Exchange (HIE)** – *the electronic movement of health-related information among organizations according to nationally recognized standards.*
- **Health Information Organization (HIO)** – *an organization that oversees and governs the exchange of health-related information among organizations according nationally recognized standards.*

HIE PLANNING EFFORTS

Central Oregon Health Information Exchange: In 2007, a number of central Oregon stakeholders explored development of an HIE to serve central and eastern Oregon. In 2009, various organizations (Cascade Health, Bend Memorial Clinic, COEMR and others) resumed active HIE planning for central Oregon. Recommendations are expected in fall 2009.

Columbia Gorge Health Information Exchange Consortium: In 2009 Mid Columbia Medical Center, La Clinica del Carino Family Health Care Center and Wasco County Public Health sponsored discussions for a community-based health information exchange serving The Dalles and surrounding area. Participating organization include Columbia River Women’s Clinic. Mid Columbia Surgical Specialists, Arlington Clinic and Morrow Clinic. The Consortium has submitted funding proposals to support further planning and HIE development.

Epic CareEverywhere - CareEpic: Epic Systems has developed a process for information exchange between providers using Epic EHR systems known as CareEpic. Epic EHRs are in use at Kaiser, OCHIN, OHSU, Salem Health (Salem Hospital, West Valley Hospital). Legacy Health System is in the process of implementing Epic. Epic

users in Oregon have begun informal discussions about health information exchange using CareEpic.

Oregon Health Information Exchange Options Report: In December 2005, the Oregon Business Council's Data Exchange Group commissioned an analysis of options for initiating a pilot project for health information exchange. The May 15, 2006 report can be found at <http://www.q-corp.org/q-corp/images/public/pdfs/OR%20HIE%20Options.pdf>.

Metro Portland Health Information Exchange (MPHIE) Mobilization Planning (2006-7): In September 2006, the Oregon Business Council's Data Exchange Group commissioned a mobilization plan to implement health information exchange in the Portland area based on retrieval of results and reports. The May 14, 2007 MPHIE Mobilization Plan can be found at <http://www.q-corp.org/q-corp/images/public/pdfs/MPHIE%20Final%20Report%20053007.pdf>. Supporting documents for the planning can be found at <http://q-corp.org/default.asp?id=61>.

Portland Metro Health Information Exchange (2009): In August 2009, six organizations including hospitals, clinics, and health systems reached a consensus for an exchange of standardized care summary documents using XDS.b tools embedded in their vendors' products. Patients will sign a paper consent form to allow exchange between each pair of participating organizations for a defined period of time. Tools from the vendors will provide a computer screen matching of the patient's registration in one system with their registration in another participating organization's system. The organizations include Kaiser Permanente Northwest, Legacy Health, OCHIN, OHSU, Providence Health and Services, and Southwest Washington Medical Center.

Salem Area Community Health Information Exchange (SACHIE): A group of Marion-Polk County community stakeholders began discussing formation of an HIE in September 2007. In 2009 grant funding was obtained to develop a technology strategy and business plan. A SACHIE Development Committee is actively engaged in the planning process under the auspices of the Physician's Choice Foundation. The technology roadmap and business plan framework are due in October 2009.

South Coast Health Alliance: Five hospitals on the southern Oregon coast (Bay Area, Coquille Valley, Curry General, Lower Umpqua and Southern Coos) are discussing health information technology strategies for the area including the use of two local efforts to leverage health information exchange among the five hospitals and local physician practices. Bay Area Hospital and the North Bend Medical Center (NBMC) are implementing Medicity-based interfaces to facilitate information exchange between the seven NBMC locations and Bay Area Hospital.

INTEGRATED HEALTH SYSTEMS

There are a number of health systems in Oregon that have multiple operating components that may include one or more hospitals, system-owned medical groups,

affiliated medical groups, home health agency, skilled nursing facilities and/or others units. These health systems strive to use a core set of HIT applications across the various settings in which they operate and work to improve the interoperability and exchange of information between their HIT applications, care settings and medical groups interacting with the health systems.

Asante Health System operates two hospitals in Jackson and Josephine Counties.

Cascade Healthcare Community operates four hospitals in central Oregon.

Kaiser Permanente operates one hospital in Portland and clinics the Portland metro area, Salem and southwest Washington.

Legacy Health System operates four hospitals in the Portland metro area, one hospital in Clark County Washington and clinics in the Portland metro area, Woodburn and southwest Washington.

PeaceHealth operates four hospitals and medical group practices in Lane County.

Providence Health and Services operates eight hospitals across the state of Oregon and medical groups in the Portland area, north coast and southern Oregon.

Salem Health operates two hospitals in Marion and Polk Counties.

Samaritan Health Services operates five hospitals and medical group practices in Linn, Benton and Lincoln Counties.

OPERATING & SOON TO BE OPERATIONAL HIEs

Mid-Rogue Health Information Exchange: Mid Rogue eHealth Services, a wholly owned subsidiary of Mid Rogue independent Physicians Association (MRIPA), has partnered with Asante Health System and is collaborating with Providence Medford Medical Center and other entities in Jackson and Josephine Counties to exchange patient data. An HIE topology has been identified and an RFP for an HIE vendor is in process. Mid Rogue eHealth Services implements Greenway PrimeSuite, an interoperable 2009 CCHIT certified EHR, and has active interfaces with four LIS, one HIS and the Oregon ALERT Immunization Registry.

OCHIN: OCHIN is a health center controlled network (HCCN) of community health clinics and small practices serving the medically underserved with seventeen members in Oregon, eight members in California and one in Washington. OCHIN provides practice management and EHR (Epic) services to member organizations. As an Organized Health Care Arrangement (OHCA) under HIPAA with a single record per patient OCHIN also functions as an HIE among the member organizations. The OCHIN master patient index contains information on 400,000 Oregonians and 600,000 lives across California, Oregon and Washington.

Providence Health & Services – Oregon Health Information Exchange:

Providence is implementing a standard-based HIE to connect the inpatient EMR (McKesson) systems with outpatient EMR systems (Centricity) serving Providence employed physicians and affiliated partners. HIE operations are scheduled to begin in October 2009. The master patient index supporting the HIE contains information on 2.x

million lives. The HIE infrastructure and standards-based approach will allow Providence to connect other vendor EMRs and community partners such as OCHIN, OHSU, Kaiser, Legacy and Southwest Washington Medical Center.

Samaritan Health Services - Health Information Exchange (SHS-HIE): In August 2009 Samaritan Health Services partnered with Medicity Systems to establish an HIE. The system allows Samaritan's 5 hospitals and affiliated practices in Linn, Benton and Lincoln counties to deliver patient data securely and efficiently. Clinics' within Samaritan's service area will be able to join the exchange and data will flow to their disparate EMR systems. SHS-HIE initially will feed information to the Benton County Health (Epic EMR) and The Corvallis Clinic (Allscripts EMR). Subsequent phases involve reciprocal information exchange and adding other clinical practices in the area.

Umpqua OneChart Health Information Exchange (Roseburg, Douglas County and surrounding area): Starting in 2005, the community-based HIE now supports a community enterprise master patient index supporting about 150 different practice management systems. These systems provide the foundation for a common EHR system (Centricity) throughout the community, leveraging single chart patient technology in a centralized data repository, including comprehensive interfaces to the Mercy Medical Center Meditech HIS, local ambulatory and cancer treatment facilities and related systems. Umpqua OneChart provides a personal health record (PHR) system compatible with both Microsoft HealthVault and Google Health. Read-only access (with appropriate privacy and security controls) is offered to authorized Roseburg VA representatives, as well as first responder summary information (face sheet form) to local EMS (ambulance, fire, police) personnel. The HIE now contains information on about 220,000 lives.

PACS - IMAGING COLLABORATIONS AND EXCHANGE

Picture archiving and communication systems (PACS) are computers, commonly servers, dedicated to the storage, retrieval, distribution and presentation of images. A number of hospital and imaging centers are collaborating to facilitate the availability and electronic exchange of medical images.

Asante Health System PACS Collaboration: Asante provides PACS services (Fuji PACS) for its hospitals in Grants Pass and Medford, and Oregon Advanced Imaging (Medford). Other Fuji PACS system users include Grants Pass Imaging and Medford Medical Clinic which have their own PACS systems but can access the Asante PACS system with appropriate security.

Cascade Medical Imaging (CMI) is a joint venture between Central Oregon Radiology and Cascade Healthcare Community which provides imaging and PACS services for central and eastern Oregon, over 33,000 square miles and serving just over 300,000 people. CMI and the Bend Memorial Clinic are able to access and exchange images. The CMI PACS network currently serves 16 physical locations (hospitals and clinics) in Deschutes, Jefferson, Crook, Harney, Grant, Lake, Wallowa and Wheeler counties.

The network serves 3,208 referring physicians with 2,304 users actively using the system.

Oregon Community Imaging (Salem) is a cooperative arrangement among community healthcare organization to facilitate the access and exchange of medical images with an imaging repository for participating practices. Current participant include Salem Hospital, Salem Radiology Consultants and West Valley Hospital (Dallas). Imaging access and exchange for Salem area NextGen EMR users is under development.

Samaritan Health PACS system is used as a common imaging repository by the five Samaritan Health hospitals and their affiliate practices and clinics. The Corvallis Clinic utilizes the Samaritan Health PACS system under an ASP arrangement with its own dedicated imaging data base. Images can be exchanged as appropriate.

South Coast: A community PACS is based at Lower Umpqua Hospital (Reedsport) also serves Coquille Valley Hospital (Coquille) and Southern Coos Hospital (Bandon).

Sources: Information in this report was collected from multiple sources including the 2009 eHealth Initiative HIE Survey report, the 2009 Oregon Hospital & Health System HIT Survey and 2009 Oregon IPA Survey. Additionally interviews were conducted with individuals involved with most of the identified HIEs activities.

HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL

SECTION 1167

As used in sections 1167 to 1173 of this 2009 Act:

- (1) “Electronic health exchange” means the electronic movement of health-related information among health care providers according to nationally recognized interoperability standards.
- (2) “Electronic health record” means an electronic record of an individual’s health related information that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care provider.
- (3) “Health care provider” or “provider” means a person who is licensed, certified or otherwise authorized by law in this state to administer health care in the ordinary course of business or in the practice of a health care profession.
- (4) “Health information technology” means an information processing application using computer hardware and software for the storage, retrieval, sharing and use of health care information, data and knowledge for communication, decision-making, quality, safety and efficiency of a clinical practice. “Health information technology” includes, but is not limited to:
 - (a) An electronic health exchange.
 - (b) An electronic health record.
 - (c) A personal health record.
 - (d) An electronic order from a provider for diagnosis, treatment or prescription drugs.
 - (e) An electronic decision support system used to:
 - (A) Assist providers in making clinical decisions by providing electronic alerts or reminders;
 - (B) Improve compliance with best health care practices;
 - (C) Promote regular screenings and other preventive health practices; or
 - (D) Facilitate diagnoses and treatments.
 - (f) Tools for the collection, analysis and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction and other health care related performance measures.
- (5) “Interoperability” means the capacity of two or more information systems to exchange information or data in an accurate, effective, secure and consistent manner.
- (6) “Personal health record” means an individual’s electronic health record that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared and controlled by the individual.

SECTION 1168

- (1) There is established a Health Information Technology Oversight Council within the Oregon Health Authority, consisting of 11 members appointed by the Governor.
- (2) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint

a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

- (3) The appointment of the Health Information Technology Oversight Council is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.
- (4) A member of the Health Information Technology Oversight Council is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2). Claims for expenses incurred in performing the functions of the council shall be paid out of funds appropriated to the Oregon Health Authority for that purpose.

SECTION 1169.

Notwithstanding the term of office specified by section 1168 of this 2009 Act, of the members first appointed to the Health Information Technology Oversight Council:

- (1) Two shall serve for terms ending January 1, 2011.
- (2) Three shall serve for terms ending January 1, 2012.
- (3) Three shall serve for terms ending January 1, 2013.
- (4) Three shall serve for terms ending January 1, 2014.

SECTION 1170.

The members of the Health Information Technology Oversight Council must be residents of this state from both the public and private sectors who are well informed in the areas of health information technology, health care delivery, health policy and health research. The membership must reflect the geographic diversity of Oregon and must include consumers and providers of health care and privacy and information technology experts.

SECTION 1171.

The duties of the Health Information Technology Oversight Council are to:

- (1) Set specific health information technology goals and develop a strategic health information technology plan for this state.
- (2) Monitor progress in achieving the goals established in subsection (1) of this section and provide oversight for the implementation of the strategic health information technology plan.
- (3) Maximize the distribution of resources expended on health information technology across this state. Enrolled House Bill 2009 (HB 2009-C) Page 525
- (4) Create and provide oversight for a public-private purchasing collaborative or alternative mechanism to help small health care practices, primary care providers, rural providers and providers whose practices include a large percentage of medical assistance recipients to obtain affordable rates for high-quality electronic health records hardware, software and technical support for planning, installation, use and maintenance of health information technology.
- (5) Identify and select the industry standards for all health information technology promoted by the purchasing collaborative described in subsection (4) of this section, including standards for:

- (a) Selecting, supporting and monitoring health information technology vendors, hardware, software and technical support services; and
 - (b) Ensuring that health information technology applications have appropriate privacy and security controls and that data cannot be used for purposes other than patient care or as otherwise allowed by law.
- (6) Enlist and leverage community resources to advance the adoption of health information technology.
 - (7) Educate the public and health care providers on the benefits and risks of information technology infrastructure investment.
 - (8) Coordinate health care sector activities that move the adoption of health information technology forward and achieve health information technology interoperability.
 - (9) Support and provide oversight for efforts by the Oregon Health Authority to implement a personal health records bank for medical assistance recipients and assess its potential to serve as a fundamental building block for a statewide health information exchange that:
 - (a) Ensures that patients' health information is available and accessible when and where they need it;
 - (b) Applies only to patients who choose to participate in the exchange; and
 - (c) Provides meaningful remedies if security or privacy policies are violated.
 - (10) Determine a fair, appropriate method to reimburse providers for their use of electronic health records to improve patient care, starting with providers whose practices consist of a large percentage of medical assistance recipients.
 - (11) Determine whether to establish a health information technology loan program and if so, to implement the program.

SECTION 1172.

- (1) The Governor shall appoint one of the members of the Health Information Technology Oversight Council as chairperson and another as vice chairperson, for such terms and with such duties and powers necessary for the performance of the functions of those offices as the Governor determines.
- (2) A majority of the members of the council constitutes a quorum for the transaction of business.
- (3) The council shall meet at least quarterly at a place, day and hour determined by the council. The council may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the council.

SECTION 1173.

In accordance with applicable provisions of ORS chapter 183, the Health Information Technology Oversight Council may adopt rules necessary for the administration of the laws that the council is charged with administering.

State HIE Cooperative Agreement Program

Summary

On August 20, the federal Office of the National Coordinator for Health Information Technology (ONC) announced the State Health Information Exchange (HIE) cooperative agreement program, funded as part of the HITECH Act within the federal stimulus law, the American Recovery and Reinvestment Act (ARRA). The Office for Oregon Health Policy and Research (OHPR), within the Oregon Health Authority (OHA) will be the applicant. OHPR staffs the Health Information Technology Oversight Council (HITOC), which will lead the work funded by this grant. Applications are due by October 16, 2009.

Oregon's funding allocation for the four year period, beginning January 15, 2010 and ending December 31, 2013 will be \$8.58 million. This award is subject to state matching fund requirements that are progressively larger in subsequent grant years.

Purpose of the program: With the passage of the ARRA, Congress envisioned advancing the use of health information technology to improve quality of care and establish a foundation for health care reform. The ARRA vision includes three short-term pre-requisites:

- Clinicians and hospitals must acquire and implement certified electronic health records;
- Systems must be established to enable information to flow securely between providers and other sources to support health care and population health; and
- A workforce must be trained and developed to gain the quality and efficiency benefits of electronic health records while protecting individual privacy and security.

The purpose of the ONC State HIE cooperative agreement program is to address the second item above, by supporting state efforts to advance appropriate and secure health information exchange (HIE) across each state's health care system, while moving toward nationwide interoperability.

This funding will provide vital support for Oregon's efforts in electronic health records adoption and the development of a statewide system for electronic health information exchange, as envisioned by the legislature in HB 2009 and directed to be led by the Oregon Health Information Technology Oversight Council (HITOC). The cooperative agreements are intended to hasten states' compliance with federal requirements for HIE capacity to increase the ability of providers in Oregon to be eligible for Medicaid and/or Medicare HIT incentive payments.

Grant activities and implementation timeline: ONC will provide applicants with four years of funding in stages, each stage contingent upon reaching specific, negotiated milestones and performance measures. The proposed grant activities will include:

- Development of a required Strategic and Operational State Plan – due 7/15/10. Funding for the planning phase to develop the State Plan will be released in mid-January, 2010.
- Upon ONC approval of Oregon's State Plan, funding will be released for implementation activities. The ONC has established a list of key accomplishments to be concluded by December 31, 2011, representing the majority of implementation activities. Activities will be more clearly defined in the State Plan, but, in general, activities will include:
 - Establishing organizational infrastructure: governance structure, legal and policy documents, contracts, project management support, systems maintenance and

- technical support, providing oversight and accountability, convening HITOC and workgroup meetings;
- Developing technical infrastructure: hardware, software, applications, network configurations;
 - Developing financial capacities: identifying public and private financing and sustainability strategies, financial reporting and auditing, establishing a State HIE business plan;
 - Education and engagement: developing strategies to encourage provider participation, convening stakeholders across the state; and
 - Consumer protection: Privacy and security policies, integration of personal electronic health records applications into statewide HIE.

The HITOC and its workgroups will lead the grant-funded work, coordinating with multiple community stakeholders, including hospitals, health systems, healthcare providers and their associations, business, consumer, and labor groups. The work will closely align with existing efforts including Oregon Health Information Network (OHN), which has been working on broadband connectivity between healthcare facilities; OCHIN, Inc., which will be applying separately for ARRA funding for Health Information Technology Regional Extension Centers; the Health Records Bank of Oregon, which has begun work on establishing a pilot personal health records bank for Medicaid beneficiaries; and other local and regional efforts towards health information exchange and electronic health record adoption. In addition, a wide range of health care stakeholders will participate in these grant activities, either as members of the HITOC or its workgroups, or by participating in annual stakeholder engagement meetings and/or a more targeted series of stakeholder meetings statewide to educate and engage Oregonians around the State Plan and its implementation over the four years.

HITOC members:

Chair: Steven Gordon, MD, Eugene, VP, Chief Quality Officer, PeaceHealth
Vice Chair: Rick Howard, Salem, CIO, Oregon Department of Human Services
Bob Brown, Portland, Retired, Board member, Oregon Health Action Campaign
Brian DeVore, Hillsboro, Director of Industry Affairs, Intel
Greg Fraser, MD, Sublimity, Medical Director of Information Systems and Informatics, Mid-Valley IPA
Bridget Haggerty, Portland, VP, CIO, Oregon Health & Sciences University
Marie Laper, Corvallis, Coordinator of Quality Improvement & Clinical Care, Benton County Health
Bill Hockett, Portland, Director, Web Strategy, ODS Services
Robert Rizk, Hermiston, Director, Information Technology, Good Shepherd Health System
Sharon Stanphill, Roseburg, Clinic Director, Cow Creek Band of Umpqua Tribe of Indians
Dave Widen, Dayton, Director of Pharmacy, Safeway

For additional information:

Carol Robinson, State Coordinator, Health Information Exchange, Director, HITOC,
503-373-1817, carol.robinson@state.or.us

Jeanene Smith, MD, Administrator, OHPR, 503-373-1625, jeanene.smith@state.or.us

State HIE Cooperative Agreement Program: <http://healthit.hhs.gov/stateHIEgrants>

HITOC: <http://www.oregon.gov/OHPPR/HITOC/index.shtml>



Oregon

Theodore R. Kulongoski, Governor

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David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Tel: (202) 690-7151
StateHIEgrants@hhs.gov

September 11, 2009

Dear Dr. Blumenthal,

On behalf of the Honorable Governor Ted Kulongoski of Oregon, the Office for Oregon Health Policy and Research within the Oregon Health Authority is submitting this letter of intent to apply for the following funding opportunity announcement (FOA):

- American Recovery and Reinvestment Act of 2009, State Grants to Promote Health Information Technology Planning and Implementation Projects, State Health Information Exchange (HIE) Cooperative Agreement Program
- Funding Opportunity Number: EP-HIT-09-001
- Catalog of Federal Domestic Assistance (CFDA) Number: 93.719

Project Title:

Oregon Health Information Exchange (ORHIE) — A Key Tool for a Healthy Oregon

As Oregon has not yet developed a state strategic and operational plan (state plan), Oregon intends to use this funding opportunity to conduct an intense planning process that will enable the state to deliver a state plan for a statewide health information exchange (HIE) to the Office of the National Coordinator (ONC) on or before July 15, 2010, in accordance with the requirements of this FOA. Upon ONC approval of the strategic and operational plan, the state or state designated entity will execute a comprehensive and accountable implementation of statewide HIE.

The State of Oregon intends to leverage its collaborative work thus far and engage an extensive network of diverse partners in support of advancing an HIE infrastructure and meaningful use of health information technology (HIT). This network includes providers and relevant stakeholders statewide, as well as across contiguous state borders, in areas where health care utilizations and services are delivered by region. Although this application is being submitted solely on behalf of the State of Oregon, discussions have been initiated with our neighboring states, Washington, Idaho and California, to assure appropriate regional electronic sharing of clinical and administrative information. All strategic planning will be focused on supporting patient needs for secure electronic health information to flow seamlessly between providers, including across state lines.

