

Health Information Technology Oversight Council

February 4, 2016, 1:00 – 4:30 pm

The Lincoln Building – Pine Room, First Floor

421 SW Oak Street

Portland, OR 97204

Call in: (888) 808-6929, Participant Code: 453773

Name	Organization	Title
Richard (Rich) Bodager, CPA, MBA	Southern Oregon Cardiology/Jefferson HIE	CEO/Board Chair
Maili Boynay	Legacy Health	IS Director Ambulatory Community Systems
Robert (Bob) Brown	Allies for Healthier Oregon	Retired Advocate
Erick Doolen	PacificSource	COO
Chuck Fischer	Advantage Dental	IT Director
Valerie Fong, RN	Providence Health & Services	CNIO
Charles (Bud) Garrison	Oregon Health & Science University	Director, Clinical Informatics
Brandon Gatke	Cascadia Behavioral Healthcare	CIO
Amy Henninger, MD	Multnomah County Health Department	Site Medical Director
Mark Hetz	Asante Health System	CIO
Sarah Laiosa, DO	Harney District Hospital Family Care	Physician
Sonney Sapra	Tuality Healthcare	CIO
Greg Van Pelt	Oregon Health Leadership Council	President

Time	Topic and Lead	Action	Materials
1:00 pm	Welcome, Introductions & Approve Minutes – Bob Brown (Vice-Chair) <ul style="list-style-type: none"> • Introductions: Health Tech Solutions • Approval of Minutes – December 2015 • Goals of Health IT-Optimized Health Care – Susan Otter • Aims & Objectives Recap – Susan Otter 	Information Discussion Action	1. Agenda 2. December HITOC Meeting Minutes 3. Edited Aims & Objectives of HIT-Optimized Health Care
1:15 pm	Priority Policy Topics: Interoperability <ul style="list-style-type: none"> • National Environment Presentation: Gary Ozanich, Health Tech Solutions • State Levers and Potential Approaches: Susan Otter • Interoperability SME Workgroup Charter: Justin Keller 	Information Discussion	
2:40 pm	Break		
2:55 pm	Priority Policy Topics: Behavioral Health Information Sharing <ul style="list-style-type: none"> • Presentation: Jefferson HIE orientation: Gina Bianco, Executive Director, Jefferson HIE • Presentation: OHA Behavioral Health Information Sharing Resources, Veronica Guerra, OHA 	Information Discussion	

3:55 pm	HITOC Workplan Discussion – Susan Otter & Justin Keller <ul style="list-style-type: none"> Review of HITOC Work Plan Draft Major Deliverables for 2016 	Information Discussion	
4:05 pm	HITOC Business <ul style="list-style-type: none"> Confirm Recurring Meeting Logistics Endorsement of Charters: Provider Directory Advisory Group, Common Credentialing Advisory Group 	Information Discussion Action	4. PDAG Charter 5. CCAG Charter
4:20 pm	Public Comment	Information Discussion	
4:25 pm	Closing Remarks – Bob Brown		

Other Materials

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Next Meeting: **April 7, 2016, 1:00 – 4:30 p.m.**
Transformation Center Training Room
Lincoln Building, Suite 775
421 SW Oak Street
Portland, OR

Vision: HIT-optimized health care: A transformed health system where HIT/HIE efforts ensure that the care Oregonians receive is optimized by HIT.

Three Goals of HIT-Optimized Health Care:

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.
- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.
- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

Health Information Technology Oversight Council

Monday, December 14, 2015; Salem, Oregon

1:00 – 4:30 pm

Council and Ex-officio Members Present: Erick Doolen (Chair), Bob Brown (Vice-Chair), Maili Boynay, Chuck Fischer, Valerie Fong, Bud Garrison, Brandon Gatke, Amy Henninger, Sarah Laiosa, Sonney Sapra

Council and Ex-officio Members by Phone: Rich Bodager, Mark Hetz

Council and Ex-officio Members Absent: Greg Van Pelt

Staff Present: Susan Otter, Rachel Ostroy, Marta Makarushka, Lisa Parker, Kristin Bork, Justin Keller, Kim Mounts, Tyler Lamberts, Frank Lassiter (Consultant)

Welcome – Susan Otter and Erick Doolen (Chair)

Refer to HITOC 14OCT15 Minutes Final document; slides 2-4

- Erick started the meeting and welcomed the group; the council members and staff introduced themselves. The Chair then reviewed the agenda for the meeting.
- The chair presented the October HITOC meeting minutes, and Bob Brown moved to approve the minutes and several HITOC members seconded. All HITOC members present and on the phone were in favor of approving the minutes; no one opposed. There were no additional comments or announcements.
- Susan reviewed the three goals of HIT-Optimized Health Care, and explained the vision of these goals in Oregon. She then spoke about the ‘ground rules’ for HITOC, noting that all meetings are public and that HITOC does not have their own budget. She also reminded the group that OHA staff are responsible for addressing the needs of HITOC and welcomed members to contact Office of Health IT staff whenever support is needed.

