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November 19, 2010

David Blumenthal, MD, National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Dr. Blumenthal:

Enclosed please find Oregon's responses to questions outlined in ONC's letter of November 8, 2010.

As we discussed with Chris Muir, this is an addendum to the Strategic and Operational Plans for HIE sent to you on August 23 rather than a rewrite of the plans. This seemed most expeditious given that most of your questions required explanation and further detail rather than a revision of our existing approach.

To expedite your review, we have simply listed your questions and included our response after each one. This document also includes two attachments: a revised project plan that also highlights the specific ways the plan helps each Oregon medical provider to meet meaningful use requirements in a timely way; and a copy of the Memorandum of Understanding that expands on the financing relationship between our HIE planning and our Medicaid program.

We hope these responses will make clear Oregon's commitment to maximizing this unique opportunity to create a healthier country by advancing our health care system through the effective use of information technology that is now central to its quality and efficiency.

My staff and I would be happy to respond to any further questions you may have. Thank you for your expeditious review of our plans and for your support of Oregon's efforts to develop the best possible health information exchange mechanism and policies.

Sincerely,

Carol Robinson
State HIT Coordinator for Oregon

cc: Chris Muir, program manager, Office of State and Community Programs

Oregon Health Authority

Oregon HIE Response to
The Office of the National Coordinator for HIT:
Addendum to
Strategic and Operational Plans for Oregon

ONC Cooperative Agreement Award 90HT0014/01:CFDA #93.719

November 19, 2010

Oregon Health Authority and
Health Information Technology Oversight Council

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Introduction

As part of the approval process for Oregon's Strategic and Operational Plans for Health Information Exchange, the Office of the National Coordinator for Health Information Technology has reviewed the plans and asked some clarifying questions. This addendum to Oregon's HIE plans will serve as a response to those requests for additional detail on specific issues. The content in this addendum will be incorporated into the plans at a later date.

Environmental Scan/Meaningful Use Attainment

ONC Question 1:

Per the ONC PIN issued on July 6, 2010, Oregon must submit an environmental scan that provides a robust description of the health information exchange currently taking place across the state and that identifies gaps in the current exchange activity including the participation of key data trading partners. Within the plan, please provide statewide information that describes:

***a. Structure lab results gap analysis** – ONC requires the state plan to include the number of labs within the state and also the number of labs able to send structured lab results. It would also be good, if available, to understand how many labs comply with LOINC coding in their results. The plan must also describe a strategy that addresses lab participation which may include coordination, policy, and services activities.*

Oregon response

Electronic Laboratory Reporting Environmental Scan

Based on the ONC PIN issued July 6, 2010, Oregon initiated a further analysis of the Oregon electronic laboratory environment and planning efforts. The expanded environmental scan and planning were not completed at the time the Strategic and Operation Plans were submitted to ONC. The results of the environmental scan, issues identified and plans for convening a Laboratory Stakeholder Group to address the guidance from the PIN are discussed below.

Clinical Laboratories in Oregon

Laboratories in Oregon are not required to have an Oregon Clinical Laboratory License in addition to a valid CLIA certificate (www.cms.gov/clia). CLIA provides five types of certificates to laboratories as shown in Table 1 on page 5. As of July 2010, Oregon has 2,361 laboratories with a CLIA certificate.

Table 1. Types of CLIA Certificates and Laboratories in Oregon, July 2010

Types of CLIA Certificates		Laboratories in Oregon
Accreditation	Certificate of Accreditation: This is the certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization by HCFA.	175
Compliance	Certificate of Compliance: This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.	268
PPM	Certificate for Provider-Performed Microscopy Procedures: The certificate issued to a laboratory in which a physician, midlevel practitioner or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waiver tests.	659
Registration	Certificate of Registration: This certificate is issued to a laboratory that enables the entity to conduct moderate- to high-complexity laboratory testing or both until the entity is determined by survey to be in compliance with CLIA regulations.	13
Waiver	Certificate of Waiver: This certificate is issued to a laboratory to perform only waiver tests.	1,246
Total		2,361

Sources: Definitions from http://www.cms.gov/CLIA/downloads/TYPES_OF_CLIA_CERTIFICATES.pdf. Laboratories by type from analysis of CLIA registrations downloaded from http://www.cms.gov/CLIA/20_CLIA_Laboratory_Demographic_Information.asp, July 7, 2010.