Oregon is well poised to plan and implement statewide HIE. This past June, Oregon's legislature passed historic health reform legislation. In particular, House Bill 2009 (HB 2009) creates an Oregon Health Authority, responsible for streamlining and aligning state health purchasers and programs to maximize efficiency, organize

state health policy and health services, and for implementing the health reform policies and programs also created in HB 2009.

Primary Point of Contact: Carol Robinson
State Coordinator, Oregon Health Information Exchange
1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
carol.robinson@state.or.us
503-373-1817

Oregon's Project Team:

The Health Information Technology Oversight Council (HITOC): A key component of Oregon's recent health reform legislation is the creation of the Health Information Technology Oversight Council (HITOC). The HITOC is charged with developing a statewide strategic plan for HIE, coordinating public and private efforts to increase adoption of electronic health records (EHR), setting technology standards, ensuring privacy and security protections, and creating a sustainable business plan with appropriate governance, oversight, and accountability mechanisms to support meaningful use of HIT to lower costs and improve quality of care. The eleven HITOC members have been appointed by the Governor and will begin meeting after Senate confirmation in early October. Council members represent large and small hospitals, health plans, the business sector, consumer advocates, public health and mental health perspectives, federally qualified health centers, Oregon's tribal communities, pharmacies, independent physician practices and the state. They embody the geographic and demographic differences of Oregon's health care providers and the patients they serve.

Key Personnel: Carol Robinson, Oregon's Coordinator for Health Information Exchange, also serves as Director of the HITOC.

The Oregon Health Authority and the Oregon Health Policy Board were created by the 2009 Legislature to streamline the existing statutory powers of multiple health-related state governmental agencies and citizen health boards into a single entity, accountable for Oregon's health care agencies and for improving the quality, access and efficiency of Oregon's health system.. The Authority will be the primary state agency to implement comprehensive health reform. By consolidating and reorganizing current commissions, the Board will be the single entity within state government that is responsible to the Governor and the Legislature for oversight and policy development related to health. The HITOC will report on the ORHIE project to the Authority and the Board. This project will involve all of the agencies, divisions and programs that comprise the Authority with special attention to Public Health, Mental Health and Addiction Services, and Medical Assistance Programs (Medicaid/ Oregon Health Plan). Additionally, the project will partner with Department of Human Services' Division of Seniors and Persons with Disability (long-term care services) and Division of Children, Adults and Families (child welfare).

Key Personnel: Bruce Goldberg, MD, OHA Director Designee and Director of the Oregon Department of Human Services (DHS); Judy Mohr-Peterson, State Medicaid Director, (also known as Director of the Division of Medical Assistance); Rick Howard, Chief Information Officer for DHS and OHA

The Office for Oregon Health Policy and Research (OHPR), the applicant for this grant program, is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. OHPR, within the Oregon Health Authority, will staff the Oregon Health Policy Board and work closely with the Governor's office, the Legislature, the other health divisions within the Authority, and the Department of Consumer and Business Services' Insurance Division. OHPR carries out specific tasks assigned by the Legislature and the Governor; provides reports and conducts analyses relating to health care costs, utilization, quality, and access; and provides staff support to health care advisory bodies including the Oregon Health Policy Board, HITOC, Health Services Commission, Health Resources Commission and the Medicaid Advisory Committee. OHPR also has extensive grant management experience, having received prior funding from the HRSA State Planning Grants, the Robert Wood Johnson Foundation State Coverage Initiatives and Changes in Health Care Financing and Organization Programs, the Center for Health Care Strategies, the David and Lucille Packard Foundation, the Ford Foundation, and the Northwest Health Foundation.

Key Personnel: Jeanene Smith, MD, MPH, Administrator; Sean Kolmer, MPH, Deputy Administrator

Governor's Office: Governor Ted Kulongoski has provided strong support for the development of statewide HIE from his office, forming the Health Information Infrastructure Advisory Committee (HIIAC) by Executive Order in March 2008 with the purpose of developing recommendations to utilize health information technology to support and advance the state's broad health reform objectives. Those recommendations were integrated into the HIE directive in HB 2009 as part of the state's overall approach to achieving substantive health reform.

Key Personnel: Dawn Bonder, JD, Senior Policy Advisor, Former Co-Chair of HIIAC

Participating Stakeholders and Key Partners: Oregon has always had an extensive public engagement process in developing health policy. In addition to the broad representation on the HITOC, this project will be undertaken in partnership with key healthcare stakeholders, including Oregon's health systems and hospitals, healthcare providers and their associations, the state's commercial insurance plans as well as its Medicaid managed care plans, educational institutions, the Tribal communities, labor organizations and consumer advocates. These stakeholders are integral to aligning the state's regional efforts in advancing EHR adoption and interconnectivity.

The Oregon HIE development will include a strong focus on measuring improvement in the quality of health care through Oregon's Quality Corporation, a multi-stakeholder nonprofit group who brings significant experience as a Robert Wood Johnson Foundation Aligning Forces for Quality grantee. Additionally, Oregon Health Network, (OHN) will complement the Oregon HIE project by working simultaneously to expand broadband capacity across the state, particularly in Oregon's rural and frontier areas. OHN is a nonprofit public benefit corporation supporting telemedicine and health care education through broadband expansion, and is the recipient of a \$20 million grant from the Federal Communications Commission (FCC) for the Rural Health Care Pilot Program (RHCPP).

This project will work closely with the Regional Extension Center applicant, OCHIN, Inc. OCHIN is a health center controlled network (HCCN) of community health clinics and small practices serving the medically underserved with seventeen members in Oregon, eight members in California and one in Washington. OCHIN provides practice management and electronic medical record (EMR) services to member organizations. OCHIN has submitted a letter of intent for the Regional Extension Center funding opportunity, with partnership from Oregon Health & Science University (OHSU), Oregon's major medical training center and an internationally recognized leader in the field of medical informatics.

Domains of Capacity:

Over the past few years, Oregon has convened several official stakeholder forums to understand the Oregon landscape of HIT adoption and interconnectivity beginning with the initial recommendations in 2005 by the Health Policy Commission, as well as the state's participation in the national Health Information Security and Privacy Collaboration (HISPC), and, most recently, through the work of the HIIAC. In addition, the state surveyed providers and health clinics in 2006 to determine rates of EMR adoption with strong statewide participation. That survey found that EMRs were present in 26.8% of the practices/clinics serving 52.8% of nonfederal clinicians. A more recent survey and broader environmental scan will be completed this month.

Legal and Policy HIE capacity: Oregon's HISPC work focused on consumer engagement in privacy and security of health information. As part of this work, Oregon's HISPC team identified privacy and security best practices, and conducted an initial analysis of state privacy laws protecting special classes of patient information. This analysis was presented as part of the HIIAC final report.

Governance capacity: In November 2008, the HIIAC put forth recommendations for employing health information technology to advance Oregon's health reform goals. Its work included a review of potential operational governance structures for HIE in the state. HIIAC recommendations will serve as a starting place for the strategic planning process when the HITOC begins official meetings in early October. The legislatively created HITOC supplants the HIIAC, but many of the members of HIIAC will be serving in key workgroup functions for the HITOC. In addition to the governance work of the HIIAC, other regional groups (described below) have studied various governance structures for regional HIE, and their work will be informative to the upcoming strategic planning process.

Business and Technical Operations capacity: On December 9, 2008, DHS replaced the previous Medicaid Management Information System (MMIS) with one that is technically more modern and functionally superior to the previous MMIS, and meets State of Oregon and federal government functional and business requirements, including HIPAA. The new MMIS provides Oregon a potential scalable platform to enable major portions of the Oregon HIE strategy as we define the current and future operational state of Oregon's Medicaid information systems using the Medicaid Information Technical Architecture process defined by CMS. Oregon is also procuring a Behavioral Health EHR solution as part of the Oregon State Hospital replacement. This solution has the potential to position Oregon for a broader community and provider-based EHR as part of the HIE strategy. Additionally, Oregon's Medicaid program has just completed extensive planning for, and design of, the electronic Health Record Bank of Oregon (HRBO) including the recent selection of vendors. The HRBO is funded by a CMS Medicaid Transformation grant.

In addition to efforts made by the state Medicaid program, planning and consensus building around HIE have occurred in three major population centers in Oregon and demonstrate the diverse, private sector engagement in HIE. Recently, consensus has been reached by six organizations in the Portland metropolitan area including hospitals, clinics, and health systems, for an exchange of standardized care summary documents. Significant progress on the development of a technology strategy and business plan has occurred between community stakeholders in Marion-Polk County, with decisions on the formation of the Salem Area Community Health Information Exchange (SACHIE), expected in late 2009. And, in Central and Eastern Oregon, various organizations including the largest health system and other providers have resumed active HIE planning with recommendations expected before the end of the year.

Technical Infrastructure capacity: Oregon's development and implementation of statewide HIE will capitalize on the expertise and motivation behind several burgeoning local HIE efforts. Two examples which may serve as leverage points for partnership within Oregon and our border states are OCHIN and the Providence Health System. As an Organized Health Care Arrangement (OHCA) under HIPAA with a single record per patient, OCHIN also functions as an HIE among the member organizations. The OCHIN master patient index contains information on 600,000 lives across California, Oregon and Washington.

The Providence Health System is the largest health care system in the state, with seven hospitals and various clinical settings throughout the state. Providence is currently implementing a standard-based HIE to connect their inpatient EMR with their outpatient EMR systems serving employed physicians and affiliated partners. When fully implemented, the Providence-led HIE will contain information on more than 2 million lives and will allow connection with other community partners such as OCHIN, Oregon Health & Science University, Kaiser Permanente and Legacy Health System, a five-hospital system in Oregon and Southwest Washington. In addition, Providence will have the ability to connect across the border to Southwest Washington Medical Center in Vancouver.

Two other regional examples are located in Southern Oregon. The Mid-Rogue Independent Physician Association has partnered with a regional health system, Asante, to exchange patient data and is currently selecting an HIE vendor, with intentions of connecting to other entities in that region. Finally, the Umpqua OneChart HIE is providing the foundation for a common EHR system that interfaces with the local hospital in Roseburg, Oregon, surrounding clinics and providers, and has collaborated with the local Veteran's Administration's hospital to allow patients access to the HIE. The Umpqua OneChart HIE currently contains approximately 220,000 lives.

Finance capacity: From late 2005 through Spring of 2007, the Oregon Business Council commissioned a series of efforts to evaluate the opportunities for HIE pilot projects and model various financing scenarios at the regional level, with a vision of a statewide scope. The work included detailed analysis of the potential savings and value propositions in the context of that timeframe; a different environment than under an enhanced payment structure for hospitals and providers with ARRA funding. However, the analytical tools and research methods used for the earlier analysis are applicable with the new variables offered by this national initiative, and the HITOC will have considerable data to review and assess as it develops the state strategic and operational plan for HIE.

In the Public's Interest: Leveraging HIE to Advance Health Reform:

After years of public and private collaboration, stakeholder input, and strong executive and legislative leadership, the Oregon Legislature passed a monumental health reform package in June 2009, House Bill 2009 (HB 2009). Guided by a Governor-appointed citizen board (the Oregon Health Fund Board) with over 100 volunteer committee members, the comprehensive health reform plan, titled “*Aim High: Building a Healthy Oregon*” united citizens and stakeholders of both the public and private sectors around a sequenced plan to improve the quality of health, access to care and improved efficiency in the health care system.

The purpose of the ORHIE project is to strengthen the state’s ability to pursue coverage expansion as a major component of reform based on the “Triple Aim” of health reform:

- To improve population health;
- To improve patient experience with care; and
- To contain per capita costs in the health care system.

The ORHIE project and the deliverables in the FOA are integral tools for Oregon and the nation to transform the healthcare delivery system by improving quality, access and efficiency in health care settings. Oregonians have been actively involved in the development of the comprehensive health reform plan resulting in HB 2009 and are watching closely as the state implements those reform initiatives, including the key strategies for widespread adoption of electronic medical records and meaningful health information exchange. The ORHIE project will also include the public at every interval, and they will help to shape the outcome. The state will engage the public around privacy and security issues, by providing outreach, education and information about the value of personal health records and electronic health information exchange, and in focused discussions as the strategic and operational plans develop. Oregon is the steward of health services for several vulnerable populations, and their interests will be an important component of consideration in HIE design and implementation. The Oregon Health Fund Board had a focus on health disparities, working to include efforts in all of its recommendations to achieve true health equity across for all of Oregon’s citizens. This same approach will be a vital component of the HITOC and its work in this project.

The State HIE Cooperative Agreement Program provides an extremely timely funding opportunity, which will better enable Oregon to develop a long-term vision with a strategic and operational plan for statewide interoperable HIE in Oregon and across our state borders that will align with Oregon’s triple aim approach to overall health reform. This vision will be directly in line with the goals of the Office of the National Coordinator and with the American Recovery and Reinvestment Act in realizing the full potential of electronic HIE to improve the coordination, efficiency and quality of health care.

The State of Oregon wishes to thank the Office of the National Coordinator for the opportunity to pursue funding under this FOA to advance the statewide HIE infrastructure for the purposes of improving the quality and effectiveness of health care delivery in Oregon. We intend to apply for the planning phase of the Cooperative Agreement by October 16, 2009, and then work diligently to develop Strategic and Operational Plans for statewide HIT adoption, meaningful use, and HIE proliferation.

Sincerely,



Jeanene Smith, MD, MPH
Administrator
Office for Oregon Health Policy and Research.



September 7, 2009

Dr. David Blumenthal
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Ave. SW, Suite 729-D
Washington, DC 20201

Re: Oregon Health Information Technology Regional Extension Center (OHITREC)

Dear Dr. Blumenthal,

It is with great pleasure that we submit this preliminary application to the Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program to develop an *Oregon Health Information Technology Extension Center (OHITREC)*.

Oregon's vision is to use Health Information Technology (HIT) as a catalyst to transform the delivery of primary care services to patients across our state, and beyond. While Oregon has one of the nation's highest rates of Electronic Health Record (EHR) adoption – nearly 60 percent – we fully recognize that installing EHRs is just the beginning of the transformation process and that this experience will become the basis for assisting the remaining 40 percent of clinics – who we expect to be the most difficult to implement. In addition to providing real-time point of care information about the right patient at the right time, HIT is the vehicle that can offer clinicians, health systems, and policy makers information that will prove pivotal to the future of our healthcare system and healthcare workforce.

The proposed *Oregon Health Information Technology Regional Extension Center* leverages the proven abilities of two lead partners – OCHIN (the applicant) and the Oregon Health & Sciences University (OHSU) – as well as the combined experience of several core, community, and technical partners who are collectively working to improve the quality of care provided to residents throughout Oregon, our region, and the nation. Given our long-standing commitment to finding creative healthcare solutions, and our proven track record of achieving implementation and meaningful use of HIT solutions in our state, OCHIN and its partners eagerly embrace the opportunity to become a designated health IT Regional Extension Center serving the State of Oregon. In so doing, we seek to position Oregon as a test bed for technology-driven transformation of health care in our region and, in collaboration with the national Health Information Technology Research Center (HITRC), across the nation.

As the lead applicant, OCHIN brings to the table our unique, long-term experience providing high quality EHR implementation, support, ongoing system maintenance, and optimization of the system to support priority providers and practices. We have substantial experience implementing and supporting Practice Management (PM) and EHR systems and their modules and we have learned how to create the most effective technology solutions. We also have an exceptional record of accomplishment and deep commitment to building capacity among our members to use EHRs in meaningful ways. We work diligently to ensure that our most vulnerable populations receive optimal care. Our practice is completely in line with our mission: *"To improve the health of the medically underserved by transforming the medial delivery system through the best use of information and information technology."*

Oregon Health Information Technology Regional Extension Center – A Statewide Model

Over the past nine years, OCHIN has developed the technical and operational capacity to provide and sustain a comprehensive program of HIT implementation and support services that benefit Safety Net Clinics and small practices throughout Oregon, California, and Washington. OCHIN has implemented PM and EHR systems in more than 200 physical locations that together comprise one of the largest collaborative networks of community health centers (in both rural and urban areas), Federally Qualified Health Centers (FQHCs), FQHC look-alikes, rural health centers, school-based health centers, and mobile health clinics on the West Coast.

As a not-for-profit Health Center Controlled Network (HCCN), OCHIN works to enhance its member clinic practices via the installation and use of HIT systems that are designed to improve the health outcomes of the medically vulnerable patients our members serve. Our initial focus on the installation and maintenance of technology solutions was geared to improve clinical workflows, optimize billing, and streamline reporting in a concerted effort to improve provider productivity. However, OCHIN quickly realized the opportunity to leverage HIT as a crucial tool for generating information, supporting research, and coordinating the development and delivery of education and workforce training that supports provider efforts to directly improve the quality of care delivered to patients.

As a result, our current EHR systems are being optimized to improve provider proficiencies and to give them access to the best information. We recognize the value of this understanding and the need to share these learnings with other areas of the state. Moreover, we are working with many partners to develop and support ongoing education and training that enables providers to use those systems to generate new knowledge that can be used to improve quality at the point of care. We have never had a failed implementation and the Health Services Record Administration (HRSA) often commends us for our leading efforts to pioneer the development of comprehensive EHR care systems, including behavioral and mental health and dental functionalities that enable providers to take an integrated approach to diagnosis and treatment. It is precisely this investment in experience and knowledge that we want to share with all users of any EHR system.

We fully understand how to use technology as a catalyst for transforming care, and we are partnering with one of the leading educational institutions in the country, OHSU, to develop strategies to strengthen the fragmented primary care delivery system through a coordinated program of technology, information, and education to help existing providers use technology more meaningfully and to develop the 21st Century healthcare workforce.

We have built solid relationships in the research arena with prestigious researchers and institutions focused on analysis and evaluation designed to improve the quality of care and inform relevant policy questions and implications with an emphasis on proactively managing chronic diseases, data aggregation and population management, and providing preventive care. The collaborative development of the Safety Net West practice-based research enterprise represents a crucial step in engaging clinicians in quality improvement activities and an evidence-based culture in primary care practice to improve the health of medically underserved patients throughout our region.

We understand the importance of building and leveraging economies of scale. We have built our organization on a business structure that generates sufficient program income to sustain our operations in a market where others have struggled. We have reduced our reliance on grant funding to less than 27 percent of our annual budget while steadily increasing our implementation, optimization, quality improvement (QI), and research capabilities.

We recognize that while technically complicated and expensive, the installation and support of HIT tools is only part of the larger challenge regionally and nationally. Our collective focus on supporting translational research, institutionalizing best practices, and advancing QI and care transformation strategies helps practicing providers use medical informatics to create the foundation to transform primary care practice. Our collaborative implementation and ability to provide robust, vendor neutral technical assistance positions us to effectively support and train thousands of providers who are continuously learning to use these systems to deliver improved levels of care.

The *Oregon Health Information Technology Regional Extension Center* partners have the proven record of accomplishment to facilitate meaningful use of HIT throughout our state and, in so doing, to serve as a national model for assisting providers in becoming meaningful users of certified EHR technology. This includes improving provider productivity through the effective use of technology, stimulating research and innovation across the primary care enterprise, and facilitating the adoption and meaningful use of HIT through continued education and workforce development.

Our partners share our collective vision and are committed to working together to realize the value of HIT to transform the quality of care delivered to our nation's medically vulnerable populations. For these reasons, we believe that it is critically important that the *Oregon Health Information Technology Regional Extension Center* receive federal support through the initial round of funding.

Oregon Health Information Technology Regional Extension Center – A Partnership Effort

OCHIN

OCHIN, Inc. is a fast-growing collaborative currently comprised of 28 federally qualified health centers (FQHC), FQHC look-alikes and rural health centers located throughout Oregon, California, and Washington that are collectively committed to improving the health of the medically underserved through the best use of information and information technology. As an HCCN, the majority of OCHIN's board members are executives from member health centers that we are organized to assist, which gives us direct access to the best possible understanding regarding the unique challenges facing primary care providers across a range of practices.

OCHIN has gained substantial experience working with large and complex county organizations and community-based practices focusing primarily on primary care and behavioral health services in critical access areas. Over the past nine years, the OCHIN collaborative, which operates much like a co-operative, has successfully implemented, supported, and optimized the use of HIT – with an emphasis on PM and EHR systems – across a region that includes over 28 distinct community health centers comprised of over 200 physical locations. Through this network, OCHIN currently supports 1,927 primary care clinicians providing services to more than 685,000 unique patients (over 5 million visits since 2003) in multiple states.

The populations we serve are heavily weighted toward those with limited resources. In 2008, 91% of patients served were below 200% of the federal poverty level; of these, 30% were uninsured, 48% were Medicaid, and 11% were primary Medicare. Hispanic patients made up 30% of the patient population; African Americans, 7%; white non-Hispanic populations, approximately 60%. A significant proportion of patients of all races were recent immigrants whose primary language was not English.

With support from the Health Records Services Administration (HRSA) Office of Health Information Technology (OHIT), OCHIN has successfully implemented PM and EHR systems in clinics that help providers reach and serve the most medically vulnerable patients throughout Oregon's fast-growing urban and sparsely populated rural communities. As one of the most successful HRSA Office of Health Information Technology grantees, we are recognized not only for our 100 percent success rate installing and supporting EHRs in community health centers, but also for our ongoing optimization of our PM and EHR systems in a collaborative manner (clinical, technical, research and leadership levels). In all areas, our work is designed to incorporate best practices and optimize system functionality. This approach enables us to ensure that our member providers use the best systems and practices to provide the highest quality of primary care provided to their patients.