Existing Oregon HIT Strategic Plan Discussion – Susan Otter, Justin Keller, Erick Doolen (Chair)

Refer to the Oregon HIT BPF Goals Aims Strategies Final document; slides 5-9

Presentation:

- Susan explained the instructions for a group exercise in exploring the aims and objectives in the Business Plan Framework, Oregon’s existing strategic plan for HIT. She highlighted the fact that the Business Plan Framework was the ‘best thinking’ in 2013, and the group was tasked with validating the aims and objectives summarized in the document and/or suggesting changes or modifications.
- The members then broke into small groups for discussion, each lead by a staff facilitator. The goal for the breakout session was to come to a group consensus on a set of questions focused on the presented aims: were the aims and objectives directionally correct; were there any significant gaps; and did significant changes need to be acknowledged?

Discussion:

- Summary of report-out from small group discussions:
 - A changed culture regarding HIT in Oregon was emphasized as an overarching aim;
 - The consensus was that the aims and objectives were directionally correct. Emphasis was made on privacy and security, interoperability of all systems, and streamlining processes/workflows;

- Gaps identified included the need for payment reform that would reimburse providers for their efforts to communicate with patients electronically, training and education to address culture change (including providers and patients), and the need to address barriers for patients to telemedicine and electronic sharing of information (e.g. internet connection);
- Other comments on the aims and objectives included: making adoption and interoperability important across all systems, not just electronic health records; HITOC members felt that Direct secure messaging was called out specifically as a standard but other standards were not specified; the group emphasized population health as an evolving area that should be considered in the future; patient-derived data, and potential provider liability around this, was also discussed as a potential update.
- Question: when will the strategic plan be updated, and what is the timeline?
 - Answer: Susan explained that this timeline will be informed by the conversations that the group is starting today. She also noted that updates would likely be started in the second half of 2016, unless there is urgency for doing it sooner.
- Question: historically we have been driven by requirements that come from the ONC because of funding. Is that still the case? How do we take that into account as we think about priorities?
 - Answer: Susan shared that the cooperative agreement with the Office of the National Coordinator for HIT (ONC) ended in February 2014 and that funding is now provided by the Centers for Medicare & Medicaid Services (CMS). These federal funds are not under a cooperative agreement and do not have the same parameters.

HIT Governance and Roles – Justin Keller, Marta Makarushka, Susan Otter

Refer to HITOC By Laws, HCOP Charter for New HITOC, Other HIT Governance Charters Combined and OHIT External Group Membership Lists documents; slides 11-28

Presentation:

- Justin reviewed the HITOC by-laws. Bob Brown motioned to approve by-laws. All HITOC members present and on the phone were in favor of approving the by-laws; no one opposed.
- Susan then gave an overview of the HIT governance environment in Oregon—including the role of the Oregon Health Policy Board (OHPB). Other groups discussed include the CCO HIT Advisory Group (HITAG), and the Emergency Department Information Exchange (EDIE) Utility Governance Committee, staffed by the Oregon Health Leadership Council.
- Marta gave an overview of the HIT/HIE Community and Organizational Panel (HCOP) including their objectives and membership. Susan asked the group to endorse the HCOP charter, which had been approved by the previous HITOC. Sonney Sagra motioned to endorse the HCOP charter. All HITOC members present and on the phone were in favor of endorsing the charter; no one opposed.
- Susan gave an overview of the Common Credentialing Advisory Group (CCAG) and the Provider Directory Advisory Group (PDAG). She explained that the proposal is to establish a reporting relationship with both of these groups, and to have them report to HITOC twice per year and as policy issues arise. Both charters will be brought back to the group at the next meeting; looking for endorsement from HITOC.

Discussion:

- Question: how often will HITOC be reporting to the Oregon Health Policy Board?