CLIA also identifies the type of facility in which the laboratory services are provided as shown in Table 2 on page 6. It should be noted that the type of facility is not the same as the type of organization. As an example many types of laboratory facilities can be under a hospital organization.

Table 2. Oregon Laboratories by Type of Facility and Type of CLIA Certificate

Lab Testing Performed In:	Accreditation	Compliance	PPM	Registration	Waiver	Total
Ambulance	0	0	0	0	65	65
Ambulatory Surgery Center	0	1	0	0	52	53
Ancillary Testing Site	6	2	2	0	16	26
Assisted Living Facility	0	0	0	0	1	1
Blood Bank	3	0	0	0	1	4
Community Clinic	4	6	48	1	22	81
Comp Outpatient Rehab Facility	0	0	0	0	8	8
End Stage Renal Disease Facility	0	0	0	0	51	51
Federally Qualified Health Center	0	3	4	0	7	14
Health Fair	2	0	0	0	15	17
Health Maintenance Organization	1	2	1	0	1	5
Home Health Agency	0	0	0	0	44	44
Hospice	0	0	0	0	18	18
Hospital	62	18	5	3	11	99
Independent	22	32	1	0	16	71
Industrial	1	0	0	0	7	8
Mobile Laboratory	0	1	0	0	61	62
Other	14	15	39	0	169	237
Other Practitioner	4	3	31	1	36	75
Pharmacy	1	0	0	0	101	102
Physician Office	53	172	502	8	388	1123
Prison	0	0	0	0	1	1
Public Health Laboratory	1	7	6	0	0	14
Rural Health Clinic	0	0	7	0	7	14
School/Student Health Service	1	5	13	0	9	28
Skilled Nursing Facility/Nursing Facility	0	0	0	0	138	138
Tissue Bank/Repositories	0	1	0	0	1	2
Total	175	268	659	13	1246	2361

For purposes of assessing the use of electronic laboratory transactions, the laboratories of greatest interest are the accredited and compliance laboratories recognized by CLIA. These include the commercial (independent), hospital and some other laboratories that provide a wide range of laboratory services.

Electronic Laboratory Health Information Exchange in Oregon
Assessing the use of electronic laboratory health information exchange services relies on several sources: ambulatory and hospital/health system EHR surveys included questions about laboratory ordering and reporting, the Department of Human Services (DHS) HIT inventory regarding the relationship between commercial and hospital laboratories to public health communicable disease reporting as well as website information and interviews with several hospital, commercial and other laboratories.

Physician - Laboratory Electronic Communication in Oregon - The majority of Oregon's ambulatory providers can send and receive clinical laboratory results electronically. As EHR adoption continues to rise, the number of electronic laboratory orders and reports will continue to go up. Highlights from the 2009 Oregon Ambulatory EHR Survey:

- 65.5% of clinicians covered by the survey work in practices with an EHR system.
- 75% of surveyed ambulatory practices and clinics with EHRs (87% of clinicians) are able to enter and review lab orders.
- 48% of surveyed ambulatory practices and clinics with EHRs (69% of clinicians) are able to electronically place lab orders.
- 72% of surveyed ambulatory practices and clinics with EHRs (91% of clinicians) have an electronic EHR–laboratory interface.

Capabilities - Currently, the capabilities and characteristics of laboratories, health providers and the public health sector in the state of Oregon include:

- **Laboratory Interest in Electronic Exchange with Physicians -** Laboratories express high interest in electronic information exchange to/from physician EHRs. From the perspective of laboratory operators, the major issue is protracted EHR adoption in physician practices.

- **Hospital Laboratory Exchange Capability -** Of the 47 hospitals in Oregon with EHRs, 43 hospitals have electronic laboratory results included in their EHR systems and/or either fully or partially implemented CPOE for laboratory services. In Oregon, 43 of 47 hospitals (98% of discharges) with EHRs have (or by 2011 will have) electronic laboratory results included in their EHR systems. 11 of 47 hospitals support laboratory CPOE. 43 of 47 hospitals (98% of discharges) with EHRs have fully or partially implemented or planned CPOE for laboratory services.

- **Hospital Affiliated Practices Exchange Capability -** Medical practices owned or operated by multi-hospital health systems in Oregon have electronic ordering and results reporting through health system EHRs. Many affiliated practices have comparable access. The major health system laboratories provide secure website access for submission of orders and retrieval of lab results comparable to commercial laboratories. Several hospital labs have implemented standard electronic interfaces to/from a number of EHR systems.