OCHIN has substantial experience reaching and serving priority practices through a collaborative and innovative approach to EHR implementation:

- OCHIN, in collaboration with its member organizations and the Oregon Clinical and Translational Research Institute (a CTSA collaboration of Oregon Health & Sciences University and the Kaiser Center for Health Research), has established the AHRQ-registered Safety Net West Practice-based Research Network (PBRN), consisting of the clinic and clinician members of OCHIN;
- OCHIN is currently co-developing a software product, HMS Solutions, that aggregates data from a variety of EHR vendors and other products including scheduling, billing, lab, population/disease management systems, and pharmacy IT systems, etc. Solutions performs calculations on the data, applies expertise, and presents the results in a common format that enables health care providers to manage quality improvement and stakeholders to use it for decisions and actions;
- OCHIN has contracted with Surescripts, the country's largest electronic prescribing network. Used in all 50 states, the Surescripts network connects prescribers through their choice of e-prescribing software to the nation's major chain pharmacies, the nation's leading payers, and independent pharmacies nationwide;
- OCHIN has developed internally an HL7 interface engine that augments the functionality of EHR and third party interfaces delivered through commercial off-the-shelf (COTS) products. This enables the sharing of relevant clinical information internally and with external entities – the initial steps in rolling out a regional Health Information Exchange (HIE).
- OCHIN is building on our experience and developing technology tools that transcend the primary care practice through the integration of behavioral, mental, and dental functionality in EHR systems; and,
- OCHIN is currently providing support and assisting in the execution, installation, and use of Personal Health Records (PHRs) for all Medicaid patients across the State of Oregon.

Oregon Health & Science University

Capitalizing on OCHIN's close working relationship and strong history of collaboration with the Oregon Health & Science University (OHSU), the state's only academic health center, *Oregon's Health Information Technology Regional Extension Center* will leverage the collective strengths of its Department of Family Medicine (OHSU FM) and Department of Medical Informatics and Clinical Epidemiology (DMICE) to train and support providers to effectively use EHR systems to transform primary and other health care services.

As the only academic health center in the nation with a school of science and engineering focused exclusively on human and environmental health, OHSU is dedicated to improving the health and quality of life through excellence, innovation, and leadership in health care, education, and research. These two OHSU departments have complementary portfolios in the area of providing these services and both are national leaders in their own fields.

OHSU has implemented EHRs for more than 2,000 providers, led quality improvement and practice redesign efforts for more than 1,500 providers, and trained over 1,000 providers in informatics through programs like "10x10," an OHSU initiative intended to train 10,000 clinicians in informatics by 2010. OHSU is nationally renowned for its leadership and innovation in teaching clinical informatics via distance learning, which enhances our ability to provide services to small practices throughout our State.

OHSU Family Medicine has a 38-year history of training family physicians to practice in our state and to assume positions of national and international leadership in the specialty of family medicine. The department plays a

major role in the continuing education of family physicians throughout the Northwest, with nearly 300 Oregon family physicians having academic appointments on the department's faculty. OHSU family Medicine is recognized for its work in preparing the primary care workforce for 21st century practice and has established working relationships with family physicians from over one-half of the state's primary care practices, ranging from large groups to solo rural practices.

- OHSU FM has 14 faculty members conducting extramurally funded research that falls into four core programs: evidence-based family medicine with an emphasis on systematic evidence reviews and comparative effectiveness research; educational research, including work on the evaluation team for the national P4 residency curriculum innovation project; health policy and health services research that leverage strong partnerships with the Oregon State Office of Health Plan Policy and Research; and a research program in primary care practice transformation.
- OHSU FM has 75 primary faculty members who are located in Portland and in their affiliated residency program in Klamath Falls, Oregon. In addition, they have over 350 volunteer faculty located in communities throughout the state. In latest edition of U.S. News & World Report ranks the department second among the nation's academic family medicine departments.

OHSU's Department of Medical Informatics & Clinical Epidemiology (DMICE), an academic and research department in the OHSU School of Medicine, is at the cutting edge of training leaders in the information sciences. The department, founded in 1989, was one of the first of its kind in the world. Today, its faculty are known for their pioneering work in the field and emphasis on the blend of teaching, research, and service, which uniquely positions DMICE to be both leaders and innovators in medical informatics and clinical epidemiology. DMICE faculty have exceptional experience in helping practices achieve meaningful use of their HIT through various grant-funded programs and are currently ranked among the top five family medicine programs in the country.

- OHSU DMICE has trained more than 2,000 providers, and has already successfully worked with hundreds of others on site to help them achieve meaningful use.
- The DMICE chair, Dr. Bill Hersh, and his colleagues are known for their leadership in informatics workforce development, education, interoperability, and information exchange. The department has deep expertise in HIT quality (e.g., Dr. David Dorr, Dr. Paul Gorman, and Dr. Judy Logan), health information management (Dr. Joanne Valerius), and assessment of the implementation and use of health information technology (Dr. Joan Ash and others) in America.
- The Care Management Plus (CM+) initiative, lead by Dr. David Dorr, is a program of primary care redesign that has trained more than 78 clinical teams to achieve meaningful use of their EHR systems by enhancing quality metrics, improving care coordination, and focusing on patient and family engagements. Studies have shown that CM+ has helped achieve significant improvements in quality and safety as well as cost savings through reduced hospitalizations.

DMICE sponsors graduate programs in medical informatics while OHSU family Medicine is a clinical department with a four-practice clinical delivery system. Two of those clinics are currently using the OCHIN record system and are fully integrated into the same data system as most of Oregon's Safety Net. DMICE, OHSUFM, and OCHIN all collaborate closely with the Kaiser Permanente Center for Health Research (KP CHR) and we are working on a formal research affiliation to learn from the database OCHIN is creating.

OHSU Oregon Practice-based Research Network

Complimenting our core technology, education and informatics expertise, the Oregon Rural Practice-based Research Network (ORPRN) has established a foundation for practice transformation based on the extension center principles using Practice Enhancement and Research Coordinators (PERC) as practice facilitators. Through

the PERC role, ORPRN has built durable relationships with these small, rural clinics and is actively supporting and working together with groups of primary care clinicians to answer community-based health care questions and translate research findings into practice. ORPRN engages clinicians in quality improvement activities and an evidence-based culture in primary care practice to improve the health of all patients they serve. ORPRN PERCs live in rural Oregon and work directly with the clinics, implementing research studies, quality improvement projects and leading practice change activities.

Many clinics have come to see the PERC as part of their practice team. In a current study, PERCs worked with information technology, billing and nursing personnel to create reports from electronic systems using national quality measures. ORPRN's reach extends to individual and small group practices, community health organizations, critical access hospitals, FQHCs and rural health clinics where resources are limited and the population is at risk. ORPRN's on-the-ground relationships will greatly enhance training efforts by increasing uptake and providing personnel to work alongside clinicians and staff to demonstrate meaningful use of HIT systems.

- Founded in 2002, ORPRN currently represents 157 primary care providers in rural Oregon, with more than 90% serving in clinics with less than 10 providers. These providers care for over 235,500 patients in Oregon, many of whom are uninsured or under-insured. Approximately half of these providers lack an electronic health record, and those having HIT report a lack of trained personnel to configure, maintain and navigate the systems.

Combining OHSU's unique and world-class research, education and workforce training centers with OCHIN's experience in technology and widespread, multi-level collaboration will enable the OHITREC team to greatly improve the capacity of existing providers and prepare the future workforce to effectively use HIT to advance the transformation of primary care practice in our state and the nation.

Additional Partners

A successful proposal and Regional Extension Center is dependant on effective partnerships. OCHIN has substantial working relationships with several public and private partners throughout the State who will be instrumental in facilitating the delivery of the proposed services to priority primary care providers throughout Oregon. In addition to OHSU, ORPRN and a number of Independent Physician Associations (IPAs), we also have strong and growing working relationships with health plans (e.g., CareOregon and Regence BlueCross and BlueShield of Oregon), hospital systems (OHSU, Kaiser Permanente, Legacy and various critical access hospitals), medical professional societies (e.g., American College of Physicians and the Oregon Medical Association), community colleges (Portland Community College), state and tribal organizations (including Multnomah, Benton, Tillamook and Deschutes county health departments, which are all OCHIN members), primary care associations (e.g., the Oregon Primary Care Association and Mid Valley IPA), local QI organizations (e.g., Accumentra and the Oregon Healthcare Quality Corporation (QCorp), as well as committed technology partners (e.g., CDW and Polar Systems), among others. We look forward to solidifying working relationships with even more partners during the development of the full proposal outlining our statewide initiative.

We are currently strengthening our working relationships with a number of Oregon-based Independent Physician Associations (IPA's) who will be crucial partners in helping us ensure that the extension effort will enhance the use of various EHR systems among their members. The IPAs support and use multiple vendor products and systems. The IPA physicians represent a critical link to serving the state's urban and rural residents who do not seek care in either the major hospitals or community health centers, especially those in sparsely populated rural areas. Oregon IPA physicians serve roughly 20 percent of the state's population. Since 2005, they have collectively been working to implement multiple vendor EHR systems and are actively engaged in providing a comprehensive and personalized approach to HIT that encompasses their entire range of practice. It is our intent to use and share their experience in an effort to bridge statewide interoperability issues.

- The Mid Valley IPA (MVIPA), for instance, supports more than 240 primary care providers (nearly 600 providers overall) who serve approximately 10 percent of Oregon’s population, over 90 percent of whom work in clinics with fewer than 5 providers.

Collectively, *Oregon’s Health Information Technology Regional Extension Center* partners have the right orientation and expertise to ensure that the regional extension center is successful in Oregon and, by implementing our vision for the transformation of primary care, are uniquely prepared to collaborate with HITRC to share knowledge with other regional extension centers ensuring success throughout the nation. Our shared vision will be realized through the substantial commitments already made by all of the partners who are collectively dedicated to working together to realize the value of HIT to transform the quality of care delivered to our nation’s medically vulnerable populations.

Request for Support – A Solid Investment in Oregon and our Region

As the process of health care reform proceeds in America, it is becoming clear that our nation’s primary care system must be both expanded and transformed to meet the demands of our country. This means that we need more primary care providers, but, more importantly, we need a new model of primary care provider, armed with new skills and better equipment for the job at hand. The EHR is a necessary tool for the patient-centered medical home, which requires proper training and implementation to produce the desired effect. Thus, a partnership between Oregon’s most experienced organization at bringing health information technology to small safety net practices (OCHIN) and the state’s health science university (OHSU) and other partners such as the IPAs is exactly the right combination to bring about this transformation.

We are committed to maximally leveraging our collective capabilities to help upwards of 40 percent of the nearly 7,582 primary care providers throughout Oregon to achieve meaningful use of their EHR systems and, by so doing, achieve greater capacity for quality improvement, electronic exchange of health information, and primary care transformation.

We were excited to learn that the federal government is committed to supporting the process of primary care transformation in this way and we stand ready to make this vision a reality in Oregon, and beyond.

Sincerely,



Abigail Sears
CEO

Oregon Health Information Technology Environment Scan

Summary Matrix – updated October 2009

Working and Evolving Draft 10/6/2009

PURPOSE: This summary matrix is intended to provide a high-level overview of Oregon's health information technology environment for the purpose of informing stakeholders and policy-makers as they contemplate development of an Oregon HIT plan to facilitate electronic health record (EHR) adoption, health information exchange and interoperability. This document is a compilation of information from multiple sources, surveys and interviews. Supporting documents and reports will be made available as they are completed to provide additional detailed information. This document and the environmental scan is a work in process that will evolve over time as additional information is developed. Corrections and suggestions are encouraged.

Oregon HIT Environmental Scan: The environmental scan is being undertaken by the Oregon Office of Health Policy and Research on behalf of the Health Information Technology Oversight Council. The scan involves a number of components including:

- Oregon 2009 Ambulatory EHR Survey
- Oregon HIT Assessment, 2009: Hospital and Health System Survey
- Oregon HIT Assessment, 2009: IPA Survey
- Oregon HIT Assessment, 2009: Health Plan Survey
- Department of Human Services HIT Environmental Scan
- Potential ARRA incentive payments to Oregon providers demonstrating meaningful use
- Tracking of e-prescribing adoption and use in Oregon
- Assess the role of two major Federal grants on Oregon HIT planning: Health Record Bank of Oregon (Medicaid Transformation Grant) and Oregon Health Network (FCC communication infrastructure).

Other elements and assessment will be added to the scan as the needs become apparent.

ENVIRONMENTAL SCAN HIGHLIGHTS

Ambulatory EHR Adoption: The 2006 Oregon Ambulatory EHR Inventory provides a baseline for tracking EHR adoption in region ambulatory care settings. The 2006 survey report is available at <http://www.oregon.gov/OHPPR/docs/OR2006EHRSurvey.pdf>. The 2009 Oregon Ambulatory EHR Inventory updates the earlier survey and collects additional information of the functionality of EHRs in ambulatory care setting. Complete results from the 2009 are not yet available.

Oregon Health Information Technology Environment Scan Summary Matrix – updated October 2009

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
Overall		<p>2006 Survey: 53% of Oregon (non-federal) clinicians (MD/DOs, PA/NP/CNMs) work in practices or clinics where EHRs are present compared to 29.2% nationally. Practices and clinics with EHRs represent just 27% of Oregon practices/clinic organizations. Higher EHR adoption rates occur in health systems and affiliated practices, large practices, practices with multiple locations and multi-specialty or mixed primary care practices.</p> <p>2009 Preliminary Results: 70% of Oregon (non-federal) clinicians work in practices or clinics where EHRs are present compared to 38% nationally (CDC-2008). 39% of surveyed practices and clinics have EHRs. 44% of Oregon clinicians are in practices using an EHR with all “basic” functions compared to 13% nationally (NEJM 2008). 10% of Oregon clinicians are in practices with “fully functional” EHR compared to 4% nationally (NEJM 2008). By 2011 respondents forecast that 46% of practice organizations will utilize an EHR covering 72% of clinicians.</p>	<p>2006: lower adoption rates in small practices, the major reasons listed by practices not planning to adopt EHRs are expense and satisfaction with paper records.</p> <p>2009: Oregon remains well ahead of national adoption of EHRs.</p> <p>Barriers to adoption remain: cost, ROI & perceived value especially in solo and small practices</p>
Clinician Organizations - MD/DOs, PA/NP/CNMs		<p>2006 Survey: 27% of physicians-owned/operated practices (36% of clinicians) were using an EHR ranging from 21% for solo practices to 50% of practices with 10 or more clinicians. Respondents projected EHR adoption to increase to 52% of practices (72% of clinicians) by 2008 ranging from 34%% for solo practices to over 80% of practices with 10 or more clinicians.</p> <p>2009 Preliminary Results: 38% of physician-owned/operated practices (58% of clinicians) are using an EHR, ranging from 26% for solo practices to 61% of practices with 10 or more clinicians.</p>	<p>2006 and 2009 Issues include EHR Adoption:</p> <ul style="list-style-type: none"> - practices without an EPM - practices with EPM, no EHR - self-developed EHR apps EHRs not certified - non certified products - current EHR version not certified

Oregon Health Information Technology Environment Scan Summary Matrix – updated October 2009

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
FQHCs - Safety Net Clinics	23 FQHCs & other safety net clinics	<p>2006 Survey: EHRs were in use by 30% of 27 responding organizations involving 35% of clinicians covered by the responses. The clinics projected that 71% of the clinics and 77% of the clinicians would have EHRs in 2008.</p> <p>2009 Preliminary Results: EHRs are in use at 56% of the 25 responding organizations in 65% of clinicians covered by the responses.</p>	<p>2006 and 2009: FQHC adoption enhanced by funding mechanisms for FQHCs and HRSA grant support.</p> <p>Most FQHCs without an EHR have implemented and EPM and well positioned for EHR adoption.</p>
Public Health, Mental Health, Tribal, College and Other Clinics		<p>2006 Survey: EHRs were in use by 20% of 49 responding organizations involving 42% of clinicians covered by the responses. The clinics projected that 46% of the clinics and 81% of the clinicians would have EHRs in 2008.</p> <p>2009 Preliminary Results: EHRs are in use by 22% of the 50 responding organizations involving 37% of clinicians covered by the responses.</p>	<p>2006 and 2009: Major funding issues impact EPM and EHR adoption.</p>
Health systems practices and clinics		<p>2006 Survey: Kaiser and VA have been fully implemented EHRs for some time. OHSU was implementing EHRs in its ambulatory settings. Other health system clinics and practices covered by 23 responses indicated EHR use in 52% of the clinics covering 95% of clinicians covered by the responses. The other health systems projected that 91% of the systems and 98% of the clinicians would have EHRs in 2008.</p> <p>2009 Preliminary Results: 70% of practices and clinics (90% of clinicians) owned or operated by health systems are using EHRs. The larger health systems with practices and clinics (Kaiser, OHSU, PeaceHealth, Providence, Samaritan Health, Veterans Administration) have comprehensive ambulatory and hospital EHR systems. Legacy will complete a comprehensive implementation in 2010.</p>	<p>2006 and 2009: Large health systems with owned or affiliated practices have made substantial EHR commitments.</p>

Oregon Health Information Technology Environment Scan Summary Matrix – updated October 2009

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
EHR & EPM Products and Vendors		2009 Preliminary Results. Nearly all practices use the same vendor and product for their EPM and EHR systems. Approximately 81 companies have EHR systems in use Oregon and 106 companies provide EPM systems. 16 vendors provide EHRs for 90% of clinicians (68% of organizations). 80% of organizations (90% of clinicians) are using EHR products from a vendor that has CCHIT certified products. Not all products in use are certified (old versions) and not all product lines from a vendor with a certified product are certified. There are a number of specialized EPM & EHR systems in specialty/sub-specialty practices that are not certified products.	A number of products are not certified and may or may not be certified in the future. Many practices may need to upgrade or change EHR products to qualify for meaningful use.

Hospital & Health System EHR Adoption: An Oregon Hospitals and Health Systems HIT Inventory is currently underway to provide information for Oregon's HIT planning process regarding EHR adoption and the functionalities of operational EHR systems.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
Acute Care Hospitals	58 acute care hospitals	2009 survey: Preliminary survey results indicate that the 47 of Oregon's 58 acute care hospitals have or are implementing EHRs by mid 2010. These 47 hospitals represented 95% of 2008 Oregon hospital discharges (348,883). The EHRs are provided by nine vendors that all have products certified by CCHIT. Not all currently installed products are certified products or versions. All eleven hospitals without EHRs are planning implementations: six hospitals within 1-2 years and five hospitals in 2-5 years.	Several health systems and hospitals upgrading systems. Delayed EHR implementation limits the potential for ARRA incentive payments.
Critical Access Hospitals (CAH)	25 CAH hospitals (subset of 58 acute hospitals)	2009 survey: Preliminary survey results indicate that 17 of Oregon's 25 CAHs currently have an EHR system. These 17 hospitals represent 76% of 2008 Oregon CAH discharges (29,277). EHRs at Oregon CAHs are provided by seven vendors. All the vendors offer CCHIT certified product although not all currently installed products/versions are certified. All eight CAH hospitals without EHRs are planning implementations: five hospitals within 1-2 years and three hospitals in 2-5 years.	Gap: eight of 25 CAHs are at least 1 to 2 years away from implementing hospital EHRs.

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Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
Multi-hospital Health Systems	35 hospitals in 9 systems (subset of 58 hospitals)	2009 survey: Preliminary results indicate that 30 of the 35 hospitals in the nine hospitals systems have implemented EHR systems. Five hospitals in two multi-hospital systems are planning EHR implementations: three hospitals in 1 to 2 years and two hospitals in 2 to 5 years. By early 2010 seven health systems will have robust deployments of certified EHRs covering all the hospitals in their systems (27 hospitals).	
Health Systems with Hospitals and Practice Groups	Kaiser, Legacy, OHSU, Providence, Peace Health, Samaritan Health, Veterans Administration	Seven health systems in Oregon include hospital operations and an owned or operated medical group practice or employed physicians and other clinicians. All seven systems have or will shortly have (early/mid 2010) robust and certified EHR systems covering both hospital and other practice operations.	

Health Information Exchange Activities: Identification of the scope of existing and planned health information exchange functions is a major goal of the 2009 HIT environmental scan and necessary to developing a statewide HIE strategy. Responses from the 2009 Hospitals & Health System HIT Survey and IPA HIT survey provided information on Oregon HIE activities. Also see the latest version of the Oregon HIE Activities Report at <http://www.oregon.gov/OHPPR/HITOC/index.shtml>.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Comments
HIE planning		Planning efforts Portland and central Oregon occurred in 2007. Current planning efforts include Central Oregon, Mid Columbia Gorge, Portland area, Salem area and discussions among Epic users.	See the Oregon HIE Activities Report for additional information.

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Domain	Scope	HIT Adoption or Role in HIT Adoption	Comments
Health Systems		Health systems with multiple hospitals or hospitals and affiliated medical groups are functionally operating health information exchanges within their health systems. Examples include Cascade Health (four hospitals), Kaiser Permanente (hospital and multiple clinic locations), Providence Health and Service (seven hospitals, Providence medical groups), PeaceHealth (four hospitals, PeaceHealth medical groups), Samaritan Health Services (five hospitals, Samaritan medical groups).	The scope of health information exchange functionalities within each health system varies and is evolving. See the Oregon HIE Activities Report for additional information.
Developing HIEs		Providence Health and Services will be implementing an HIE infrastructure in late 2009 to integrate inpatient and outpatient EHRs and connect EHRs of affiliated medical groups.	See the Oregon HIE Activities Report for additional information.
Active HIEs		OCHIN, Umpqua OneChart HIE, Mid-Rogue HIE, Samaritan HIE provide and are evolving information exchange services.	See the Oregon HIE Activities Report for additional information.
Imaging Collaborations		Imaging collaborations, shared PACS systems and imaging exchange mechanisms have and are evolving in Oregon communities.	See the Oregon HIE Activities Report for additional information.