- Answer: Susan explained that the statute says HITOC must report to the Oregon Health Policy Board ‘regularly;’ OHA anticipates this could be approximately twice per year. OHA must also report to the legislature on the status of the Oregon HIT program at least annually. OHA’s goal is to align these reports.
- Question: where does Common Credentialing fit into the committees under the OHPB?
 - Answer: Susan shared that the Common Credentialing work is legislatively mandated and that members of CCAG are assigned by the OHA director. Currently the CCAG does not report to the OHPB. However, the proposal shared today is that this group will report to HITOC.
- Question: is the agreement between CCOs contractual or informal?
 - Answer: Susan explained that there is a memorandum of understanding between OHA/OHIT and the 16 CCOs for the \$3 million in state Transformation funds dedicated to leverage federal investment and support statewide HIT efforts.
- Question: Is Jefferson Health Information Exchange a vendor?
 - Answer: Justin explained that Jefferson HIE is a community-based non-profit organization, and that they work with a vendor, Medicity, for their HIE product.

HITOC Work Plan – Justin Keller, Susan Otter

Refer to slides 29-39

Presentation:

- Justin thanked the group for completing the work plan survey and then walked through the results, including the priority policy topics, strategic planning for health IT in Oregon, committees, and monitoring of the HIT environment. He then reviewed a draft work plan for 2016-2017.
- Susan highlighted the priority policy topics of interoperability and behavioral health information sharing, including the associated objectives and potential work products for OHA and HITOC moving forward.

Discussion:

- HITOC members discussed how to approach the priority policy topics work. Comments included:
 - Committees could provide input or bring ideas forward, but not necessarily organize and prioritize the work;
 - Committees could do the ‘first pass’ at digesting information and make recommendations to HITOC;
 - Specific aims and objectives should be highlighted and targeted (e.g. how are we working to effect the specified aim?);
 - National/federal environment regarding interoperability could inform the work;
 - A shared definition for interoperability should be addressed early on in the conversation;
 - Important for interoperability work to distinguish between minimum capabilities/expectations and aspirational goals.
 - These policy topics will likely take time to work through. HITOC may need additional stakeholder involvement to ensure the necessary expertise is represented, and to supplement HITOC’s time and effort. Workgroups might be needed;
 - Bringing patients or consumer advocates to the table will be helpful. Bob Brown is HITOC’s current consumer advocate representative.

- Question: how long do you think it will take to do an HIT environmental scan? It seems like it will inform the updates to the strategic plan.
 - Answer: Susan explained that OHA has an HIT environmental scan as required by CMS, but that some areas need to be updated and that this will take place within the next year. OHA plans to identify additional data to reflect the current environment regarding HITOC specific aims and objectives.

HITOC Meeting Logistics – 2016 – Justin Keller

Refer to slides 40-42

Presentation:

- Justin explained that the goal is to confirm a recurring HITOC meeting time to assist with scheduling and travel concerns (for February, April, June, August, October and December 2016). HITOC members mentioned potential conflicts and Justin agreed to survey the group separately about the time.
- The question was also asked about if meetings should continue to alternate between Portland and Salem. Susan noted that OHIT staff will follow up about the determination of the meeting location.

Public Comment – Erick Doolen

- Hearing no comment, the Chair closed the public comment period at 4:31 p.m.

Closing Remarks – Erick Doolen

- The meeting was adjourned at 4:32 p.m.

The next meeting will be held on February 4th, 2016 in Portland.

Oregon HIT/HIE Business Plan Framework: Goals, Aims, Strategies – 2016 Update

Overarching Aims & Objectives	Strategies
1. Improved culture of HIT-optimized health care where providers and other stakeholders value and expect electronic access to shared information	<ul style="list-style-type: none"> Assess the changing environment and convene stakeholders Educate stakeholders regarding HIT's role in the changing healthcare environment Share promising practices, positive outcomes and value Promote policies that ensure HIT is incorporated into expectations for Oregon health care organizations
2. Increased alignment of standards to promote interoperability	<ul style="list-style-type: none"> Promote alignment with federal and national standards where they exist and develop state standards or guidance where needed Advocate for federal and national standards that are meaningful for Oregon stakeholders Educate and provide guidance regarding specific standards in alignment with federal and national standards where possible Encourage the collection, management, and use of discrete data
3. Improved distribution of financial burden for supporting HIT investments as payment models evolve	<ul style="list-style-type: none"> Educate and promote value reimbursement for telehealth, including e-visits, telemedicine, and other resources Promote HIT cost-consideration within payment models Promote the use of alternative payment models that rely on, and support financial burden of, the use of associated HIT
<p>Goal 1 of "HIT-Optimized Health Care": Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver "whole person" care</p> <p>❖ Provider role in support of "HIT-Optimized Health Care": have the technology capabilities and workflows to participate in care coordination, including: (1) Pursue meaningful use of HIT (particularly for those eligible for EHR Incentive Programs); (2) Participate in care coordination and health information exchange that is inclusive of all members of the care team, including the patient</p>	