- **Commercial Laboratory Exchange Capability -** Commercial and most hospital laboratories providing services to ambulatory practices are able to receive electronic laboratory orders and provide electronic reports based on industry standards. Labs have implemented standard interfaces to/from most EHR vendor systems used by practices referring specimens. Commercial labs provide secure website access for submission of orders and retrieval of lab results that can be used by practices with and without EHRs.

Electronic Reporting of Laboratory Data: Reportable Conditions

Another measure of the electronic reporting capabilities of commercial and hospital laboratories is reflected by their participation in the Oregon Electronic Laboratory Reporting (ELR) system for submission of laboratory data for reportable conditions. The ELR project is a long-term effort of the Oregon Public Health Division to convert major labs, county health departments and the state Public Health Division to electronic data interchange. The ELR functions as an electronic hub to accept, translate, process and route electronic HL7 messages containing lab and clinical data. The ELR system currently receives electronic laboratory data from 14 clinical labs in addition to the Oregon State Public Health Laboratory (OSPHL) as shown in Table 3 on page 8.

Table 3: ELR System Participants for Reportable Diseases, October 2010

ELR System Participants for Reportable Diseases	Start date electronic transfer of reportable disease records	Other Condition Reporting (Conditions not considered "reportable diseases")			
		Cancer	Diabetes	HPV	Flu
OREGON HEALTH SYSTEMS					
ADVENTIST	----*NA*-----			HPV	
KAISER PERMANENTE	June 2005		Diabetes		
LEGACY	June 2005			HPV	
OCHIN	----*NA*-----				Flu
OHSU	March 2010			HPV	
PEACE HEALTH (OREGON MEDICAL LABORATORY)	December 2001		Diabetes		
PROVIDENCE	September 2008				Flu
ST. CHARLES MEDICAL CENTER	March 2007				
TUALITY	----*NA*-----			HPV	
OREGON LABORATORIES					
OSPHL – STATE PUBLIC HEALTH LAB	May 2006				
PATHOLOGY CONSULTANTS	----*NA*-----	Cancer		HPV	
SPECIALTY LABORATORIES	April 2010				
NATIONAL LABORATORIES					
ARUP	January 2001				
BOSTWICK	----*NA*-----	Cancer			
CARIS	----*NA*-----	Cancer			
INTERPATH	August 2009				
LABCORP	February 2003	Cancer		HPV	
MAYO	April 2009				
MEDTOX	October 2002				
QUEST DIAGNOSTICS	March 2001			HPV	
QUEST NICHOLS – blood lead	October 2005				
QUEST NICHOLS – Other Conditions	September 2010				
TAMARAC	August 2004			HPV	
WEST COAST PATHOLOGY	----*NA*-----			HPV	
PENDING - IN EARLY DEVELOPMENT / DISCUSSION					
FANNO CREEK CLINIC					
SALEM HOSPITAL					
TUALITY					

Volume - In Oregon about 80% of mandatory communicable disease reporting (positive or negative tests conducted in the state and indicating presence or absence of a mandatory reportable communicable disease or condition) pass through the ELR system. With certain other reportable diseases and conditions, such as HIV and blood lead level, reporting levels through the ELR system approach 90%. The total 12-month volume of records processed through the ELR system has grown in the last seven years from 11,462 (2003) to 110,447 (2009-2010).

Mechanisms - The ELR system consumes HL7 standardized files, which are typically forwarded automatically by participating labs in a batch format, via secure FTP, VPN or PHINMS, which provides authentication and secure communications. Generally lab production of batch files for transfer to the ELR system is done on an automated basis by Laboratory Information Systems (LIS) although some labs may manually prepare and forward files. Consumption of HL7 coded batch files by the ELR system is also automated, with some operator oversight required to ensure data integrity.

Distribution - The current function of the Oregon ELR is to consume reportable disease information from participating labs and forward that information to county health departments. While smaller counties may receive a text report, larger counties receive a direct file transfer, and all counties participate. In addition, ELR is being integrated with the new ORPHEUS system, which allows counties to directly view their own reportable disease information.