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IPAs and Health Plans: Surveys are currently underway of Oregon IPAs and health plans to identify their involvement in facilitating the adoption of EHR and HIT systems and provide information for Oregon’s HIT planning process.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
Independent Practice Associations (IPAs)		Several IPAs and affiliated organizations are involved in facilitating the adoption of EHRs. <ul style="list-style-type: none"> - Central Oregon EMR, an affiliate of Central Oregon IPA, offers EHR services to COIPA members (eClinicalWorks) and non-members (eClinicalWorks and Allscripts-MyWay). - Douglas County IPA and affiliated ITechSS provides EHR services Centricity in the greater Roseburg community. - Mid-Rogue e-Health Services, a subsidiary of Mid-Rogue IPA offers EHR services (Greenway) to MRIPA members and non-members. - Mid Valley IPA offers EHR services (NextGen) to its members. - Portland IPA provides it members with implementation, training and ongoing support eClinicalWorks PM and EMR installations. 	
Health Plans	FCHPs & Insurance Plans	2009 survey: results not yet summarized	

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Personal Health Record Adoption: The November 2008 HIIAC report adopted by the Oregon Health Fund Board into its health reform plan for the state, establishes a goal that “All Oregonians have access to a personal health record by 2013.” A number of efforts are underway related to the deployment of personal health record systems. Information about PHRs is derived from the HRBO project and survey responses from hospitals and health plans.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
Health Record Bank of Oregon		<p>CMS Medicaid Transformation Grant for \$5.5 million was awarded in October 2007 to the Oregon Department of Human Services (DHS) to implement a health record bank (HRB) project for Medicaid clients and evaluate the project. The HRBO is unique among the 49 grants totaling \$150 million made to 34 states in 2007. Of the 26 grants awarded for health information technology (HIT) projects, the Oregon project is the only project building a personal health record (PHR) using a health record banking approach.</p> <ul style="list-style-type: none"> • Initial grant term: 18 months - October 2007 to March 2009. • CMS approved a grant extension to March 31, 2010. • An extension request through March 31, 2011 is expected. <p>An RFP was issued in March 2009 to select an HRBO vendor. The contract with the selected vendor should be in place in late August 2009. The HRBO is scheduled to go-live in early 2010.</p>	<p>The November 2008 HIIAC report to the Oregon Health Fund Board considered the HRBO as a fundamental building block in developing health information exchange in Oregon.</p> <p>Further evaluation of the HRBO in light of ARRA and other HIE efforts in Oregon will be required.</p>
Provider-based PHRs		Tethered PHRs identified to date are provided by provider organizations include Kaiser and OHSU (Epic’s MyChart), UmpquaOneChart	Incomplete list
Health plan-based PHRs		Tethered PHRs identified to date are provided by health plans include Providence Health Plan (WebMD), Regence BS/BC, ODS (WorldDoc with synchronization through HealthVault)	Incomplete list
Other PHRs	Unknown	There are number of commercial PHR vendors offering services to individuals and employer groups.	Information not available

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Electronic Prescribing: SureScripts prepares a State Progress Report on Electronic Prescribing. The last report as of December 31, 2008 shows that Oregon ranks favorably against national statistics. The SureScripts reports are available at <http://www.surescripts.net/e-prescribing-statistics.html>.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
Prescriptions routed electronically		For 2008 Oregon ranked 15 th nationally with 4.39% of prescription routed electronically. Growth in 2008 over 2007 was 180%.	
Visits with a prescription benefit request		For 2008 Oregon ranked 19 th nationally with 7.86% of patient visits with a prescription benefits request and 4.37% with a prescription benefit response. Growth in 2008 over 2007 was 300%.	
Physicians routing e-prescriptions		As of 12/31/2008 Oregon ranked 11 th nationally with 15.43% of physicians routing e-prescriptions (1,030 physicians). Growth in 2008 over 2007 was 170%.	
Payer coverage		For 2008 Oregon ranked 36 th nationally with 55.83% of patients with available prescription benefit information.	
Pharmacy participation		As of 12/31/2008 Oregon ranked 27 th nationally with 76.86% of community pharmacies (475) activated for e-prescribing. Growth in 2008 over 2007 was 12%.	

Other Health Care Delivery Settings: A number of other health care settings may need to be considered as Oregon HIT planning efforts move forward.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Adoption Gap or Comments
Nursing Homes	Unknown	Not yet addressed	
Home Care & Home Health Agencies	Unknown	Not yet addressed	

Oregon State Government: A number of State of Oregon programs involving health and social services programs have implications for HIT planning. The Oregon Department of Human Services (DHS) is developing an inventory of programs with significant HIT components. The DHS HIT scan reviewed 64 separate program areas and identified 32 programs that have one or

Oregon Health Information Technology Environment Scan Summary Matrix – updated October 2009

more technology applications for further consideration. A structured assessment is under development for eleven program areas. Addition programs may be added as the DHS HIT scan proceeds. Selected DHS HIT programs are included below. The Department of Corrections and Oregon Youth Authority provide health services in the adult and youth correctional facilities. Efforts are contemplated to include these agencies in the EHR and HIT environmental assessments.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Comments
DHS - Medical Assistance Programs (DMAP)		DMAP operates the Oregon Health Plan (OHP) including the Medicaid program. The Medicaid Management Information System (MMIS) is an essential infrastructure component for administering the OHP and processing eligibility and provider claims data. The new MMIS system was activated in December 2008 to replace the 30 year old legacy system and consolidate a number of separate applications and data bases.	The MMIS conversion encountered a number of conversion and implementation issues that are being resolved. The roles of MMIS in statewide HIT and HIE planning need further analysis and discussion.
DHS- Addiction & Mental Health Division (AMH)		AMH has completed a several year process for planning a comprehensive Behavioral Health Information Project (BHIP) designed to provide an EHR, other clinical and administrative systems to support the state hospitals (OSH replacement project and Blue Mountain Recovery Center) 500 mental health and addiction services community-based programs and 13 acute care hospital programs. Responses for the BHIP system RFP were due in late July 2009.	BHIP has implications for HIE planning and interoperability of BHIP with EHRs of various provider organizations and health systems. The roles of BHIP in statewide HIT and HIE planning and need further analysis and discussion.
DHS - Public Health		A number of public health programs have direct involvement and linkages to providers that are being more fully described in the DHS-HIT scan including <ul style="list-style-type: none"> - Immunization Information System (ALERT) - Orpheus – communicable disease reporting - Emergency medical services - OR-Kids - FamilyNet Child Health Record - Vitals Statistics OVERS - Oregon Electronic Laboratory Reporting (ELR) project - DHS-LIMS – laboratory information management system - Prescription Drug Monitoring 	The roles of the various public health programs in statewide HIT and HIE planning and need further analysis and discussion. Integration of distinct applications into an overall DHS & HIE framework will require careful planning and phasing.
Dept of Corrections		The Department of Corrections (DOC) operates 15 clinics in its adult correctional facilities. DOC is exploring EHR systems for its corrections population.	

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Domain	Scope	HIT Adoption or Role in HIT Adoption	Comments
Oregon Youth Authority		The Oregon Youth Authority (OYA) operates correctional facilities for minors: seven closed facilities and four transitional facilities. OYA operates six clinics in support of the closed facilities. OYA is exploring EHR systems for its corrections population	

Telehealth and Telemedicine: During September and October 2009, the Oregon Health Network Applications Committee plans to compile an inventory of telehealth and telehealth applications in Oregon.

Domain	Scope	HIT Adoption or Role in HIT Adoption	Comments
Telehealth applications		A number of telehealth – telemedicine applications are operating in Oregon. Example projects include pediatric intensive care video consultations and monitoring (OHSU and Sacred Heart), tele-genetics counseling (OHSU, Medford, Bend, Boise) – currently suspended until payer reimbursement is activated, psychiatric video consultations (OHSU, a prison, a tribal clinic), specialty telemedicine consults (eastern Oregon and Idaho hospitals), cardiology Stemi consults and data transfers (southern Oregon hospital, EMS ambulance and emergency department), trauma consults to triage patient appropriately, pediatric and adult image interpretation and overreads (store and forward)..	OHN and the Telehealth Alliance of Oregon (TAO) will be undertaking an inventory of telehealth applications in fall 2009.
Oregon Health Network (OHN)		Oregon Health Network (OHN) has been approved by the Federal Communications Commission (FCC) to receive up to \$20.2 million in funding reimbursement under the Universal Service Fund to build a comprehensive and robust broadband infrastructure and telehealth network that will connect hospitals, clinics and community colleges throughout Oregon. The project will connect eligible health care facilities under the FCC's Rural Health Care Pilot Program (RHCPP). Four RFPs are in various stages of solicitation and contracting for implementing the FCC grant. Additional information is available at www.oregonhealthnet.org .	Slow process to work through RFPs and contract for projects.

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Other Oregon Assets to Advance HIT Adoption (partial list): Oregon benefits from the presence of a number of organization that play unique roles supporting EHR and HIT adoption and in meeting the ARRA meaningful use requirements. An incomplete list of such organizations includes the following:

Domain	Scope	HIT Adoption or Role in HIT Adoption	Comments
Acumentra Health		Acumentra Health is Oregon’s federally-designated Medicare Quality Improvement Organization (QIO) as well as the External Quality Review Organization for Medicaid in Oregon and Washington. Acumentra Health has been involved in a number of HIT-related projects including Oregon Diabetes Collaborative (2001-2, 2003-4), Oregon Rural Collaborative (2005-7), DOQ-IT (2005-8), and EHR Preventive Care Initiative (2008-11). Acumentra Health also coordinates HIT activities of the Oregon IPA Collaborative (representing over 4,300 providers) and pharmacy project activities of the Medicare Advantage Health Plan QI Collaborative. Additional information is available at http://www.acumentra.org/	Interests include facilitating EHR adoption and optimization, HIE development, regional extension centers, quality metrics and practice-based quality improvement.
OCHIN		OCHIN is a health center controlled network (HCCN) of community health clinics and small practices serving the medically underserved with 18 members in Oregon, 9 members in California and one in Washington that operate clinics in over 200 locations. OCHIN provides a comprehensive suite of products including practice management and EHR (Epic) services, panel and population management tools to member organizations. As an Organized Health Care Arrangement (OHCA) under HIPAA with a single record per patient OCHIN also functions as an HIE among the member organizations. The OCHIN master patient index contains information on over 400,000 Oregonians and 600,000 lives across California, Oregon and Washington. OCHIN also operates SafetyNetWest, a practice-based research network that solicits proposals and coordinates research projects involving safety-net populations. Additional information is available at http://www.ochin.org/	Interests include regional extension centers, EHR adoption, HIE development, HIT-based quality improvement and collaborative research among safety net organizations, workforce development. OCHIN is the lead organization in Oregon’s Regional Extension Center proposal.

Oregon Health Information Technology Environment Scan Summary Matrix – updated October 2009

Domain	Scope	HIT Adoption or Role in HIT Adoption	Comments
OHSU-DMICE		<p>Department of Medical Informatics & Clinical Epidemiology (DMICE) is an academic and research department in the Oregon Health & Science University (OHSU) School of Medicine. DMICE blends teaching, research, and service activities in medical informatics and clinical epidemiology. The medical informatics program features a diversity of research activities on the application of information technologies in health care as well as graduate education programs available on-campus or via distance learning. The clinical epidemiology program includes the AHRQ-funded Oregon Evidence-Based Practice Center that conducts systematic reviews of medical tests and interventions, and clinical effectiveness studies. Additional information is available at http://www.ohsu.edu/ohsuedu/academic/som/dmice/</p>	<p>Interests include workforce development, regional extension centers and applied informatics.</p> <p>OHSU-DMICE is a partner organization in Oregon's Regional Extension proposal.</p>
Oregon Health Care Quality Corp		<p>The Oregon Health Care Quality Corp's Partner for Quality Care initiative is using pooled encounter and medications (claims) data (96 million claims, 1.6 million unique individuals) to measure and report quality metrics for 2,212 adult primary care physicians (120 medical groups with 308 clinic sites). 19 practices representing about 729 physicians are using a secure interactive web portal to access data about their patients. Metrics based on clinical EMR data are planned. This effort is part of the Robert Wood Johnson Foundation Aligning Forces for Quality program. Quality Corp is also a Federally-designated Chartered Value Exchange (CVE). Additional information is available at http://www.q-corp.org/</p>	<p>Interests include quality metrics from claims data and EHRs, HIE development, practice-based quality improvement, quality reporting metrics and consumer engagement.</p>

Oregon Health Information Technology Environment Scan

Summary Matrix – updated October 2009

Abbreviations:

AMH: addiction and Mental Health Division
CAH: critical access hospital
COEMR: Central Oregon EMR
COIPA: Central Oregon IPA
CVE: chartered value exchange
DHS: Department of Human Services
DMAP: Division of Medical Assistance Programs
DMICE: OHSU Department of Medical Informatics & Clinical Epidemiology
EHR: electronic health record
EMR: electronic medical record
EPM: electronic practice management system
FCHP: fully capitated health plan
FQHC: federally qualified health center
HIIAC: Health Information Infrastructure Advisory Committee
HIE: health information exchange
HIO: health information organization
HIT: health information technologies
HITOC: Health Information Technology Oversight Council
HRB: health record bank
HRBO: Health Record Bank of Oregon
IPA: independent practice association
OAHHS: Oregon Association of Hospitals and Health Systems
OHP: Oregon Health Plan
PHR: personal health record
QIO: quality improvement organization
RHC: rural health center
RHIO: regional health information organization
SBHC: school-based health center

Oregon Health Fund Board



Health Information Infrastructure Advisory Committee

Report to the Oregon Health Fund Board

October 2008

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Committee Membership

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Legacy Health System

Ree Sailors, Co-Chair
Governor's Office

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Oregon Health Fund Board – Health Information Infrastructure Advisory Committee Recommendations

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Oregon Health Fund Board – Health Information Infrastructure Advisory Committee

Section 1: Background and Committee Process

I. Introduction

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care.

Recognizing the need for Oregon to develop a strategy for health information technology (HIT) as a part of this comprehensive reform and long-term system transformation, Governor Kulongoski created the Health Information Infrastructure Advisory Committee (HIIAC) by Executive Order 08-09 (See <http://www.oregon.gov/OHPPR/HIIAC/ExecutiveOrder2008.pdf>) in early 2008. The Governor appointed 23 members to the HIIAC, representing a wide variety of provider groups, payers, purchasers, consumers, researchers and state government.

The HIIAC was designated to make recommendations about policies to: reduce barriers to health information exchange, while maintaining the privacy and security of individuals' health information; establish an appropriate role for the state in building and maintaining health information infrastructure; facilitate the adoption of state health information infrastructure standards and interoperability requirements, based on federal requirement and national standards; facilitate collaboration between statewide partners; and develop evaluation metrics to measure the implementation of health information technology and the efficiency of health information exchange in Oregon.

As its first official task, the Executive Order directed the HIIAC to provide a report to the Oregon Health Fund Board by the end of July 2008, with recommendations to be considered as part of the Board's comprehensive reform plan. The HIIAC members strongly believe that a carefully developed, secure, widespread HIT system must be a keystone to any successful and sustainable reform plan. The following report explores challenges in the current health care system and opportunities to transform the system through wider adoption and utilization of HIT and provides specific, actionable recommendations to facilitate and accelerate this transformation.

II. Health Information Technology Background

A. Why is Health Information Important?

1. Challenges in the Current System

Health care delivery in Oregon and across the nation faces many significant challenges. Health care spending in the U.S. represents 16 percent of GDP, with health care spending in Oregon alone exceeding \$19 billion in 2008.¹ At the same time, the system is highly fragmented and in many instances does not deliver high-quality, efficient, and safe care. Research shows that Americans receive only 55 percent of recommended care² and one-third of patients experience coordination problems, including lab test results or records that were not available at the time of the appointment or duplicated tests.³

Patient safety is a major concern, with the Institute of Medicine estimating that between 44,000 and 98,000 people are killed every year in hospitals by preventable medical errors. Beyond the human toll, medical errors in hospitals cost the health care system between \$17 and \$29 billion every year.⁴ In addition, at least 1.5 million adverse drug events occur in the U.S. every year.⁵

Physicians and patients often do not have the information they need to make informed health care decisions. In an age defined by significant advancements in technology and electronic information exchange, a significant portion of the health care industry remains dependent on fax, mail, and telephone transactions. Furthermore, clinicians often do not have point-of-care access to clinical support guidelines and other tools to help them maximize quality of care. 10 to 81 percent of the time, physicians report that they cannot find necessary information in a

¹ J. McConnell. 2007. Health Care Reform Reference: 2008 Oregon Health Care Spending Estimates. Office for Oregon Health Policy and Research. Available at: <http://www.oregon.gov/OHPPR/OHREC/Docs/OregonHealthCareSpendingEstimates06thru08.pdf>

² E. McGlynn, et al. 2003. The Quality of Care Delivered to Adults in the United States, *New England Journal of Medicine*. 248(26): 2635-2645.

³ C. Schoen, et al. 2005. Taking the Pulse of Health Care Systems: Experiences with Patients with Health Problems in Six Countries. The Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=313012.

⁴ L. Cohen, J. Corrigan, and M. Donaldson, eds. 2000. *To Err is Human: Building a Safer Health Care System*. Committee on Quality of Health Care in America. The Institute of Medicine. National Academy Press: Washington, DC.

⁵ P. Aspden, J. Wolcott, L. Bootman, and L. Cronenwett, eds. 2007. *Preventing Medication Errors*, Committee on Identifying and Preventing Medication Errors. Institute of Medicine. National Academies Press: Washington, DC.

paper-based medical record, which often leads to duplicative services and inefficient care.⁶

2. How Health Information Technology Can Improve Health Care Delivery

An emerging body of research supports the use of HIT to improve quality and safety, most notably in the areas of adherence to clinical guidelines, enhanced surveillance and monitoring, and decreased medication errors.⁷ HIT can help ensure that the right information is available at the right time and access to high-quality information is a vital component of a high performing health care system. Many players in the health care system can benefit from more widespread use of HIT and the Minnesota e-Health Initiative has laid out a number of areas in which HIT can improve quality of care and care coordination and has provided the following examples.⁸

Effective use of the growing array of information technologies in health care enables clinicians to:

- Ensure a newly prescribed medication does not conflict with existing medications.
- Avoid duplicate tests because the previous results can be transmitted electronically.
- Readily access clinical guidelines and other evidence-based information most relevant to the patient's current condition.
- Avoid medication and other errors due to illegible or misinterpreted handwriting.
- Improve continuity of care by being able to exchange information with patients' other providers.
- Receive reminders about preventive services that patients are due to receive.
- Receive alerts when a prescribed action may be contraindicated.
- Improve clinical workflow processes to achieve greater efficiencies while also improving outcomes.
- Access a patient's record from home when receiving a call at night.
- Support delivery of telehealth and telemedicine services, enabling patient access to care otherwise unavailable in their community.

⁶ J. Marchibrota. 2004. Testimony Before the Subcommittee on Health of the House Committee on Ways and Means. United States House of Representatives. Available: <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1654>.

⁷ B. Chandhry, et al. 2006. Systematic Review: Impact of Health Information technology on Quality, Efficiency, and Costs of Medical Care. *Annals of Internal Medicine*. 144:E-12-E-22.

⁸ Adapted from: Minnesota e-Health. 2008. Vision to Action: The Minnesota e-Health Initiative, Report to the Minnesota Legislature. Minnesota Department of Health.

HIT can also have tremendous value in increased patient satisfaction and patient engagement by:

- Enabling the patient to access their health information online, including links to tailored prevention, disease management, and other information resources.
- Allowing patients to contact their providers through email.
- Synchronizing information as a patient moves between a clinic, hospital, and long-term care facility and making the patient's records available at whichever site the patient visits.
- Easily graphing and displaying a person's key biometric data over time.

In addition, HIT has the potential to reduce health care spending by increasing efficiency. A few examples of opportunities to use HIT to reduce administrative and clinical costs for hospitals or practices include⁹:

- Directly dictating to an electronic health record versus paying for transcription services.
- No longer having to pull, manage, and store paper records.
- Reducing duplication of services and repeated tests.
- Experiencing enhanced revenue capture and fewer claims denials.
- Having fewer pharmacy call-backs.
- Increasing productivity by decreasing time spent tracking down health information.
- Alerting physicians if a generic version of a prescribed drug is available.
- Contributing to lower malpractice premiums.

In 2007, the Office for Oregon Health Policy and Research and the Oregon Health Quality Corporation sponsored a study of the potential impact of widespread HIT on health care spending in Oregon. The researchers found that the widespread adoption of advanced health information technology, including electronic health records (EHR) systems with capabilities for the authorized and secure electronic exchange of information between hospitals, physicians and other service providers, could result in a net savings of \$1.0 to \$1.3 billion per year within 12 years.¹⁰

3. Barriers to Adoption of HIT

Although HIT can provide the health care industry with tools to improve efficiency, contain costs, and achieve better health outcomes adoption rates remain low throughout the country. Currently, only 17% of physicians have

⁹ Ibid.

¹⁰ D. Witter and T. Ricciardi. 2007. Potential Impact of Widespread Adoption of Advanced Health Information Technologies on Oregon Health Expenditures. Oregon Health Care Quality Corporation and Office for Oregon Health Policy and Research. Available at: <http://www.q-corp.org/q-corp/images/public/pdfs/OR-HIT%20Impact%20Final.pdf>

access to an EHR system, with only 4% of physicians having a fully functioning EHR.¹¹ Oregon is ahead of the national trends in EHR adoption, but even here only an estimated 53% of non-federal clinicians are working in practices or clinics where EHRs are present.¹² Hospitals also show low levels of adoption with only 37% with electronic health records, 46% utilizing clinical decision support and only 13.9 with computerized physician order entry.¹³

A range of barriers to HIT adoption have been discussed in the literature. A recent article in the *New England Journal of Medicine* acknowledged prohibitive capital costs as the most common barrier cited by providers. In addition, providers without access to electronic health record system also widely indicated the following barriers: not finding a system that met their needs, uncertainty about their return on investment, and concern that a system would become obsolete.¹⁴ In addition, many providers who have access to EHRs and other HIT do not fully utilize their capabilities because they are difficult to use or providers feel they interrupt workflow.