Aims & Objectives	Strategies
1. Increased adoption of standards-based technology for data capture, use, and exchange	<ul style="list-style-type: none"> Promote¹ participation in the EHR Incentive Program and standards that align with Meaningful Use and other quality incentive programs Promote adoption of certified HIT and support those who may face challenges navigating the vendor arena Promote and encourage streamlined processes to increase likelihood of adoption
2. Improved ability to capture, produce and use interoperable standards-based data in formats that are structured to be integrated and automated within EHRs and workflows	<ul style="list-style-type: none"> Establish a "compatibility program" that sets baseline expectations for community, organizational and statewide HIT/HIE efforts to ensure interoperability, privacy and security and to facilitate the sharing of information [See Overarching Aims above]

¹ Activities that "Promote" can include educating, outreach, informing, advocating, convening, providing guidance, as well as applying state levers such as contract requirements, policies, aligning reporting requirements, etc.

Aims & Objectives	Strategies
3. Improved access to and sharing of meaningful patient information across organizational and technological boundaries	<ul style="list-style-type: none"> • Connect and support entities with existing HIT infrastructure by providing foundational and enabling HIT services (e.g., Provider Directory, hospital notifications) • Ensure all members of a care team have a means to participate in the basic sharing of information needed to coordinate care (e.g., CareAccord) • Promote statewide Direct secure messaging as a common baseline for HIE and promote other standards that enable interoperability across all systems of care Promote information sharing and care coordination with behavioral health, dental, long-term care providers • Promote the ingestion of relevant patient data into the EHRs to increase the likelihood of its use • Pilot innovation (e.g., telehealth, behavioral health sharing)
4. Ensured protection of privacy and security of patient information	<ul style="list-style-type: none"> • Establish, promote and use policies and best practices that protect patient information • Provide resources to increase awareness, knowledge, and the means for ensuring privacy and security. • Support work to establish policies, processes, and documents to increase privacy and security of patient information
5. Improved provider experience and workflows, reduced burden, and increased workforce capacity	<ul style="list-style-type: none"> • Provide guidance, information, and technical assistance • Identify and take action to remove barriers • Seek efforts that reduce administrative complexity and burden (e.g., Common Credentialing, align metrics) • Support efforts to increase workforce capacity

Goal 2 of “HIT-Optimized Health Care”: Systems effectively and efficiently collect and use aggregated clinical data for quality improvement, population management, and incentivizing health and prevention

- ❖ **Systems’ (e.g., CCOs, Health Plans) role/responsibility in support of “HIT-Optimized Health Care”:** (1) Implement HIT tools for data collection, processing, and reporting; (2) Align clinical metric reporting requirements with meaningful use clinical quality measures; (3) Encourage and support meaningful use and health information exchange among contracted providers

Aims & Objectives	Strategies
1. Improved use of HIT tools for data collection, analytics, and reporting	<ul style="list-style-type: none"> • Promote adoption of certified HIT and support providers who may face challenges navigating the vendor arena • Share promising practices, positive outcomes and value • Advocate for federal and national standards and oversight that are meaningful for Oregon stakeholders
2. Increased use of aggregated data, including clinical data for population management, quality improvement, and alternative payment methods	<ul style="list-style-type: none"> • Provide guidance, information, and technical assistance • Identify and take action to remove barriers • Support the appropriate collection and use of individual level clinical data where needed for more effective uses • Assess the changing environment and convene stakeholders • Support efforts to improve provider workflow to ensure accuracy and reliability of data • Support efforts to increase workforce capacity

3.Reduced reporting burden for data needed to support the coordinated care model across programs	<ul style="list-style-type: none"> Align metrics and reporting across state programs with meaningful use specifications or other standards, ensuring metrics specifications are well-defined Provide a clinical metrics data registry for Medicaid (CCO reporting and Medicaid EHR Incentive program) and, if valuable, expand registry to capture reporting for other programs
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Goal 3 of “HIT-Optimized Health Care”: Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers

❖ **Individuals’ and families’ role/responsibility in support of “HIT-Optimized Health Care”:** (1) Expect providers to have electronic access to their relevant information; (2) Inform providers where they can access patient-generated information (e.g. personal health record); (3) Access their health records via available patient portals; (4) Communicate electronically with providers.