Progress and Status- The ELR system anticipates adding an additional three to six labs in the near future. These additional laboratories are not the largest, but they do fall in the high-volume category (30 reports/ month or more). The Oregon Public Health Epi-User System (Orpheus) is anticipated to be fully operational in the near future.

Oregon's Strategic Plan for Health Information Exchange – Electronic Laboratory Reporting Approach

Oregon's Strategic Plan describes the approach to Electronic Clinical Laboratory Ordering and Results Delivery (p. 39) as follows:

> The workflow and transactions involved in laboratory ordering and results delivery are primarily handled through direct relationships between providers and commercial or hospital laboratories as well as the Oregon State Public Health Laboratory. These transactions are increasingly brokered electronically by the provider EHR and its lab interface. Oregon's high level of EHR adoption and willingness of commercial and hospital laboratories to electronically process orders and reports support continued reliance on these health information exchange functionalities. Provision of laboratory ordering and reporting services and infrastructure through a local HIO or the governance entity are not currently considered a priority that would accelerate the electronic laboratory transaction adoption and use in most communities. Progress in clinical laboratory electronic transactions adoption will be closely monitored as part of Oregon's HIT and HIE overall efforts. During Phase 1, HIO roles in provision of electronic laboratory ordering and reporting for small hospitals and rural providers will be evaluated. Phase 1 will also consider coordination strategies involving the local HIOs, Oregon Electronic Laboratory Reporting (ELR) of the Oregon Public Health Division and the Oregon State Public Health Laboratory. HITOC and the SDE will support and facilitate adherence to transaction and data standards for lab ordering and reporting.

Issues in Increasing Electronic Laboratory Reporting

In addition, Oregon's electronic laboratory reporting plan to further the attainment of meaningful use focuses upon three key activities:

1. Retrieve and collate additional data about the current state of electronic laboratory reporting capabilities in the State; based upon the data available, identify key measures of adoption that will be used to determine the efficacy of adoption strategies enacted over the coming year. The utilization of LOINC coding in Oregon is not currently known but will be assessed in the collection of additional data by the Laboratory Stakeholder Group in early 2011.
2. To improve statewide participation bring together key stakeholders in the state who are involved with laboratory services and "ask the experts" what the barriers are to adoption, in addition to what the research reflects as well as gaining more insight into the barriers identified with the environmental scan. Enlist the experts to identify, design and help develop the interventions necessary to improve electronic laboratory reporting and the integration of available electronic reporting capabilities in various EHR systems with special attention to issues in small practices and rural communities.

3. Identify next steps based upon stakeholder input. Implement the recommended steps using key success measures to determine the efficacy of the strategy on inclusion of structured laboratory data into provider EHR systems and moving providers closer to achieving meaningful use requirements for Stages 1-3.

Laboratory Stakeholder Group

A Laboratory Stakeholder Group is being formed to address issues related to the electronic reporting of laboratory data. The stakeholder group includes representatives from major commercial and hospital laboratories, the state laboratory monitoring inspection program, state Electronic Laboratory Reporting system, vendors implementing laboratory interfaces and EHRs, physician practices and hospitals. The group will begin meet monthly in December 2010. Invitations are being extended to the following organizations, while additional stakeholders are being identified: Oregon State Public Health Laboratory, PeaceHealth, Mid-Columbia Medical Center, Mid-Valley IPA, State Office of Disease Prevention and Epidemiology, Healthco, Ignis Systems, Labcorp, and others.

b. *e-Prescribe gap analysis* – *The plan must include the total numbers of pharmacies within the state and also the number of pharmacies participating in e-prescribing activities. Also, ideally, the state would be able to identify reasons why pharmacies are not currently participating. The plan must also describe a strategy that addresses pharmacy participation which may include coordination, policy, and services activities. ONC encourages Oregon to use the information that was provided during the Salt Lake City regional meeting for the e-prescribe gap analysis and strategies.*

Oregon response

e-Prescribing Environmental Scan

As with the electronic laboratory reporting environmental scan data, this section reflects an update of the e-prescribing environment in Oregon since the Strategic and Operational Plans were submitted in August.

e-Prescribing has increased significantly in Oregon over the last several years. Nearly all chain pharmacies in Oregon are able to accept electronic prescriptions from prescribers. However, less than 50% of independent pharmacies are registered/activated for e-prescribing. In early 2009, the Oregon electronic health record (EHR) survey showed that 65% of clinicians were in practices with an EHR system. For practices with an EHR system, (a) 76% of the clinics and practices (87% of clinicians) had the capability to print a prescription from their EHR and (b) 57% of the clinics and practices (74% of clinicians) were able to electronically transmit a prescription to a pharmacy. During 2009, physician use of e-prescribing grew significantly.