Many will say that the most powerful utilization of HIT comes with interoperable systems that allow for the exchange of information between care sites. Currently, efforts to create interoperability are hampered by a lack of standard sets of requirements and standards for technology systems utilized for exchange throughout the state. In addition, health information exchange concerns many individual patients, who do not believe current systems offer enough privacy and security standards. Stronger consumer protections are needed before there will be widespread patient participation in health information exchange.

4. HIT as Part of Comprehensive Health Care Reform

The evidence supports the important role for information technology in any reform effort aimed at improving the quality, safety and efficiency of Oregon's health care system. The Oregon Health Fund Board's Delivery System Committee clearly stated the need for a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across the state. The Delivery Systems Committee also called for state

¹¹ The George Washington University, Massachusetts General Hospital, and The Robert Wood Johnson Foundation. 2008. *Health Information Technology in the United States: Where We Stand, 2008*. Available at: <http://www.rwjf.org/files/research/062508.hit.exsummary.pdf>.

¹² D. Witter, Jr., J. Pettit, D. Nicholson and T. Edlund. 2007. *Oregon Electronic Health Record Survey Ambulatory Practices and Clinics, Fall 2006*. Office for Oregon Health Policy and Research and Oregon Health Care Quality Corporation.

¹³ M.Furukawa, et al. 2008. *Adoption of Health Information Technology for Medication Safety in U.S. Hospitals, 2006*. *Health Affairs*, 27(3): 865-875.

¹⁴ C. DesRoches. 2008. *Electronic Health Records in Ambulatory Care – A National Survey of Physicians*. *New England Journal of Medicine*. 359: 50-60.

action to facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensures that the right information is available at the right time to patients, providers and payers. Many of the Committee's recommendations focused on improving transparency of clinical and performance data across the system and technologies are needed to make this information easier to collect and disseminate. The Oregon Health Fund Board and other state agencies must align with national and Oregon-based efforts to overcome the barriers to HIT adoption and integrate the utilization of interoperable technology across the health care sector.

B. Current Efforts to Promote the Adoption of Health Information Technology

There is a great deal of work going on at the national and state levels in both the public and private sectors to overcome the barriers to widespread implementation of advanced EHRs, e-prescribing, and other HIT to improve overall safety, quality and effectiveness of health and health care. Brief descriptions of several key examples of these initiatives are below. Oregon should be careful not to use limited resources to duplicate existing efforts, but must coordinate and build upon other initiatives and whenever possible, align standards and requirements.

1. The National Landscape¹⁵

The National Committee on Vital and Health Statistics (NCVHS) performs the vital role of reviewing and recommending approval of health-related data standards to the U.S. Department of Health and Human Services. Throughout this process, NCVHS solicits advice from a broad spectrum of public and private-sector stakeholders, as well as leading organizations actively involved in efforts to standardize health information. See <http://www.ncvhs.hhs.gov>.

The National Health Information Infrastructure (NHII) initiative of the Department of Health and Human Services has proposed a network of interoperable systems covering key health information areas: clinical, personal, research, and public health. See <http://aspe.hhs.gov/sp/nhii/index.html>.

The Office of the National Coordinator for Health Information Technology (ONCHIT) collaborates with public, private, and non-profit sectors to facilitate the widespread adoption of interoperable electronic health records for all Americans. See <http://www.hhs.gov/healthit/mission.html#>.

The Consolidated Health Informatics (CHI) initiative establishes a portfolio of existing clinical vocabularies and messaging standards that enable federal agencies to build interoperable health data systems that “speak the same language” and share information. CHI standards will work in conjunction with the Health Insurance Portability and Accountability Act (HIPAA – See Glossary) transaction records and code sets, and HIPAA security and privacy provisions. See www.ncvhs.hhs.gov.

¹⁵ Adapted from materials of the Minnesota e-Health Initiative including: The 2005 Roadmap and Preliminary Recommendations for Strategic Action: Report to the Minnesota Legislature and The 2008 Prescription for Meeting Minnesota’s 2015 Interoperable Electronic Health Record Mandata.

The Public Health Information Network (PHIN) initiative of the Center for Disease Control is developing a network for crosscutting and unifying data streams to enhance the detection of public health issues and emergencies. See <http://www.cdc.gov/phn/>.

The Doctors' Office Quality-Information Technology (DOQ-IT) project of the Center for Medicaid and Medicare Services promotes the adoption of EHR and other health information technology systems in small-to-medium sized physician offices. See <http://www.doqit.org/doqit/jsp/index.jsp>.

The Foundation for the National e-Health Initiative was created to serve as a national forum for the discussion of the policy issues relevant to the application of technology to support health and to articulate and execute a vision of a better health care system enabled by technology, to improve the quality, safety, and efficiency of health care, as well as consumers' experiences with managing their health. See <http://www.ehealthinitiative.org/about/foundation.msp>.

The Markle Foundation's Connecting for Health initiative is a collaborative of public and private sector participants focused on addressing the policy, technical, and legal barriers to establishing an interconnected health information infrastructure. See <http://www.connectingforhealth.org>.

The Certification Commission for Healthcare Information Technology (CCHIT) certifies EHR software and HER networks based on objective criteria. CCHIT's mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. See <http://www.cchit.org>.

The Health Information Technology Standards Panel (HITSP) is a public-private cooperative working to develop a widely accepted and useful set of standards specifically to enable and support widespread interoperability among health care software applications, as they will interact in local, regional and national health information networks. See <http://www.hitsp.org>.

The Bridges to Excellence (BTE) Physician Link Program encourages adoption of HIT by providing monetary incentives to physicians for utilizing health information technology and information systems that improve quality of care. See <http://bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=19>.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) provided critical provisions that will promote the adoption of data standards, including the standards requirements included in the electronic prescription program. In addition, the MMA created the Commission on System

Interoperability which will develop a comprehensive strategy, timelines and priorities for the adoption and implementation of healthcare information technology standards.

The Agency for Healthcare Research and Quality has established a Health Information Technology grant program for providers and other healthcare stakeholders planning and implementing health information technology-related projects. See <http://healthit.ahrq.gov>.

The Nationwide Health Information Network (NHIN) program of the U.S. Department of Health and Human Services is attempting to build a “network of networks” by developing and testing prototypes to connect state and regional health information exchanges. See <http://www.hhs.gov/healthit/healthnetwork>.

The Health Information Security and Privacy Collaborative (HISPC) is a national collaborative of states and territories working together to address privacy and security policy questions affecting interoperable health information. Oregon is one of the 41 states and territories participating in the project. See <http://www.rti.org/hispc>.

The NGA Center for Best Practices State Alliance for e-Health initiative is a collaborative body that enables states to increase the efficiency and effectiveness of the health information technology (HIT) initiatives they develop. The Alliance provides a nationwide forum through which stakeholders can work together to identify inter- and intrastate-based health information technology policies and best practices and explore solutions to programmatic and legal issues related to the exchange of health information. See <http://www.nga.org/center/ehealth>.

Various states and regional efforts to establish *health information exchanges* (HIE) have been established across the country. In 2006, an eHealth Initiatives survey identified 165 HIE efforts in 49 states, the District of Columbia, and Puerto Rico. While many of these initiatives were still in the planning phase, one-third reported transmitting a broad range of data electronically and 26 identified themselves as fully functional. A great deal can be learned from studying the successes and failures of various HIE efforts around the country.¹⁶

¹⁶ eHealth Initiatives. 2006. Third Annual Survey of Health Information Exchange Activities at the State, Regional and Local Levels. Available at: <http://toolkits.ehealthinitiative.org/assets/Documents/eHI2006HIESurveyReportFinal09.25.06.pdf>

2. The Oregon Landscape

The Health Records Bank (HRB) of Oregon is Oregon's Medicaid Transformation grant project funded through a \$5.5 million grant from the Centers for Medicare and Medicaid Services. The HRB project is currently in the planning stage, but will eventually store Medicaid clients' health information electronically and make it available on a secure-web site. Goals of HRB Oregon are to: assemble existing patient information from multiple sources and provide one place for patients and their providers to share that information; provide a reliable and trusted repository of patient-specific health information; improve quality and coordination of care by providing patient-specific historical health information and decision support tools and resource information to enhance patient participation in their health and health care; and protect patient privacy. Initial implementation plans will limit HRB participation to a specific geographic area. See <http://healthrecodbank.oregon.gov>.

OCHIN is a non-profit organization with the mission to improve the health of the medically underserved through the best use of information and information technology. OCHIN is collaborative of 21 member organizations serving both rural and urban populations and leverages the size of the collaborative to make electronic medical records (EMR) affordable for safety-net clinics to implement and maintain. See <http://www.community-health.org>

In 2007, *The Oregon Health Quality Corporation* and *Oregon Business Council* supported a team to explore opportunities to begin building a system for sharing health information in the Portland Metropolitan area. The group prepared a complete Metropolitan Portland Health Information Exchange Mobilization Plan, which included business and operational plans for the first steps for implementing a results and reports viewing system. The project is currently identifying and addressing barriers to mobilization. See <http://www.q-corp.org/default.asp?id=13>.

III. Committee Process, Vision, Mission and Guiding Principles

A. Committee Meeting Processes

The HIIAC first met in April 2008 and held a total of 9 meetings between April and then end of September. Dick Gibson, senior vice president and chief information officer at Legacy Health Systems and Ree Sailors, senior health policy analyst for the governor, were elected as co-chairs of the HIIAC.

The group spent significant time during its first few meetings developing and revising a set of statements and principles to guide the committee process and recommendation development. In particular, the HIIAC members agreed on a mission, vision, and guiding principles, as well as the elements of a productive process, the elements of productive recommendations/findings, a decision making process for HIIAC, and the role of the HIIAC in summer 2008. The final versions of these statements, which were confirmed by the HIIAC on July 23,

2008 can be found in sections B below. The group also developed a logic model to create a pictorial representation of the elements of system transformation the HIIAC plans to address and the inputs and strategies the HIIAC will need to utilize in order to reach these system improvement goals. The logic model can be found in section C below.

At the second meeting, the HIIAC members brainstormed an initial list of recommendations to encourage HIT adoption and utilization across the state. At the next meeting, members rated each option based on the following criteria: time frame (short or long term), impact on cost containment, availability of privacy protections, scope of impact, potential to improve care, support of the Delivery Committee recommendations, degree to which scalable or amenable to pilots or demos, technical feasibility, degree to which supports public-private partnerships and fosters shared responsibility, support of population research and intervention, and creation of staging opportunities. Based on these ratings and HIIAC member discussion, this large initial list was condensed into a list of twenty-five potential strategies.

The twenty-five remaining strategies were sorted into topic “buckets” which included: HIT adoption, evidence based medicine and clinical decision support, health information exchange, and privacy and security. The HIIAC was divided into four subgroups that coincided with these topic areas and each subgroup was asked to develop a limited number of recommendations in their assigned areas. The meetings in late July, August, and September were designed to allow the subgroups to work individually to develop recommendations and allow opportunities for each subgroup to report on their progress and receive feedback from the HIIAC group as a whole. Audience members were invited to participate in the small groups and the HIIAC would like to thank representatives from the ACLU, Regence Blue Cross Blue Shield, and Harkins Systems for their active participation in these discussions. These finalized recommendations and the rationale used in developing them can be found in Section 2 of this report.

B. HIIAC Vision, Mission, and Guiding Principles

1. HIIAC Vision

In order to improve health and reduce costs, an Oregonian’s health information:

- Is available when and where it is needed to support clinical-decision making and high quality care
- Is private and secure and only exchanged with the authorization of the individual in ways that comply with federal and state law
- Improves public health and population-based care decision-making

- Enables individuals to take an active role in their health through access and control of their health information and tools to help them make informed choices.

2. HIIAC Mission

From the Executive Order No. 08-09, Office of the Governor (See Appendix A):

To fulfill the **MISSION** of developing a strategy for the implementation of an Oregon health information infrastructure, the HIIAC shall:

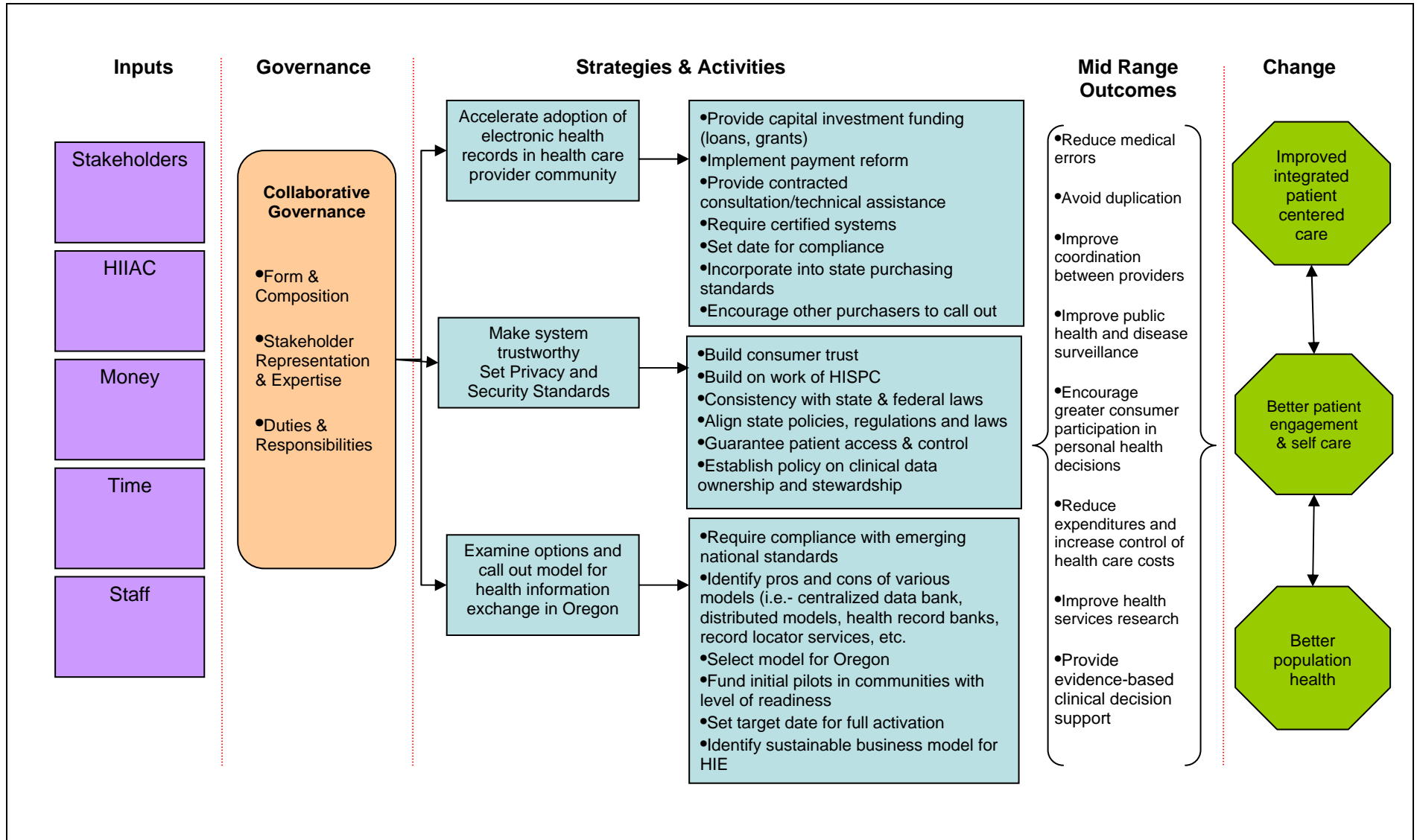
- Review and identify obstacles to the implementation of an effective health information exchange infrastructure in Oregon and provide policy recommendations to remove or minimize those obstacles;
- Outline the role of the State in developing, financing, promoting and implementing a health information infrastructure;
- Recommend how to facilitate the statewide adoption of health information system standards and interoperability requirements to enable secure exchange of health information exchange;
- Monitor the development of federal and applicable international standards, coordinate input to the Nationwide Health Information Network, and ensure that Oregon's recommendations are consistent with emerging federal and applicable international standards;
- Identify partnership models and collaboration potential for implementing electronic health records and exchange systems, including review of current records and exchange systems, including review of current efforts in the state and opportunities to build upon those efforts;
- Recommend a plan for the creation of a health information infrastructure that preserves the privacy and security of Oregonian's health information, as required by state and federal law; and
- Develop evaluation metrics to measure the implementation of health information technology and the efficacy of health information exchange in Oregon.

3. Guiding Principles

1. We will operate from a model of collaboration and partnership between the private and public sectors and will leverage that collaboration whenever possible to seek solutions for all Oregonians.

2. We will only support solutions that meet or exceed national and industry standards, or that promote their development and adoption where no standards exist.
3. We will enable individuals to take an active role in their health through access and control of their health information and tools to help them make informed choices.
4. We will only recommend plans/strategies for health information exchange that protect the integrity, availability and confidentiality of the consumer's information.
5. We will identify and align incentives for all stakeholders to support HIT adoption and interoperability.

C. Logic Model for Health Information Infrastructure Development



SECTION II: RECOMMENDATIONS AND NEXT STEPS

IV. HIIAC RECOMMENDATIONS

Objective 1: Stimulate, coordinate, and support as a priority statewide efforts to increase the utilization of interoperable health information technology.

Strategy A: Bring public and private stakeholders together to develop a strategic health information technology plan, provide oversight for the implementation of this plan, and maximize the impact of resources being spent on health information technology across the state.

ACTION STEP:

1.A.1 Authorize a health information technology oversight council charged with focusing state, federal and private sector resources and activities to accelerate the adoption of personal health records (PHR), electronic health records (EHR), and electronic data interchange among healthcare providers¹⁷, patients and consumers. The council membership must reflect the geographic diversity of Oregon and must include consumers, providers, and privacy and technology experts.

Rather than create a new council, the Governor could expand the authority of HIIAC to work in this capacity and in conjunction with the Oregon Health Fund Board to carry out a health information technology strategic plan for Oregon.

The council will:

- Be comprised of members from the private and public sector who are knowledgeable in the areas of HIT, health care delivery, public policy, and research;
- Serve as the oversight council for a purchasing collaborative designed to help providers obtain affordable rates for EHR, PHR, and interoperability infrastructure;
- Identify and select the industry standards required for all subsidized HIT promotion based, where available, on existing national standards and the current Certification Commission for Healthcare Information Technology certification requirements;

¹⁷ The term providers, as used throughout the HIIAC recommendations, refers to both behavioral and physical health providers.

- Select, support, and monitor HIT vendors contracting with the state purchasing pool for the provision of HIT hardware, software and support services;
- Enlist and leverage community resources to advance HIT adoption;
- Educate the public and providers on the benefits and risks of IT infrastructure investment;
- Educate providers and assist with pre-selection and implementation planning to assist in ensuring the value (cost savings and quality) is realized following EHR installation and EHRs remain interoperable so as to support the exchange of health information in Oregon;
- Coordinate healthcare sector activities that move HIT adoption forward and achieve HIT interoperability;
- Define, catalog and disseminate incentive-based participation strategies to be funded by the state and other payers;
- Guide resource use;
- Reasonably ensure that any endorsed vendors' applications include appropriate privacy and security controls and the data cannot be used for other than patient authorized health care activity as allowed by law;
- Support current state efforts to implement a personal health records bank for Oregon Health Plan enrollees;
- Develop a strategic plan for the development of a statewide health information exchange and closely monitor its implementation; and
- Incorporate the responsibilities as recommended by HIIAC for privacy and security (Objective 4 of this report).

Strategy B: Set specific goals for the adoption of electronic health records (EHRs), personal health records (PHRs), decision support tools, e-prescribing and other health information technology as well as the establishment of a system for state health information exchange.

The state must set ambitious goals for Oregon in all areas of health information technology that align with the statewide health information technology strategic plan and must monitor progress toward these goals.

ACTION STEPS:

1.B.1. Set health information technology goals for Oregon.

The health information technology oversight council, acting in conjunction with the Health Fund Board should set ambitious goals for Oregon in all areas of health information technology, including: electronic health record and personal health record adoption; use of clinical decision making, evidence based practice support, and population management tools; and e-prescribing. While Oregon providers have adopted health information

technology more readily than providers across the nation, there are still over 40% of providers who do not utilize electronic health records (EHRs). The state should set ambitious goals to lead to full adoption of EHR systems and monitor progress toward these goals. In addition, incentives should be put in place to reward providers who are using EHRs in their practice to improve health outcomes and provide decision support consistent with the state's need to set goals for more widespread utilization of electronic prescribing, evidence based guidelines, and other decision support tools.

In addition, every Oregonian should have the opportunity to have a personal health record and the state should set and monitor goals to make personal health records available to and used by people across the state.

The state should also set ambitious goals for interoperability and health information exchange that would ensure the right information is available to the right people at the right time.

The goals should include, but not be limited to:

- Increase percent of Oregon practices with EHRs by 10% every year.
- All Oregonians have access to a personal health record by 2013.
- By 2013, 50% of Oregonians' health information will be included in systems that allow for electronic exchange. By 2014, 85% of Oregonians' health information will be in systems that allow for electronic exchange.

1.B.2 Evaluate progress toward these goals.

The health information technology oversight council, working in conjunction with the Health Fund Board and other state agencies, should monitor progress toward these goals. The Office for Oregon Health Policy and Research currently conducts a survey of Oregon's physicians to determine the rate of adoption of EHRs. This effort should be expanded to allow the survey to capture more detailed information about the utilization of HIT and health information exchange across a wider range of providers. In addition to measuring statewide adoption of health information technology, the council should analyze the impacts of health information technology on population health and quality of care, including: reduction in medical errors, increased consumer participation in their care, decreased costs, and the availability of appropriate information when and where it is needed.