Aims & Objectives	Strategies
1.Increased patient access to/use of their complete health records	<ul style="list-style-type: none"> Promote participation in Meaningful Use, which requires eligible providers to give patients secure, electronic access to their health information. Support innovations (e.g., Open Notes) Educate patients on the benefits of accessing their health information
2.Improved ability for individuals to provide relevant information into their health records	<ul style="list-style-type: none"> Assess changing environments and convene stakeholders Share promising practices, positive outcomes, and value Provide information regarding the legal liabilities of patient-uploaded data
3.Increased capacity for individuals to facilitate care management by sharing information with their providers	<ul style="list-style-type: none"> Promote participation Meaningful Use, which requires eligible providers to support electronic patient engagement via messaging
4.Ensured confidence in the privacy and security of electronic health information	<ul style="list-style-type: none"> Support transparency in communicating to patients about providers’ policies and safeguards for information

**Oregon Health Authority
Provider Directory Advisory Group
Draft Charter, May 2015**

Provider Directory Advisory Group Draft Charter April 2015		
Advisory group name: Oregon Provider Directory Advisory Group (PDAG)		
Objective		
The PDAG will serve as the external subject matter expert and stakeholder body that provides guidance to the Oregon Health Authority (OHA) related to statewide provider directory services.		
Advisory group members		
Name	Title	Affiliation
Gina Bianco	Acting Director	Jefferson HIE
Christopher Boyd	Data Analyst Supervisor	Women’s Healthcare Associates
MaryKay Brady	Consultant	Oregon Medical Association
Monica Clark	Business Systems Analyst	Kaiser Permanente
Mary Dallas, MD	Chief Medical Information Officer	St. Charles Health System
Liz Hubert*	Asst. Director Provider Systems & Strategy	Regence Blue Cross Blue Shield
Martin Martinez	IT VP	PacificSource
Laura McKeane	Oral Health Integration Coordinator	AllCare
Maggie Mellon	Senior Digital Product Manager	Providence Health & Services
Kelly Keith	IT Admin	Greater Oregon Behavioral Health
Jessica Perak	Manager, Provider Analytics, Underwriting & Actuarial	Moda
Robert Power *	VP-Chief Information Officer	Samaritan Health Services
Stephanie Renfro	Research Associate	OHSU Center for Health Systems Effectiveness
Nikki Vlandis	Provider Data Mgmt. and Credentialing	FamilyCare
Hongcheng Zhao	CIO	Portland IPA
*Co-chair		
OHA staffing		
<ul style="list-style-type: none"> • Karen Hale, Lead Policy Analyst, Office of Health Information Technology, OHA, karen.hale@state.or.us, 503-378-1767 • Nick Kramer, Policy Analyst, Office of Health Information Technology, OHA, nicholas.k.kramer@state.or.us, 503-373-7859 • Rachel Ostroy, Implementation Director, Office of Health Information Technology, OHA, rachel.e.ostroy@state.or.us • Susan Otter, Project Sponsor, Director of Health Information Technology, OHA, susan.otter@state.or.us 		
Project background		
Provider directory services (PDS) will allow healthcare entities access to a statewide directory of healthcare provider and practice setting information. It will seek to leverage data existing in current provider databases and add critical new information and functions. The project comprises design, development, implementation, and maintenance of the technical solution as well as operations and ongoing management and oversight of the program. It can be used by health plans, CCOs, healthcare		

practitioners including providers, clinics, hospitals, researchers, long-term care entities, social service organizations, OHA/DHS and other state programs, Health Information Exchanges (HIEs) and Health Information Services Providers (HISPs) to support operations, analytics, and the exchange of health information.