Surescripts Data: Oregon 2006-2009

Surescripts annually prepares a State Progress Report on Electronic Prescribing. The last report, as of December 31, 2009, shows that Oregon ranks favorably against national statistics. The Surescripts reports are available at http://www.surescripts.net/e-prescribing-statistics.html. Anecdotal information from providers and pharmacies suggests that substantial numbers of physicians and providers initiated electronic prescribing in 2009.

Table 1. Surescripts State Progress Report on Electronic Prescribing

	Oregon 2006	Oregon 2007	Oregon 2008[1]	Oregon 2009[2]	U.S. 2009[3]
Safe-Rx State Ranking	**38**	**18**	**15**	**14**	
Physicians routing e-prescriptions at year end	1.04%	5.71% (381 of 6,672)	15.43% (1,030 of 6,675) Rank =11	36.93% (2,464 of 6,672)	About 25% of all office-based prescribers
Community pharmacies activated for e-prescribing	65.41%	70.88% (426 of 601)	76.86% (475 of 618) Rank =27	87.85% (528 of 601)	About 85% 97% chains, 62% other
Prescriptions routed electronically	0.10% (14,177 scripts) Rank =38	1.65% (247,748 scripts) Rank =18	4.39% (693,112 scripts) Rank =15	16.22% (2,658,578 scripts) 3.8 times 2008 level	Almost 12% 2.8 times 2008 level
Patient visits with a prescription benefits request	2.00% (201,818 requests)	1.96% (198,665 requests)	7.86% (795,319 requests)	34.09% (4,505,065 requests)	More than tripled over 2008
Patient visits with a prescription benefit response	0.29%	0.87%	4.37% Rank =19		
Patients with available prescription information available from payers	0.00%	48.45%	55.83% Rank =36	58.56%	
Prescription history information delivered to prescribers	State-level data not available	State-level data not available	State-level data not available	1.88%	Increased 5-fold over 2008 to 81 million

Sources: State Progress Report on Electronic Prescribing: Oregon - data as of December 31, 2008 with data for 2006, 2007, 2008, © Surescripts 2009; State Progress Report on Electronic Prescribing: Oregon – data as December 31, 2009 with data for 2007, 2008, 2009, © Surescripts 2010.

Oregon EHR Systems and e-Prescribing, Spring 2009

The 2009 Oregon Ambulatory EHR Survey conducted from February to June 2009 provides additional information about the availability of EHR systems in ambulatory clinics and practices and the capabilities of the EHR systems to support e-prescribing. Highlights of the survey indicate:

- 65.5% of clinicians covered by the survey work in practices with an EHR system.
  - 54.2% of clinicians covered by the survey work in clinician owned/operated private practice settings with an EHR system
  - 78.4% of clinicians covered by the survey work in ambulatory setting of hospitals, health systems, safety net, public and other clinics.
- 76% of surveyed ambulatory practices and clinics with EHRs (87% of clinicians) are able to generate printed prescriptions from their EHR systems.
- 57% of surveyed ambulatory practices and clinics with EHRs (74% of clinicians) are able to electronically transmit an electronic prescription to a pharmacy.
- 64% of surveyed ambulatory practices and clinics with EHRs (83% of clinicians) have an electronic interface to pharmacies.

[1] Oregon data for 2006-2008 from Surescripts State Progress Report on Electronic Prescribing, available at http://www.surescripts.com/e-prescribing-statistics-charts.aspx?name=OR2009, accessed March 26, 2010.

[2] Preliminary Surescripts data for 2009.

[3] Surescripts press release, March 2, 2010 available at http://www.surescripts.com/container_pdf.aspx?name=downloads/Surescripts_Releases_2009_National_Progress_Report.pdf.

Oregon Pharmacy e-Prescribing July 2010

As of July 14, 2010, the Oregon Board of Pharmacy licenses over 1,000 retail pharmacies and other dispensing locations in Oregon as shown in Table 2. Some pharmacies have more than one license for the same location.