Objective 2: Accelerate widespread, effective use of health information technology (HIT) by health care providers and patients/consumers to improve health outcomes and health care quality.

Strategy A: Restructure reimbursement systems to provide adequate incentives and compensate providers for utilizing health information technology to improve health outcomes.

The infrastructure and on-going maintenance costs associated with the use of health information technology is an enormous barrier to building an interoperable network of providers throughout Oregon. This barrier is felt at all levels of the delivery system but seems to have a profound effect on small practices and providers serving vulnerable populations, such as safety net and rural providers. Organizations that utilize health information technology to improve patient outcomes deserve the opportunity to recoup some of the added burden of these systems as many of the greater cost benefits are realized by other parts of the delivery system.

ACTION STEP:

2.A.1. Determine a fair and appropriate way to reimburse providers for their use of electronic health records (EHRs), starting with providers who serve a large percentage of Medicaid patients.

The health information technology oversight council, in conjunction with the Health Fund Board, will make recommendations on how to fairly and appropriately compensate providers for costs associated with using health information technology to improve patient care. Options that are considered should include, but not necessarily be limited to: setting aside money to fund increased fee-for-service rate adjustments in Medicaid; requiring Medicaid MCO contracts to reimburse higher rates for health information technology adoption; and building pay for performance into the Medicaid reimbursement methodology and similar options to be used by other payers across the state. The possibility of the state using its bonding authority to support the acceleration and adoption of health information technology should also be explored, especially with respect necessary capital for infrastructure development. Without these types of policy and administrative changes, organizations will continue to delay adoption, discontinue technology use, and/or carry the misaligned burden of these costs.

Strategy B: Create a public-private purchasing collaborative or another mechanism to help solo providers, primary care providers, small and rural practices, and those providers who serve a large percentage of Medicaid patients, obtain affordable rates for high-quality electronic health records (EHR) hardware, software and supporting services. Set quality, performance,

and service standards for the technology vendors that will contract with this collaborative.

A recent study conducted by the New England Journal of Medicine revealed that major barriers to adoption of EHRs include capitol costs, difficulties identifying a system that meets practice needs, uncertainty about the return on investment, and concern that a system would become obsolete.¹⁸

Capital cost is the barrier to EHR and other health information technology adoption most commonly cited by providers, especially those in small practices, rural settings or underserved areas. Small practices do not have the same purchasing power as large hospitals and health systems and thus are not able to negotiate with vendors for reduced prices. Even if they are able to pay for initial installation of an EHR system, many of these practices cannot pay to maintain systems or provide ongoing support to staff to effectively use the products to improve patient care.

There are a wide range of products on the market and it is often difficult for providers to determine the EHR functionalities that are needed to support improved patient care and which vendors will be able to provide them with a high-quality product and continued high-quality support and service. In addition, it is difficult for these practices to identify EHR service companies that will be able to provide ongoing support and technical assistance to practices as they integrate the use of EHR into their practice infrastructure. Where providers are using health information technology, different systems are often not interoperable, which limits opportunities to improve care coordination and ensure that complete health information is available to the patient when they want it and to the provider at the time of care.

The state can help practices overcome these barriers by leveraging the knowledge of the health information technology oversight council in identifying a small number of EHR vendors and service companies who meet quality, performance, and service standards set out by the state. In addition, the state could create a purchasing collaborative or participate in a public-private purchasing pool that utilizes bulk purchasing power to negotiate more affordable rates. In order to maximize the utility of these systems for providers and patients, it is important for the state to select systems which are interoperable with one another following implementation and with other systems used around the state.

¹⁸ DesRoches C. 2008. Electronic Health Records in Ambulatory Care – A National Survey of Physicians. The New England Journal of Medicine. 359: 50-60.

Strategy C: Encourage and support providers in utilizing technology that supports clinical decision making (CDM), evidence-based practice (EBP), population-based management and quality improvement.

It is vital for providers to have access to health information technology that will maximize their ability to measure and report on quality metrics and take advantage of interoperable EHR chart information, clinical guidelines and other evidence that can improve the quality of care patients receive. In addition, while some of these tools have been developed, there is more work that needs to be done to ensure that the tools are easily integrated into practice workflow. In addition, electronic health records and other technology utilized by providers must allow for easy reporting of important quality and outcomes information so that it can be used for regional, statewide and practice-based improvement efforts. When providers, health plans, and other stakeholder groups invest in the installation and utilization of health information technology systems, it is vital that these systems include useful CDM, EBP and population-based management components to support high-quality patient care.

ACTION STEP:

2.C.1. Create a purchasing collaborative to help small practices afford a small number of state-supported electronic health record (EHR) vendors and service companies that meet quality, performance, privacy and service standards and offer the most aggressive price.

The health information technology oversight council, acting in conjunction with the Health Fund Board, should establish a public purchasing collaborative or collaborate with private partners to create a public-private purchasing pool. The collaborative should use the contracting process to select a small number of EHR vendors and a small number of EHR service companies able to support providers using the selected EHR products that will be offered through the collaborative. The contracting process should be built on quality, performance, privacy, and service criteria, as well as cost and value, and selected vendors must have a proven track record of providing good products and services to customers. In addition, the contracting process must establish a mechanism for monitoring vendors' performance and remedying noncompliance with contract specifications.

Standards to be considered for inclusion in the contracting for *electronic health record vendors* should include, but not be limited to:

- Meeting or exceeding current Certification Commission for Healthcare Information Technology standards
- Valuable clinical decision support, evidence-based medicine, population management and quality improvement tools to be used by providers at the point of care and the ability to report on key quality metrics

- Interoperable data exchange with other EHRs, personal health records, and the Oregon Health Records Bank
- Adherence to HIIAC privacy and security principles (Objective 4 of this report)
- Ability to record, store, and report quality of care and health outcomes measures
- Ability to be utilized in a range of care settings
- Other standards as determined by HIIAC in conjunction with the Health Fund Board

Requirements to be considered for state contracting with electronic health record *service companies* should include, but not be limited to:

- Ongoing support of the EHR systems selected by the EHR *vendor* contracting process
- Implementation support
- Conversion from paper records or another EHR to one of the state-selected EHRs
- Interface support
- Support practices in optimizing use of EHR
- Support quality reporting
- Support participation in health information exchange
- Adherence to HIIAC privacy and security principles (Objective 4 of this report)
- Other standards as determined by HIIAC and through public forums

The contracting RFP process should be completed by January 1, 2010.

Strategy D: Subsidize installation and ongoing management of health information technology in small and rural practices.

Even with reduced prices negotiated by the state or a purchasing collaborative, many practices need financial support to purchase and/or maintain an EHR system. The state should first focus financial assistance on primary care solo and small practices serving underserved and Medicaid populations. The state should only provide support for the adoption of EHR vendors and service companies that meet quality, performance, privacy, and service standards as determined by the state and should be careful not to undermine related community efforts. Grants to support the purchase and installation should be matched by community foundations and other private partners to leverage public dollars.

ACTION STEP:**2.D.1. Establish a program to subsidize provider use of state-selected electronic health record (EHR) vendors and service companies.**

Establish a program through legislation to provide subsidies, in the form of grants or low-interest loans, for providers who cannot afford to purchase and/or maintain an EHR system. Priority should be given to small, rural and/or primary care practices and providers serving a large percentage of Medicaid patients. The health information technology oversight council, acting in conjunction with the Health Fund Board, should be responsible for designing the subsidy programs and the program will be administered by the Department for Human Services. Subsidies must be used to purchase EHRs from state-selected EHR vendors or support services from state-selected EHR service companies available through the purchasing collaborative. Amounts of subsidies will be determined on a sliding scale, based on service to underserved populations and service to Oregon's Medicaid population, as well as other factors such as size of practice and practice location. The subsidy program should be designed to maximize federal match, community matching funds, and other private funds. The technology oversight committee should also explore opportunities to use the state's bond authority to finance the subsidy program.

Objective 3: Have by 2012 a statewide system for electronic exchange of health information.

Strategy A: Support the use of DMAP's (Division of Medical Assistance, Department of Human Services) Health Record Bank (HRB) as a fundamental building block for a statewide system for health information exchange which ensures that patients' health information is available and accessible when and where they need it.

Health information exchange facilitates the electronic movement of health-related information among patients and authorized providers and organizations.

DMAP's Health Record Bank project provides an opportunity for the state to build upon the investment and work that is already being done in the area of health information exchange. The HRB is Oregon's Medicaid Transformation grant project funded through a \$5.5 million grant from the Centers for Medicare and Medicaid Services. The HRB project is currently in the planning stage, but will eventually store Medicaid clients' health information electronically and make it available on a secure web site. Goals of HRB Oregon are to: assemble existing patient information from multiple sources and provide one place for patients and their providers to share that information; provide a reliable and trusted repository of patient-specific health information; improve quality and coordination of care by providing patient-specific historical health information and decision support tools and resource information to enhance patient participation in their health and health care; and protect patient privacy.

The input of the private sector will be a key to ensuring the HRB will be interoperable with those outside Medicaid. Ensuring the DMAP Health Record Bank is built to be interoperable with the electronic health records used by providers serving enrollees in health plans through the Public Employees' Benefits Board, Oregon Educators' Benefits Board, and the Department of Corrections will lay the ground work for eventual health information exchange throughout the state.

The HRB should also encompass strong privacy and security protections and resolve the issues of patients' rights with respect to the use and ownership of their personal health information. A public education program targeted at both providers and patients will be necessary to allow patients and providers to have trust and confidence in the system, thereby increasing participation.

ACTION STEP:

3.A.1. The health information technology oversight council ensures support of the Health Record Bank project and requires that the system be built with interoperability as a main focus.

The health information technology oversight council works with DMAP to ensure that the Health Record Bank is developed in line with the overall

strategic goals for statewide health information exchange and that will allow it to interoperate with other systems used across the state.

Strategy B: Facilitate ongoing planning for the development of a statewide system for exchange of health information.

The Health Record Bank is only the first step in creating a system that allows for health information to be effectively, efficiently, and securely exchanged between patients and their providers. The state should coordinate efforts across the public and private sectors to build capacity for health information exchange, promote the development of interoperable technology, and leverage available resources to support a system for statewide exchange. Over time, the state should consider opportunities to partner with private sector and other partners to develop a self-sustaining model for health information exchange.

ACTION STEPS:

3.B.1. The state designates the health information technology oversight council as the oversight entity for promoting a statewide system for exchange of health information technology.

The health information technology oversight council should develop a strategic plan for the development of a statewide system for the exchange of health information technology. This includes setting the goal of having a statewide system for health information exchange in place by 2012 and monitoring progress toward this goal. By 2013, 50% of Oregonians' health information should be able to be exchanged through this system and by 2014, 85% of Oregonians should be included.

3.B.2. The state allocates the appropriate funding to create a statewide system for health information exchange.

Over time, the state should consider working with private and other partners to develop a self-sustaining model for health information exchange.

Objective 4: Ensure the highest level of privacy and security protections for Oregonians' personal health information in an electronic exchange environment to promote widespread participation by providers and patients in these systems.

Strategy A: Any policy developed related to health information exchange must reasonably ensure that systems are in place that protect people's security and privacy and provide for meaningful remedy if these policies are violated.

The federal Health Information Portability and Accountability Act (HIPAA) and current Oregon law offer strong protections for the security and privacy of people's health information. While additional safeguards will be needed over time, strict enforcement of current policies and the existence of penalties for the misuse – including negligent misuse – of information will result in more secure systems being adopted and more privacy and security safeguards being instituted from the beginning.

Strategy B: Utilize an opt-in policy for health information exchange to give individuals' control over their information and who has access to it.

Ensuring clear law and rules for patients and providers involved in electronic health information exchange will increase the use and effectiveness of these systems. Requiring that consumers actively opt-in to a health exchange system will ensure that they know their information will be exchanged electronically.

Strategy C: Ensure that required administrative, physical, and technical safeguards are in place to protect individuals' health information that is specially protected under federal and Oregon state law . Require patients to provide authorization for every instance of exchange of health information that falls within these specially protected categories.

ACTION STEPS:

4.1.The health information technology oversight council will analyze the policies and programs it develops to ensure that the privacy and security of health information is maintained, especially as health information exchange systems are established and expanded.

4.2.The HIIAC will continue to work on privacy and security issues and identify opportunities for Oregon to strengthen state law to protect the privacy and security of Oregonians' health information (See Next Steps).

V. NEXT STEPS

Although the HIIAC members spent significant time discussing privacy and security issues over the last few months, the group was unable to reach consensus on a number of specific focus areas. The group will focus their discussion over the next few months on developing more detailed privacy and security recommendations and will report to the Legislature during the 2009 Legislative session.

Some of the areas the group has identified for further discussion include:

- Patient control of records
- Authorization for individual instances of exchange
- Protection of providers if patient does not allow their information to be fully exchanged
- Right of the patient to keep parts of their record from being exchanged
- Specific penalties and remedies for security breaches
- Ability for patient to correct errors in their record
- Emergency allowances for exchange
- Third party access to information
- Policies that allow for research and public health monitoring while protecting patient privacy

Appendix A: Health Information Technology Glossary

Definitions from:

The National Alliance for Health Information Technology, Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms, April 28, 2008.

Available:

http://www.hhs.gov/healthit/documents/m20080603/10_2_hit_terms.pdf

Electronic Health Record – an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Personal Health Record - an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

Electronic Health Exchange – The electronic movement of health-related information among organizations according to nationally recognized standards.

Appendix B: HISPC Values and Principles

From the HISPC Final State Implementation Report:

HISPC Values & Principles

The goal of this effort is to keep Oregonians health information private and secure. The following values frame Oregon's policy for assuring the privacy and security of electronic health information.

- Trust
- Privacy
- Autonomy
- Feasibility
- Balance
- Portability
- Equality
- Transparency
- Public Accountability

The Oregon HISPC project team carefully studied the research on privacy and security of health information exchange in search of a framework appropriate to guide solution recommendations for Oregon. The Markle Foundation's *Connecting for Health* principles regarding the individual and their health information provide such a framework that will allow Oregon to achieve all the solution recommendations detailed in this report. The Steering Committee recognized the importance of the principles in building trust among all parties in Oregon and embraced the principles as the foundation for health information exchange in Oregon.

1. Individuals should be guaranteed access to their own health information.
2. Individuals should be able to access their personally identifiable health information conveniently and affordably.
3. Individuals should have control over whether and how their personally identifiable health information is shared.
4. Individuals should know how their personally identifiable health information may be used and who has access to it.
5. Systems for health information exchange must protect the integrity, security, and confidentiality of an individual's information.
6. The governance and administration of health information exchange networks should be transparent and publicly accountable.

Appendix C: Specially Protected Health Information and Oregon Law

Oregon HISPIC Project Specially Protected Health Information & Oregon Law March 30, 2007

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A. Introduction:

Oregon law provides special protections for limited classes of health information. Such protections preempt the HIPAA privacy rule because they are more stringent than HIPAA. More stringent is defined as providing greater protections for the patient/health plan member or providing the patient/health plan member greater access to his/her individually identifiable health information (IIHI). The purpose of this document is to identify the different classes of specially protected health information given current Oregon law.

It should be noted that there have been no significant changes to classes of information considered specially protected for some time with two exceptions. The Oregon Legislature provided greater protections for genetic information during the 2005 legislative session. Also, the Oregon Department of Human Services (DHS) recently promulgated rules that allowed freer access to HIV/AIDS test information (keeping in mind that this does not provide any less protection than afforded by the HIPAA privacy rule).

Legislation was passed during the 2003 session that was considered HIPAA conforming legislation. This legislation did not change what was already considered specially protected health information under Oregon law. It merely made sure Oregon law conformed to federal regulations. The only additions to Oregon law, over and above HIPAA, were to establish a maximum amount providers could charge patients for a copy of their medical record and established in statute a model authorization form.

B. Classes of Specially Protected Health Information:

Oregon law, like most other states, provides special protections for certain classes of health information. While laws differ from state to state, generally the categories of health information afforded additional protections are relatively similar. In a number of cases, the primary difference between states is the level of protections found in statute or rule. As an example, Oregon probably has the most stringent genetic privacy law in the nation. Another good example is California – overall California provides greater privacy protections than any other state and has been a leader in enacting consumer-focused legislation that enhances the privacy of the individual.

The different classes of information afforded special protections under Oregon law include:

- Genetics
- Mental health
- Alcohol and chemical dependency (also specially protected under federal law, 42 CFR pt. 2)
- HIV/AIDS
- Health information about a minor (generally a minor 14 years of age or older and specific to alcohol and chemical dependency, birth control, mental health and sexually transmitted diseases)

When health care information is specifically protected, it generally requires a specific authorization from the patient/health plan member for any release, including for treatment, payment and healthcare operations. The authorization to release information needs to be specific, event driven or time limited and can be valid for no more than 18 months. Also, authorization forms need to indicate that no protections are guaranteed after initial release; that the information can be re-released and, at that point, not necessarily protected by the provisions of Oregon law. The exception to this is information about alcohol and chemical dependency. This exception, mandated by 42 CFR pt. 2, requires all authorizations include language indicating that the information cannot be re-released without specific authorization from the patient/health plan member.

C. Legal Specifics:

The following includes the specific legal information regarding specially protected health information under Oregon law.

- a. **HIV/AIDS - Authorization required:** No person may be compelled to disclose the identity of a person upon whom an HIV-related test is performed, or the results of such test in a manner which permits identification of the subject of the test except as required or permitted by law or authorized by the person whose blood is tested. ORS 433.045(3).
 - i. Authorization requirement includes third party payers. OAR 333-012-0170(8)(a)
 - ii. Authorization to release HIV test results must contain:
 1. The statement that HIV test information is to be released
 2. The purpose for which the information may be released
 3. The identity of those to whom the information may be released
 4. The time period during which the release may occur
 5. The date of the authorization and the signature of the person giving authorization. OAR 333-012-0270(8)(a).

Exceptions: The following disclosures do not require authorization:

- iii. Emergency treatment
- iv. To those who “must review the record for the purpose of delivering health care to the individual or for routine administrative procedures”.

- v. Notification in cases of substantial exposure, without disclosing identity of person who is source of exposure
- vi. Reporting to public health authorities
- vii. Notification related to anatomical gifts. OAR 333-012-0270
- viii. But, ORS 430.045(3) prohibits disclosure “except as required or permitted by federal law, the law of this state or any rule...”

NOTE: Recent changed in Oregon Administrative Rule (OAR) allow disclosure of a positive HIV test result or positive diagnosis for purposes of treatment, payment or health care operations without authorization. Negative test results are no longer subject to special protection but such information is still considered protected health information (PHI) under the HIPAA privacy rule and all requirements regarding the sharing of PHI continue to apply.

- b. **Alcohol and Chemical Dependency** – (Oregon Law: ORS 430.399; 430.306)
Treatment Facility: Written records for patient in a drug and alcohol “treatment facility” may not be disclosed without authorization. “Treatment facility” means:
 - i. Outpatient facilities, inpatient facilities and other facilities the Department of Human Services deems suitable, which may provide diagnosis and evaluation, medical care, detoxification, social services or rehabilitation for alcoholics or drug-dependent persons and which operate as a general hospital or state hospital, hostel, foster home, clinic or other suitable form. ORS 430.399(5); ORS 430.306(9)

Minors: Fact of admission to treatment facility must be disclosed to parents or guardian. ORS 430.397

Public Provider: Written records held by a “public provider“ also require authorization unless an exception applies. (ORS 179.505) “Public provider” includes:

- i. Public and private entities that are licensed, approved, established, maintained, operated, or under contract with community mental health programs or with the Department of Human Services for care of substance abuse, mental illness or developmental disabilities. ORS 179.505(1)(g).

Exceptions:

- i. Medical emergency
- ii. Scientific research
- iii. Audit and evaluation
- iv. To State to defend legal action
- v. By a treating provider to officers or employees of that provider, its agents or cooperating health care services providers who are currently acting within the official scope of their duties to evaluate treatment programs, to diagnose or treat or to assist in diagnosing or treating an individual when the written account is to be used in the course of diagnosing or treating the individual.
- vi. Government payers

But...

ORS 179.505(2) says “or unless otherwise permitted or required by state or federal law...” HIPAA permits disclosure of protected health information without authorization in a number of circumstances. It does not specially protect drug/alcohol records. In this case, federal law preempts state law that is more permissive or allows freer exchange of patient information.

Federal Law: (42 CFR sec. 2.12 – 2.67) Patient authorization is required for disclosure of records by a federally assisted drug abuse program, whether or not recorded, unless the patient is incompetent. This applies to information that:

- i. Would identify a patient as an alcohol or drug abuser;
- ii. Is drug abuse information obtained by a federally assisted drug abuse program for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment. (42 CFR sec. 2.12(a)(1))

Program means:

- i. An individual or program (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or
- ii. An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment.
- iii. Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers. 42 CFR sec. 2.11
- iv. Does not apply to a hospital emergency room (ER) unless the primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral or the ER holds itself out as providing services. 42 CFR sec. 2.12(e)(1); United States v. Eide, 875 F.2d 1429 (9th Cir. 1989)

Federally Assisted means:

- i. Conducted by a U.S. department or agency, either directly or by contract
- ii. Licensed, certified registered or given authorization by a U.S. department or agency
- iii. Supported by funds of any department or agency of the U.S. 42 CFR sec. 2.12(b)

Exceptions: (42 CFR sec 2.51- 2.53, 2.61, 2.63)

- i. Medical emergency
- ii. Communication between a program and an entity providing services to a program such as data processing, bill collecting, laboratory analyses, legal or other professional services
- iii. Research
- iv. Audit and evaluation

- v. Reports of suspected child abuse and neglect, but only reports
- vi. Crime on premises or against program personnel
- vii. Court order but only if:
 - 1. Is necessary to protect against an existing threat to life or of serious bodily injury;
 - 2. Is necessary for investigation or prosecution of an extremely serious crime;
 - 3. If the patient offers testimony in an administrative or a litigation proceeding.