The development of the PDS will be incremental. Initially, PDS will focus on the authoritative provider directory data from the common credentialing program/database and data from provider directories that comply with new standards for healthcare directories called [Healthcare Provider Directory](#) (HPD), and data from existing healthcare provider and facility directories via file exchange/upload. It is expected that other key sources, including OHA/DHS sources will be integrated into the provider directory as well. While the provider directory is being built to support the Medicaid Enterprise, it is expected that the users of the provider directory will expand beyond the Medicaid Enterprise with enabling legislation (HB2294, 2015).

Provider Directory outcomes/success factors

- Accurate Direct secure messaging addresses for providers, as queried
- Attribution of providers to their healthcare delivery settings (clinics, practices, hospitals)
- Support of CCO, OHA and health plan analytics that rely on attributing providers to clinics
- An architecture that supports query and response across existing provider directories using the Health Provider Directory (HPD) standards
- Ingestion of the data available from the Common Credentialing solution and other designated data
- Operational processes and procedures that allow onboarding of users and data sources, user support, and data quality management

Advisory group role

The PDAG will meet regularly to provide guidance to OHA on a variety of topics surrounding the provider directory services and share information with other stakeholders. The group's role includes the following:

1) Guidance:

- The provider directory workgroup will be tasked with providing guidance on policy, program, and technical considerations, as Oregon moves forward to implement statewide provider directory services, such as:
 - Data access
 - Permitted use and network participation
 - Data quality standards
 - Onboarding
 - Security provisions
 - Ongoing monitoring of policies and procedures
 - Functionality and value of a provider directory service
 - Fees and fee structure, if OHA is granted the authority to offer services outside the Medicaid Enterprise (HB 2294)

2) Information sharing:

- PDAG members are expected to provide advisory group information to their organization to share broadly and also connect to their organization's members in other related health IT committees, such as OHLC's Administrative Simplification workgroup, Common Credentialing Advisory Group, etc.
- OHA staff will share regular reports about progress on the provider directory shared with the CCO's Health Information Technology Advisory Group (HITAG) and the [Administrative](#)

[Simplification workgroup.](#)

- OHA will publish documentation from the meetings on our website.

Duration

The PDAG is expected to meet from April 2015 through 2016.

Decision making linkage

The PDAG shall make technical, policy, and operational recommendations to OHA for the statewide PDS. Decisions by the group will be made by consensus. OHA will coordinate decision making with stakeholder members as necessary and coordinate communication with the HITAG and Administrative Simplification workgroup regarding recommendations from the PDAG.

Meetings

Expectations	Location	Date and Time
<p>Monthly 3-hour public meetings will be held throughout 2015. Staff will deliver materials the week prior to each meeting for members to review. Meeting materials and notes will be posted to the OHA’s Provider Directory website. OHA may also call for member participation outside the regularly scheduled meetings if needed.</p> <p>The PDAG is expected to meet throughout 2016 although meeting length and frequency will be evaluated for 2016. Due to the nature of the discussions, in-person attendance at the meetings is preferred. Meetings, as shown below, will be held at locations convenient for the group.</p>	Portland - Lincoln	April 15, 2015, 1:00-3:00 pm
	Wilsonville – CCC campus	May 13, 2015, 10:00-1:00 pm
	TBD	June 17, 2015, 10:00-12:00 pm
	TBD	July 15, 2015, 10:00-12:00 pm
	TBD	Aug 19, 2015, 10:00-12:00 pm
	TBD	Sept 16, 2015, 10:00-12:00 pm
	TBD	Oct 14, 2015, 10:00-12:00 pm
	TBD	Nov 18, 2015, 10:00-12:00 pm
	TBD	Dec 16, 2015, 10:00-12:00 pm
	TBD	2016 TBD

Resources

- Business Plan Framework - The state-level provider directory is one of several elements of [new state level HIT services](#) that supports new models of care under Oregon’s health system transformation efforts.
- [Provider Directory Subject Matter Expert Workgroup Summary](#) - In 2014, the OHA convened a Provider directory workgroup. Members on the committee were comprised of users or managers of provider directories, such as those working in IT, analytics, or healthcare operations. Discussions were focused on key uses, data elements, parameters, and next steps for statewide provider directory services.
- Common Credentialing - The statewide provider directory is a complimentary effort with the work of the [Common Credentialing Advisory Group](#); which will advise the agency on the implementation of a legislative requirement for OHA to establish a program and database for the purpose of providing credentialing organizations access to information necessary to credential all health care practitioners in the State. OHA staff are working closely together on both efforts.