Table 2. Oregon Board of Pharmacy Licensees July 14, 2010

Type of Pharmacy or Dispensing Location	Number of Locations
Retail drug outlets	742
Institutional drug outlets: hospitals, prisons, other pharmacies	130
County health: includes health departments, school-based and similar clinics	86
Correctional facilities and jails	56
Family planning	51
Home dialysis	2
Remote dispensing	1
Total Licensed Locations	**1,068**

There are a number of categories among 742 retail drug outlets. Table 3 shows the number of outlets within each of several categories and the number of outlets registered with Surescripts for e-prescribing as of July 2010. Among the 484 outlets operated by chain stores (e.g., Wal-Mart, Costco, Fred Meyer, Walgreens, Rite-Aid), 467 outlets or 96.5% are registered for e-prescribing with Surescripts, consistent with the national rate of 97% reported by Surescripts as of December 2009. Among the 129 independent pharmacies, 58 (45%) are registered for e-prescribing with Surescripts, lower than the national rate of 62% reported by Surescripts as of December 2009. For other categories (i.e., hospitals, safety net and other clinics and specialized services), some organizations may have internal pharmacy or EHRs systems that support e-prescribing directly to the internal pharmacy without the need for a Surescripts registered system.

Table 3. Percentage of Retail Drug Outlets Registered with Surescripts

Retail Drug Outlet Categories	Board of Pharmacy Retail Drug Outlets July 2010	Registered with Surescripts for e-Prescribing July 2010	% of Retail Drug Outlets Registered for e-Prescribing
Chain pharmacies	484	467	96.5%
Independent pharmacies	129	58	45.0%
Hospital pharmacies	98	10*	10.2%*
Safety net clinics, colleges, etc.	17	5*	29.4%*
Specialized pharmacy services	14	2*	14.3%*
Total retail drug outlets	742	542	73.0%

* Does not include e-prescribing systems that may be part of pharmacy or EHR systems within the organizations.

The availability of Surescripts registered e-prescribing at chain and independent pharmacies varies across Oregon. Table 4 on page 14 shows the availability of e-prescribing at chain and independent pharmacies by regions/counties in Oregon. The combined availability rates range from 75% to 93% with a state average of 86%.

Table 4. Availability of e-Prescribing by Oregon Regions/Counties, July 2010

Regions/Counties	Number of Counties	Chain Pharmacies	% Chains on Surescripts	Independent Pharmacies	% Independents on Surescripts	Combined % on Surescripts
Metro Portland	3	188	95.2%	37	37.8%	85.8%
Marion-Polk	2	46	95.7%	8	62.5%	90.7%
Linn-Benton-Lincoln	3	36	97.2%	9	77.8%	93.3%
Lane	1	54	96.3%	12	16.7%	81.8%
Douglas	1	14	92.9%	6	33.3%	75.0%
Southern Oregon	4	39	97.4%	20	80.0%	91.5%
Central Oregon	3	27	100.0%	8	12.5%	80.0%
Gorge	4	10	100.0%	1	0.0%	90.9%
NW Oregon	4	30	96.7%	10	50.0%	85.0%
NE Oregon	5	20	100.0%	8	25.0%	78.6%
SE Oregon	4	8	100.0%	4	75.0%	91.7%
SW Oregon	2	12	100.0%	6	33.3%	77.8%
Total	36	484	96.5%	129	45.7%	85.8%

Oregon Strategic Plan – Electronic Prescribing Approach

Oregon's Strategic Plan describes the approach to Electronic Prescribing and Refill Requests (p. 37) as follows:

> Electronic prescribing (eRx) in Oregon is widely handled through providers' EHRs and standalone modules. Oregon's high level of EHR adoption and the increased use of eRx in the last two years support continued reliance on the direct interactions between prescribers and pharmacies. Meaningful use criteria for eligible professionals establish the expectation that certified EHR systems have the capability for electronic prescribing. Provision of eRx application services and infrastructure through local HIOs or the governance entity is not currently considered a priority that would accelerate eRx adoption and use. However, the HIOs will need to interoperate with electronic prescribing and fulfillment related to compilation of medication histories. Progress in eRx adoption will be closely monitored as part of Oregon's HIT and HIE overall efforts including the potential that HIO services may provide services to further eRx adoption and use. HITOC and, later, the state designated entity (SDE) will support and facilitate adherence to transaction and data standards for electronic prescribing.