Notable non-exceptions:

- a. Continuing medical care
- b. Subpoena

No Re-disclosure: A disclosure made with patient consent must be accompanied by a written statement prohibiting re-disclosure. 42 CFR 2.32

- c. **Mental Health - Authorization Required:** Written authorization required for disclosure of records held by “public provider.” (ORS 179.505) It should be noted that there is some ambiguity in the law that has resulted in the industry practice of requiring authorization from the patient/health plan member prior to release of any mental health information.

Exceptions: No authorization required for:

- i. Medical emergency
- ii. Scientific research
- iii. Audit and evaluation
- iv. To State to defend legal action
- v. By a treating provider to officers or employees of that provider, its agents or cooperating health care services providers who are currently acting within the official scope of their duties to evaluate treatment programs, to diagnose or treat or to assist in diagnosing or treating an individual when the written account is to be used in the course of diagnosing or treating the individual.
- vi. Government payers

Form of Authorization: ORS 179.505 specifies requirements. State model form likely qualifies.

“Private” Mental Health Record: Mental health records held by a non-public provider do not require authorization for disclosure, except:

- i. Authorization Required for “Psychotherapy Notes”: Psychotherapy notes are notes recorded by a mental health professional in the performance of the official duties of the professional that document or analyze the contents of conversation during a counseling session, and that are maintained separately from the rest of the individual’s medical record. (ORS 179.505(1)(e); 42 CFR sec. 164.501 - HIPAA Privacy Standards)

- d. **Genetic Information** – (Oregon Law: ORS 192.531 to 192.549; OAR 333-025-0105 to 333-025-0130) Authorization Required:
- i. "...a person may not disclose or be compelled, by subpoena or any other means, to disclose the identity of an individual upon whom a genetic test has been performed or the identity of a blood relative of the individual, or to disclose genetic information about the individual or a blood relative of the individual in a manner that permits identification of the individual..." (ORS 192.531)

Genetic Information is defined as: "Information about an individual or an individual's blood relative that is derived from a 'genetic test'." (ORS 192.531)

Genetic information does not include:

- i. Family history
- ii. Clinical diagnosis of a genetic or heritable condition, if not derived from a genetic test.

Exceptions:

- i. Law enforcement purposes (identification, investigation)
- ii. Court order
- iii. Medical diagnosis of relatives of decedent
- iv. Identification of body

Paternity Testing: Consent of individual not required to obtain genetic information for purposes of establishing paternity "as authorized by statute." (ORS 192.535)

Form of Authorization: Administrative rules incorporate State model form.

Notice of Use and Authorization Requirements: ORS 192. 538; OAR 333-025-0100-0165 :

Beginning July 1, 2006, health care providers other than "indirect providers" are required to provide a notice to patients explaining the possible use of their biological specimen or clinical information for coded genetic research now or at some point in the future and give the patient the right to opt of such use.

Individuals or Entities Required to Provide Notice: This applies to all providers whether or not the provider conducts genetic research. Covered health care providers include:

- i. Collect biological specimens or clinical individually identifiable information from patient;
- ii. Are HIPAA covered entities; and
- iii. Have a direct treatment relationship with an individual. OAR 333-025-0165

Individuals or Entities (health care providers) not required to provide the notice:

- i. A provider who is not a HIPAA covered entity. These providers may comply with the notice requirement but are not required to. An example of a person who is a health care provider but not necessarily a HIPAA covered entity is a publicly employed EMT who never bills for services or the increasingly rare physician who runs an entirely paper practice.
- ii. An indirect health care provider. An indirect care provider is defined as a health care provider having a relationship with an individual in which:

1. The health care provider delivers health care to the individual based on the orders of another health care provider; and
2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual. (OAR 333-025-0100(26))

Notifications Need to Include:

- i. The patient's biological specimen or clinical individually identifiable health information may be used for anonymous or coded genetic research;
- ii. Provide the patient or the personal representative an opportunity to opt out of such use.
- iii. Specifically, the notification must include:
 1. A place where the patient may mark to indicate the patient's opt-out statement;
 2. A general explanation of the meaning of anonymous and coded research;
 3. A statement describing the biological specimen or clinical individually identifiable health information may be used at some undetermined point in the future without further notice to the patient;
 4. A statement that a refusal to allow use of biological specimens or clinical individually identifiable health information will not affect access to or provision of health care by the provider originally providing notice;
 5. A statement specifying that the patient retains the right to make or revoke an opt-out statement by submitting in writing such a request to the health care provider originally providing notice;
 6. A statement indicating that an opt-out statement will be valid from the date received by the health care provider;
 7. A prominent heading indicating the purpose of the notice; and
 8. The name or title and telephone number or other contact information of a person or office to contact for further information. (OAR 333-025-0165(7))

Notice Must be Provided no later than the time required for federal privacy notices by the Federal Privacy Rule for services rendered on or after July 1, 2006. (OAR 333-025-0165(3))

Frequency of Notice Provision: The notice need only be provided once, even if the provider sees the patient multiple times. (OAR 333-025-0165 (4))

Provider's obligation to disclose an opt out to other providers: Direct care providers must, at the time they disclose biological specimen or clinical individually identifiable health information to an indirect provider, inform the indirect provider that the individual's biological specimen or clinical individually identifiable health information is subject to an opt out statement. (OAR 333-025-0165(9))

Provider receipt of an opt out statement or the patient changes their mind regarding opt out after the provider has disclosed information about the patient: If an opt out statement is received after completion of the first service delivery and within the first 14 days from the completion of the first service delivery, a health care provider is

encouraged, but is not required, to make a good faith effort to inform the indirect health care provider of the opt-out statement. (OAR 333-025-0165(9))

Provider requirements to notify indirect providers outside the state of Oregon: The law requires Oregon health care providers notify indirect providers who are the intended recipient of an individual's biological specimen or clinical individually identifiable health information of an opt out. The law does not create an exception for notification of indirect providers with business operations outside Oregon.

Providers notification of indirect providers of an opt out: Methods of informing indirect providers may include, but are not limited to, marking or noting the biological specimen container or clinical individually identifiable health information as subject to an opt out. (OAR 333-025-0165(9))

Enforcement: The genetic privacy statutes contain criminal as well as civil penalties. None of these penalties, however, appear to directly apply to the requirement to notify individuals of their right to opt out of disclosure of their clinical individually identifiable health information or biological specimen and notify indirect providers. (ORS 192.541, 192.543 and 192.545)

- e. **Minors** – Minors have a number of rights under Oregon statute. Some are defined by age, some are defined by age and condition and some are defined by virtue of the fact that the minor is emancipated. Following is a description of a minor's rights under all of these conditions in the state of Oregon. It should be noted that additional provisions regarding institutionalization (e.g., mental illness, juvenile crime, etc.) may allow the State and institutions greater access and ability to disclose protected minor health information (similar to laws governing the health information for institutionalized adults).

There is a conflict between Oregon law, HIPAA and ERISA. If the minor child seeks treatment in a situation where parental consent or knowledge is left up to the minor, if the minor seeks payment under the parent or guardian's health insurance policy, ERISA requires the policy holder be provided an explanation of benefits. This, in and of itself, often discloses the treatment provided the minor in a situation where the minor would have elected not to involve a parent or guardian or disclose any information about the treatment provided. At this point in time, there is no legal solution and it becomes a matter where the minor is required to pay for the services to avoid unwanted disclosure to a parent or guardian.

Right to treatment for venereal disease without parental consent: A minor who may have come into contact with any venereal disease may give the health care provider consent for diagnosis or treatment. If the disease or condition is one where Oregon law requires the diagnosis/treatment be reported to a public health agency, the information must still be reported.

The consent of a parent or legal guardian of the minor cannot be required to diagnosis and treatment from an Oregon health care provider. In this situation Oregon law clearly states that without parental or guardian consent, the parent or legal guardian is not be liable for payment of any such care rendered. This also means, though, that the parent or guardian does not have the right to

access diagnosis and treatment information without the authorization of the minor. (ORS 160.110)

Provision of birth control information and services: Any physician or nurse practitioner may provide birth control information and services to any person without regard to the age of the person. This means a minor has the right to consent to provision of birth control information and services. Generally if the patient (in this case, the minor) is “at the age of consent” for medical services, the minor in essence controls the information and access to the information. In other words, the minor would need to authorize the sharing of any birth control services information to parents or guardians, as an example. (ORS 190.640)

Right to medical or dental treatment without parental consent: A minor 15 years of age or older may consent to hospital care, medical or surgical diagnosis or treatment by a physician licensed by the Board of Medical Examiners for the State of Oregon, and dental or surgical diagnosis or treatment by a dentist licensed by the Oregon Board of Dentistry, without the consent of a parent or guardian. Also, a minor 15 years of age or older may consent to diagnosis and treatment by a nurse practitioner who is licensed by the Oregon State Board of Nursing without the consent of a parent or guardian of the minor. In this case, the parents or guardians may be informed or advised of treatment without minor consent (see following). (ORS 109.640)

Disclosure without minor’s consent: A hospital, physician, nurse practitioner or dentist may advise the parents or legal guardian of a minor of the care, diagnosis, treatment or need for treatment without the consent of the minor. Also, Oregon law specifically states that any hospital, physician, nurse practitioner or dentist who chooses to advise the parents or legal guardian without consent cannot be held liable. (ORS 109.650)

Right to diagnosis or treatment for mental health or chemical dependency without parental consent: A minor 14 years of age or older may obtain, without parental knowledge or consent, outpatient mental health or chemical dependency diagnosis or treatment by a licensed physician, psychologist, nurse practitioner, clinical social worker or a DHS approved community mental health and developmental disabilities program (see ORS 430.620).

Exception: The approved health care provider managing or providing treatment is required to involve the parents or guardians of the minor before the end of treatment unless the parents refuse or unless there are clear clinical indications where the provider determines parental involvement would be to the detriment of the minor (must be documented in the treatment record). This exception does not apply to:

- A minor who has been sexually abused by a parent or guardian; or

- An emancipated minor (see ORS 109.510 and 109.520 or 419B.550 to 419B.558). The minor is considered emancipated for mental health or chemical dependency treatment only if the minor has not lived with the parents or guardian and is self-sustaining for a period of 90 days prior to seeking treatment. (ORS 109.675)

Mental health or chemical dependency treatment disclosure without minor's consent: A physician, psychologist, nurse practitioner, licensed clinical social worker or community mental health and developmental disabilities program may advise the parent or parents or legal guardian of any minor regarding diagnosis or treatment when the disclosure is deemed by the provider to be clinically appropriate and the provider considers such disclosure to be in the best interests of the minor's treatment because the minor's condition has deteriorated or the risk of a suicide attempt requires inpatient treatment, or the minor's condition requires detoxification in a residential or acute care facility. If the parents or guardian are notified, the physician, psychologist, nurse practitioner, licensed clinical social worker or community mental health and developmental disabilities program is not be subject to any civil liability for advising the parent or legal guardian without the consent of the minor.

It should be noted that the general practice of mental health practitioners is a reluctance to notify parents or the guardian. There is a concern that such notification will not be in the best interest of the minor. (ORS 109.680)

Parent or guardian not liable for payment: If a minor is diagnosed or treated for mental health or chemical dependency without the consent of the minor's parent or legal guardian, the parents or legal guardian are not be liable for payment for treatment or diagnosis. If the minor elects to seek payment under the parents or guardian's health insurance policy, the policy holder (parent or guardian) will be notified by the health plan through an explanation of benefits. (ORS 109.690)

Emancipation: A minor is treated as an adult regarding health care and health care privacy rights if the minor is legally emancipated by the courts. That means that any provisions regarding specially protected health information (e.g., mental health, HIV/AIDS, etc.) apply regarding release and the requirement for authorization for release. (ORS 419B.552)

Majority of married persons: Even if a minor has not reached the age of majority, the minor is considered an adult if the minor is legally married. A minor can marry at the age of 17 with the consent of parents or legal guardian. (ORS 109.520)

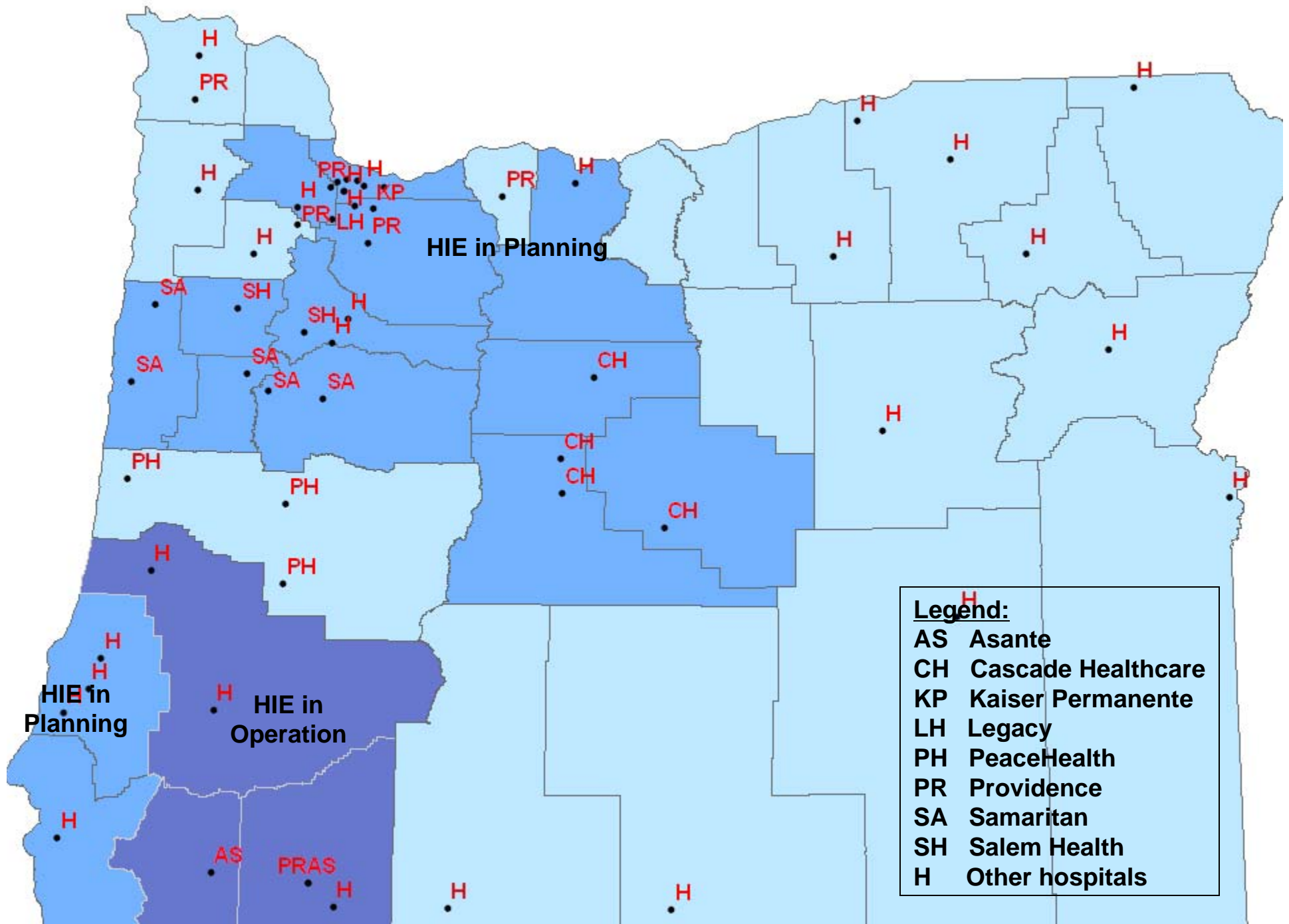
D. Summary:

Oregon law provides certain additional privacy protections for what are generally

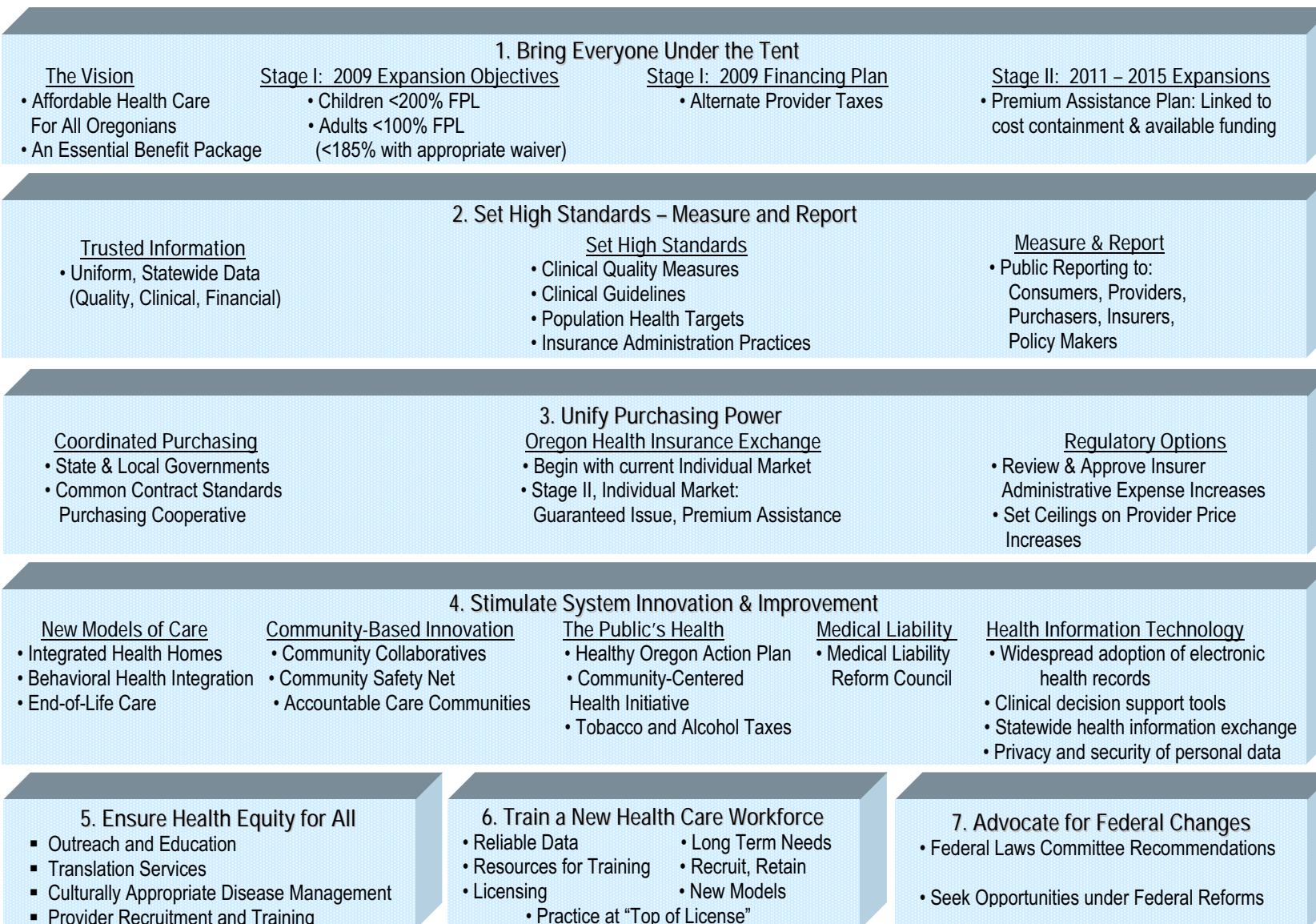
considered specially protected health information. Also, federal law aside from HIPAA provides additional protections for certain types of health conditions. Most federal and state laws that are more stringent than HIPAA were enacted prior to the advent of electronic health information exchanges. Congress is reluctant to preempt any state law and it is especially politically unpalatable to preempt more stringent privacy laws (provides greater protections to the patient). The same is true at the state level. The Oregon Legislative Assembly would be equally reluctant to tamper with additional privacy protections because of consumer and political backlash.

While it is worth reviewing Oregon law in an effort to make it more consistent and takes into account the different world presented by electronic health information exchange, it would be wise to conduct a thorough review, involve the appropriate advocates and the appropriate practitioners. As an example, behavioral health practitioners are especially protective of the health information of their patients, whether legally required or not.

It is important to remember that a number of the statutes on the books today that provide special protections are there for a reason. Mental illness and chemical dependency, as an example are conditions where individuals with mental illness or chemical dependency have been stigmatized by society and, to some extent, the health care system. There are a number of vocal advocates that will strongly oppose any changes if such changes do not continue to provide what would be considered adequate protections or appear to take privacy rights away. In the meantime, the healthcare industry takes specially sensitive health information very seriously and, even if not specifically protected by statute, may impose additional restrictions to access over and above legal requirements. Any changes would also require a cultural change in addition to a legal one.