Issues in Increasing Electronic Prescribing

In addition, Oregon's e-Prescribing strategic plan for enhancing adoption to support providers' attainment of meaningful use focuses upon three key activities:

1. Retrieve and collate detailed data about the current state of e-prescribing in the state; based upon the data available, identify key measures of adoption that will be used to determine the efficacy of adoption strategies enacted over the coming year.
2. To improve statewide participation bring together all the factions in the state who are involved with e-prescribing and "ask the experts" what the barriers are to adoption and what the research reflects; also, gain more insight into the barriers identified with the environmental scan. Enlist the experts to identify, design and help develop the interventions necessary to enhance e-prescribing adoption in both urban and rural communities.
3. Identification of next steps based upon stakeholder input. Implement the recommended steps using key success measures to determine the efficacy of the strategy on increased e-prescribing and moving providers closer to achieving meaningful use requirements for Stages 1-3.

Oregon has already launched the work for Steps 1 and 2 of the action plan above.

Review of the e-prescribing environmental scan reveals substantial participation in e-prescribing among Oregon physicians and pharmacies. 37% (2463/6672) of physicians route about 16% of total prescriptions electronically, and almost 88% (528/601) of Oregon pharmacies are activated for e-prescribing. This participation exceeds the US average.

A group of e-prescribing stakeholders was convened on September 24, 2010, to begin to identify gaps in participation and barriers to e-prescribing and to develop strategies for improvement. These stakeholders represent critical constituencies in retail, hospital and health system pharmacy; prescribers; academia, and state regulatory agencies. Here is a list of the participants:

Providence Medical Group: Debi Farr RPh, Manager, Department of Pharmacy Operations
Coalition Chair: Marcus Watt
Board of Pharmacy: Ken Wells
BiMart: Brian Cook, Vice President of Pharmacy
OSU College of Pharmacy: Roberto Linares
Consonus Pharmacy: Eric Lintner
ODS, Managed Care: Thad Mick
Oregon Association of Hospitals and Health Systems: Robin Moody, Director of Public Policy
Mid-Columbia Medical Center: Brian Ahier, HIT Evangelist
Mid-Valley IPA: Greg Fraser MD, Medical Director of Information Systems and Informatics
Pacific University College of Pharmacy: Michael Millard, MS, RPh
The Robertson Group: Nan Robertson, Owner
Witter and Associates: Dave Witter, Principal
Pacific University: Dave Widen, Adjunct Professor
Oregon Dept. of Medical Assistance Programs: Donald Ross, Manager, Policy and Planning Section
Oregon Prescription Drug Program: Missy Dolan, Manager
Paul Gorman, MD

At the initial meeting it was noted that hospital, independent, and specialty pharmacies lag significantly behind the chain pharmacies in e-prescribing participation as reflected in Table 3 above.

The stakeholder group identified several reasons for lack of participation among independent pharmacies:

- Current pharmacy dispensing systems are outdated and don't receive e-prescribing data.
- Existing pharmacy dispensing system is not a SureScripts-certified system.
- The pharmacy work flow has become fragmented causing the workforce to have many different ways to receive a prescription (fax, in person, phone, e-prescribing etc.).
- Market drivers – as more prescribers adopt e-prescribing due to the impact of meaningful use, there will be an incentive to activate e-prescribing to continue to receive prescription business.
- Independent pharmacies are concerned about the cost of Surescripts; one cost/transaction of $.17 - $.30 (pharmacies are paying for the system) – there is resentment among independent pharmacists for having to pay for government mandate (physicians don't have to pay).

The stakeholder group was uncertain about the reasons for lack of participation among the hospital pharmacies, and will further engage the hospital stakeholders to discuss possible reasons for the low participation. Some reasons that were discussed include:

- Lack of need to dispense or refill prescriptions
- Lack of information about e-prescribing
- Lack of medication profile information in interoperable EHR to use in medication reconciliation programs

The specialty pharmacies need to be further identified and outreach to these practitioners made to further identify the e-prescribing issues among this group.

e-Prescribing Stakeholder Group to Begin Regular Meetings

Starting in December 2010, the e-Prescribing Stakeholder Group (listed above) will begin meeting monthly to develop and implement strategies with a goal of further improving eRx adoption in 2011. Strategies for increasing participation will be developed by bringing in Surescripts representatives, adding key state program administrators and developing a needs and barriers survey for all non-participating pharmacies in the state. Once the gaps can be better identified and understood, the stakeholder group will create and implement a focused operational plan to remove barriers and reduce gaps. Further analysis of additional functions such as medication histories and refill authorization requests through the electronic exchange need to be quantified and examined by the Stakeholders Group in a similar manner as outlined for prescription transmission.