BUILDING A HEALTHY OREGON: THE 7 ESSENTIAL BUILDING BLOCKS



Health Information Technology Oversight Council
Future Meeting Dates 2009

Thursday, November 5, 2009

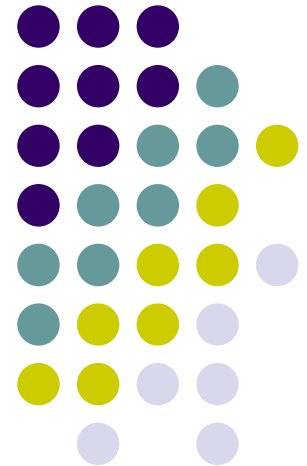
1:00 pm – 5:00pm
NW Vitaculture Center
212 Doaks Ferry Road
Salem, Oregon

Wednesday December 9, 2009

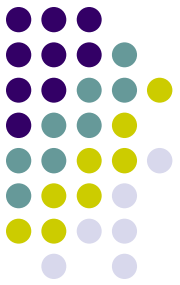
1:00 pm – 5:00pm
Portland State Office Building 1B
800 NE Oregon St.
Portland, Oregon 97232

Health Information Technology Oversight Council

First Meeting
October 8, 2009
2:00-5:00 PM
Portland State Office Building
800 NE Oregon Street
Room 918



HITOC Members



Chair:

Steve Gordon, M.D., Eugene, VP, Chief Quality Officer, PeaceHealth

Vice Chair:

Rick Howard, Salem, CIO, Oregon Department of Human Services & Oregon Health Authority

Bob Brown, Portland, Retired, Board member, Oregon Health Action Campaign

Brian DeVore, Hillsboro, Director of Industry Affairs, Intel

Greg Fraser, M.D., Sublimity, Medical Director of Information Systems and Informatics, Mid-Valley IPA

Bridget Haggerty, Portland, VP, CIO, Oregon Health & Sciences University

Bill Hockett, Portland, Director, Web Strategy, ODS

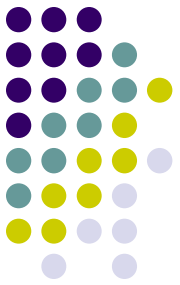
Marie Laper, Corvallis, Coordinator of Quality Improvement & Clinical Care, Benton County Health Services

Robert Rizk, Hermiston, Director, Information Technology, Good Shepherd Health System

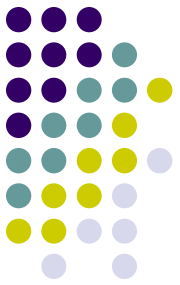
Sharon Stanphill, Roseburg, Clinic Director, Cow Creek Band of Umpqua Tribe of Indians

Dave Widen, Dayton, Director of Pharmacy, Safeway

Staff



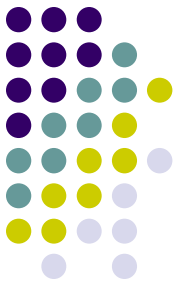
- Carol Robinson, State Coordinator for Health Information Exchange, Director of HITOC
- Jeanene Smith, MD, MPH, Administrator, Office of Health Policy & Research
- Dawn Bonder, JD, Senior Policy Advisor to Governor Ted Kulongoski
- Rick Howard, CIO, Dept. of Human Services & Oregon Health Authority
- Sean Kolmer, Acting Deputy Administrator, Office of Health Policy & Research
- Susan Otter, Policy Analyst, Office of Health Policy & Research
- Additional support staff from the Office of Health Policy & Research



Consulting Team

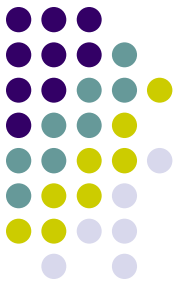
- Shaun Alfreds, MBA
National Academy of State Health Policy
- Jay Himmelstein, MD, MPP
University of Massachusetts
- Julie Harrelson
The Harrelson Group
- Dave Witter, MA
Witter & Associates

AGENDA



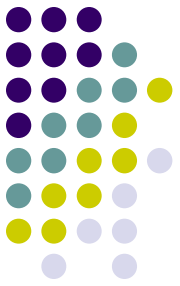
- 2:00- 2:20 Welcome and Introductions
- 2:20- 2:30 Review Agenda and Proposed Outcomes
- 2:30-3:00 Key Operating Considerations
 - Bylaws and Policies
 - Review Public Meeting Laws
 - Guiding Principles
- 3:00- 3:15 HITOC Charter and Objectives
 - House Bill 2009
 - Federal Cooperative Agreement Program
- 3:15- 3:35 Progress to Date
 - Letter of Intent
 - Application for Cooperative Agreement Program
 - Environmental Scan
- 3:35- 4:15 National Perspective of HIE
- 4:15- 4:45 Vision and Strategies for HITOC
 - Working Principles
 - Draft Work Plan with Timeline
- 4:45- 5:00 Next Steps, Questions

Key Operating Considerations



- Review and Adopt Bylaws
- Review and Adopt Conflict of Interest Policy
- Synopsis of Public Meeting Law Included in Notebook

Guiding Principles for HITOC (DRAFT)

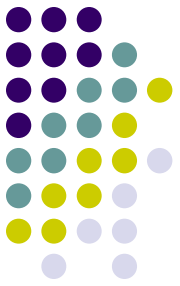


1. We will operate in collaboration and partnership between the private and public sectors, leveraging current investments where possible.
2. We will be transparent in our work and inclusive of stakeholder input.
3. We will only support solutions that meet or exceed national and industry standards.
4. We will adopt policies that protect the integrity, availability and confidentiality of the consumer's health information.
5. We will employ strategies that assist individuals in making informed health decisions.
6. We will identify and align incentives for all stakeholders for the purposes of improving the quality and efficiency of health care in Oregon and across our borders.

HB 2009 Sections 1167- 1171

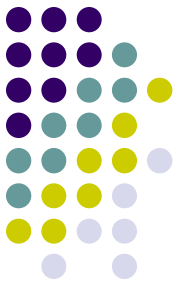
The duties of the Health Information Technology

Oversight Council:

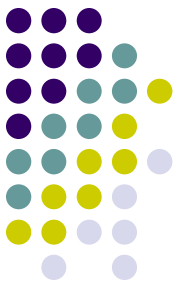


- (1) Set goals and develop a strategic plan
- (2) Monitor progress
- (3) Maximize the distribution of resources
- (4) Create a mechanism to help with adoption of technology
- (5) Identify and select the industry standards
- (6) Enlist and leverage community resources
- (7) Educate the public and health care providers
- (8) Coordinate health care sector activities
- (9) Support and oversee efforts to implement a personal health records bank for medical assistance recipients
- (10) Determine a fair, appropriate method to reimburse providers for their use of electronic health records
- (11) Determine whether to establish a health information technology loan program

ARRA, HITECH and State Responsibilities



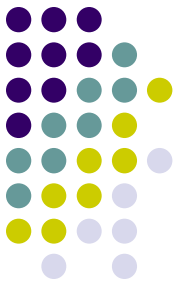
- **7/15/2010:** A statewide strategic and operational plan for Health Information Exchange (HIE), to be implemented by the State or by a State Designated Entity (SDE)
- **Ongoing:** Close collaboration with the state applicant (OCHIN with partnership from OHSU) for the Regional Extension Center (REC)
- **Early 2010:** HIT Planning- Advance Planning Document (PAPD) from State Medicaid office to CMS
- **Necessary to Administer Medicaid Incentive Payments to Eligible Providers:** State Medicaid HIT Plan (SMHP)



Progress to date

- September 1, 2009-HITOC nominations announced
- September 11, 2009- Letter of Intent filed for HIE Cooperative Agreement Program
- September 8, 2009- OCHIN files application for Regional Extension Center
- September 24, 2009-Contingent attends National Governors Association education conference
- September 29, 2009- OCHIN is invited to submit full application for 1st round of REC funding
- September 2009- Consulting team hired
- October 1, 2009-HITOC nominees confirmed
- October 1, 2009- Environmental scan complete
- October 8, 2009 HITOC launch
- October 16, 2009 Cooperative Agreement Grant Application due

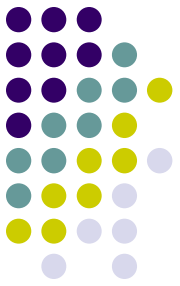
Environmental Scan: Oregon's Readiness for HIE



Well positioned:

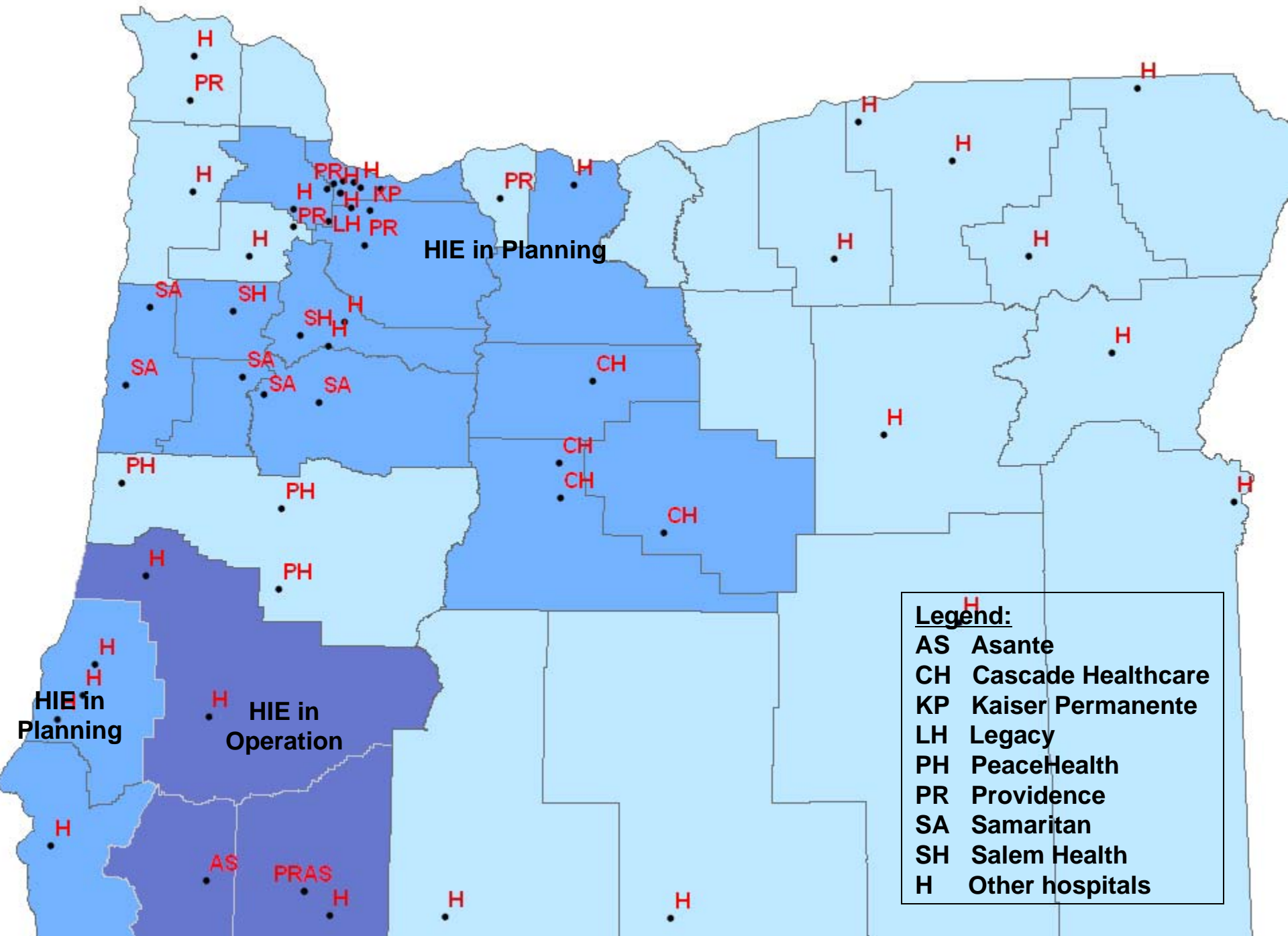
- Health systems
- Mid to large practices
- More urbanized areas
- Federally Qualified Health Centers

Environmental Scan: Oregon's Readiness for HIE



In Need of the Most Help:

- Small and Rural Practices
- Local Public Health Departments
- Corrections
- 30% of Critical Access Hospitals
- Freestanding Public Sector Applications



Nationwide Transformation



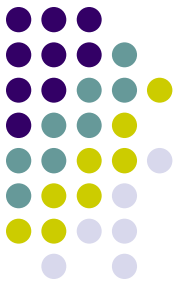
President Obama signed the American Recovery and Reinvestment ACT in February 2009

“To improve the quality of our health care while lowering its cost, we will make the immediate investments necessary to ensure that, within five years, all of America’s medical records are computerized.

This will cut waste, eliminate red tape, and reduce the need to repeat expensive medical tests. But it just won’t save billions of dollars and thousands of jobs; it will save lives by reducing the deadly but preventable medical errors that pervade our health care system.”

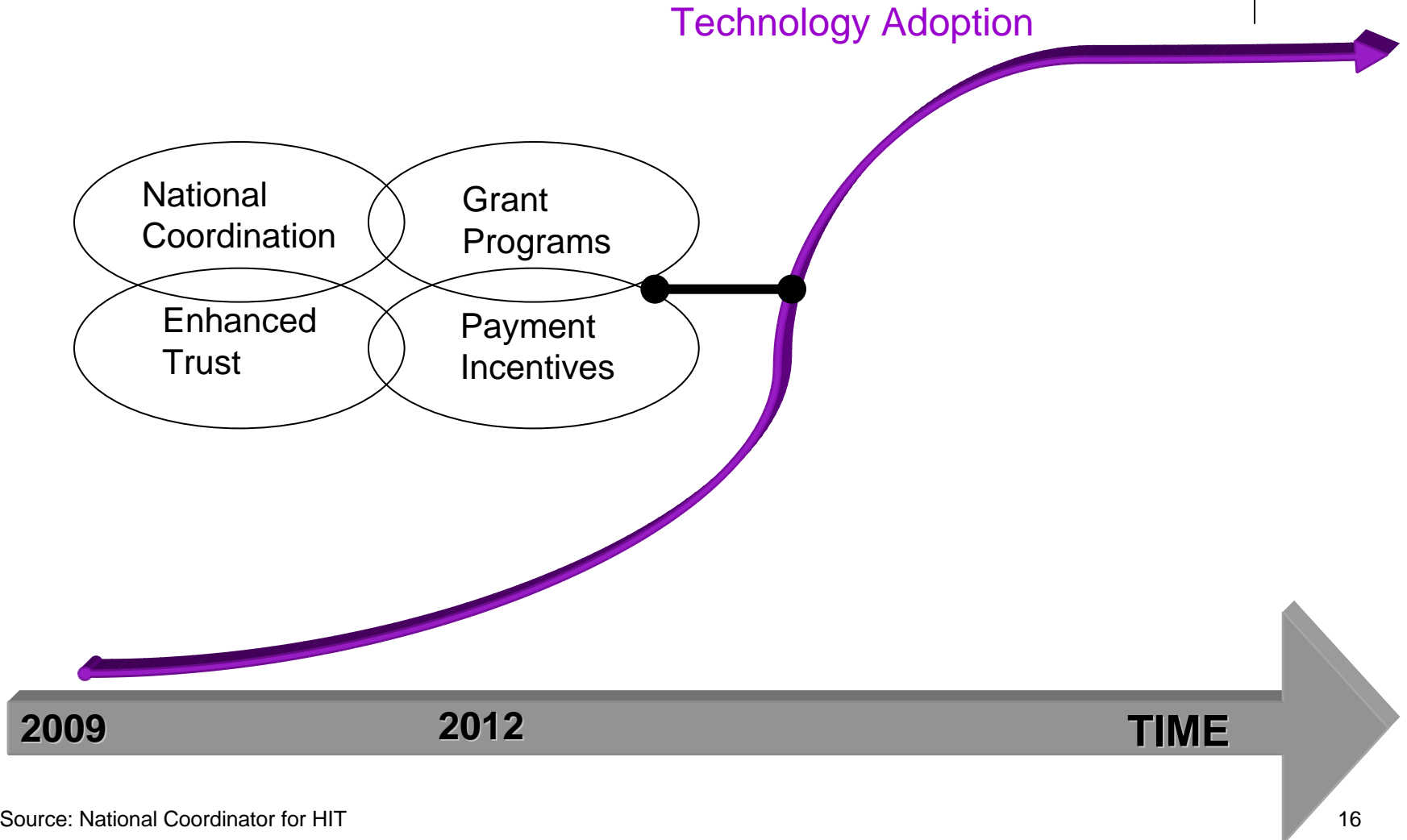
President Barack Obama

Federal HIT Market-Infusion



- American Recovery and Reinvestment Act
 - Codified National Coordinator for HIT and Policy & Standards Committee
 - \$44.7B estimated incentive payments from Medicare and Medicaid and administrative funds to support planning
 - \$600M to plan and implement sustainable State-Level HIE (All states govts. required to have an HIT Coordinator)
 - \$600M to support Regional “HIT Adoption” Extension Centers
 - Additional Funds for:
 - Broadband and telehealth
 - Community health center and Indian health infrastructure
 - Social Security Administration

Goal: Move the HIT Tipping Point

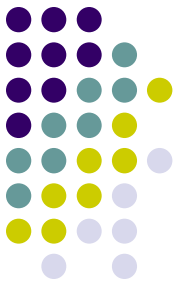


CMS Incentives for HIT Adoption



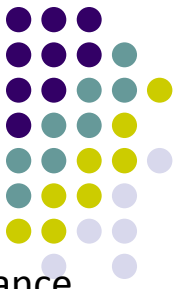
- *\$44.7B estimated incentive payments from Medicare and Medicaid*
 - *\$23B Medicare, \$21B Medicaid*
- *A hospital or eligible provider must be a “meaningful user” to receive payment incentives*
 - Use a certified EHR
 - Exchange health information
 - Report quality measures
 - Meaningful use definitions are expected to be published by 12/31/2009
- Eligible Medicaid Professionals: Up to a maximum of \$63,750 over a 6 year period
- Eligible Medicare Professionals: Up to \$44,000 through 2015
- Hospitals: Amounts determined through formula
- *90% FFP Administrative Funds to Medicaid State Agencies*
 - Administer the incentive payments
 - Conduct oversight, tracking meaningful use attestations and reporting
 - Pursue initiatives to encourage adoption of EHR technology to promote quality

State HIE Cooperative Agreement Program: State's Critical Role



- **States will be expected to use their authority, programs, and resources to:**
 - Determine roles and responsibilities of State Designated Entity
 - Develop and implement Strategic and Operational Plans
 - Develop and enable technical services for HIE within and across contiguous states
 - Remove barriers and create enablers for HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information trading partners
 - Convene health care stakeholders to ensure trust and support for a statewide HIE
 - Ensure that an effective model for HIE governance and accountability is in place
 - Coordinate an integrated approach with Medicaid and state public health programs to enable public and private HIT (administrative and clinical)
 - Develop or update privacy and security requirements for HIE within and across state borders
- **The HITECH Act requires states or SDEs to submit and receive approval of State Strategic and Operational Plans for HIE**

Regional Extension Center Program



Each Regional Center is expected to provide federally supported individualized technical assistance to a minimum of 1,000 priority primary-care providers in the first two years of the four-year cooperative agreement project period.

- Applicant: Non Profit Organization (with stakeholder representation and letter from Medicaid)
- Core Services: Outreach and educational activities; Local workforce support; Participation peer-learning and knowledge transfer activities facilitated by the HITRC
- Direct Technical Assistance:
 - Group purchasing of EHR software
 - Onsite EHR Implementation Technical Assistance
 - Onsite Practice and Workflow Redesign
 - Technical Assistance on functional Interoperability and HIE
- Target Providers:
 - Primary-care providers in individual and small group practices (fewer than 10 physicians and/or other health care professionals with prescriptive privileges) primarily focused on primary care;
 - Physicians, physician assistants, or nurse practitioners who provide primary care services in public and critical access hospitals, CHCs, RHCs, and in other settings that predominantly serve uninsured, underinsured, and medically underserved populations.

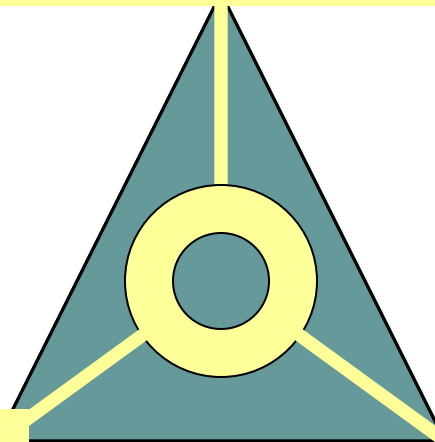
Vision and Strategies for HITOC Oregon's Triple Aim Goal



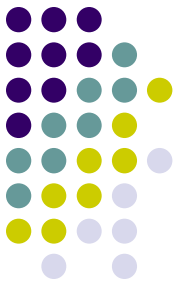
Improved Patient Experience

Improved Population Health

Lower Per Capita Costs



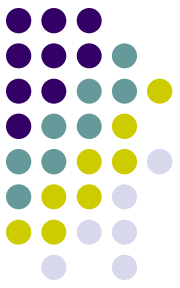
Building on Oregon Health Fund Board's Goals



- Bring everyone under the tent
- Set High Standards
- Unify purchasing power
- Stimulate Innovation and Improvement
- Ensure health equity for all
- Train a new Health Care Workforce
- Advocate for Federal Change

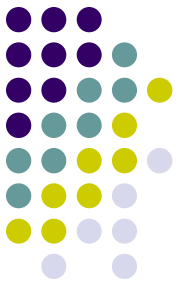
Building on HIIAC

Recommendations



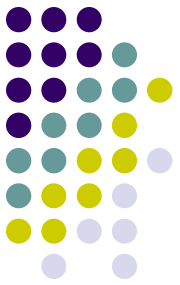
- Stimulate, coordinate and support as a priority to increase the utilization of interoperable health information technology
- Accelerate widespread, effective use of health information technology (HIT) by healthcare providers and patients/consumers to improve health outcomes and health care quality
- Have by 2012 a statewide system for electronic exchange of health information

Working Principles



Roles and Responsibilities of:

- Council members
- Staff
- Consultants
- Stakeholders



Next Steps

Meeting Dates:

- November 5th, 1:00-5:00 PM Salem
- December 9th, 1:00-5:00 PM Portland

Information Needs:

Carol.robinson@state.or.us

503-373-1817