Oregon has made a strong start toward e-prescribing, and through the collaborative effort of the assembled e-Prescribing Stakeholder Group of HITOC, and Oregon's participation in the ONC e-prescribing Community of Practice and its advisory committee, this momentum will continue through the meaningful use designation.

c. Summary of Care Exchange *– the plan must also address the State's approach to ensuring summary of care record exchange across non-affiliated entities.*

Oregon response

In order to meet the requirements laid forth in PIN-001, the SDE will offer the core HIE services necessary for basic health information exchange to occur among all eligible providers and hospitals. These core services include the HIE Registry and the Provider Registry, which enable entity-level and individual-level directory lookups for addressing and routing, Trust Services necessary to ensure the security and fidelity of patient health information, and messaging-based transport services such that health information can be exchanged between providers, regardless of HIO affiliation. These services will be operated initially by the State of Oregon, then operations will be transitioned to the SDE once said entity has been formed or designated and a sustainable finance plan has been developed and ratified by stakeholders. The state will not directly provide the EHR technology necessary to generate clinical summaries, but will direct providers in need of such technology to the Regional Extension Center for assistance. More detailed use cases regarding the exchange of clinical summaries can be found in the response to Question 10.

The state/SDE will not place artificial constraints on the usage of the core services, but will strongly encourage providers and hospitals to consider participation in their local HIOs prior to engaging the state/SDE as their health information exchange services provider.

ONC Question 2:

ONC requires a description of the coverage of these three services (structured lab results, e-Prescribing and Summary of Care record exchange) from the current HIE services already being offered in the state. Without an understanding of the services offered and the numbers of providers reached by current data exchange activities, it is difficult for ONC to understand the extent of current services and how Oregon's statewide services fit in. Additionally, ONC requires additional information of the "white space strategy" in which there is a detailed description about how the areas not covered by current information exchange activities will be addressed.

Oregon response

Structured Laboratory Data Coverage

As reflected in the Strategic Plan and the response to Question 1.a, our interviews with major commercial laboratories and the larger hospital/health system laboratories indicated that they are capable of providing electronic laboratory data back to ordering physicians. Several developing local HIOs are closely affiliated with local hospitals/health systems and expanding their health information exchange capabilities to provide electronic laboratory data to provider EHRs. As of early 2009, 65% of surveyed clinicians were ambulatory practices and clinics with EHRs, with 87% of those clinicians able to enter and review lab orders, 69% of clinicians able to electronically place lab orders and 91% clinicians in practices with an electronic laboratory interface. Efforts in

Oregon to further enhance the availability of electronically integrated, structured laboratory data in EHRs include enhancing adoption of certified EHRs, implementing electronic lab interfaces and working with laboratories to further standardize the reporting of results with ELINCS and LOINC. The Laboratory Stakeholder Group will be addressing these issues in 2011. Oregon's approach to the electronic exchange of laboratory orders and results reporting emphasizes the use of the existing relationship between providers and laboratories with careful monitoring of gaps and white spaces.

E-Prescribing

As reflected in the Strategic Plan and the response to Question 1.b, e-prescribing is growing rapidly in Oregon. As of early 2009, 65% of surveyed clinicians were in ambulatory practices and clinics with EHRs, with 74% of those clinicians able to electronically transmit a prescription to a pharmacy. Additionally the growth of e-prescribing by physicians during 2009 was significant. Virtually all the pharmacies associated with retail chains support e-prescribing. However, less than 50% of independent pharmacies were registered with Surescripts in mid 2010. Further growth in e-prescribing in Oregon seems related to the expanded adoption of certified EHR systems with e-prescribing capabilities and addressing the implementation barriers of independent and specialty pharmacies. The e-Prescribing Stakeholder Group has begun addressing these issues. Oregon's approach to e-prescribing emphasizes the use of the existing e-prescribing service solutions that can support physicians and pharmacies. The Strategic Plan contemplates the ongoing monitoring of e-prescribing services and utilization including geographic and functional service gaps rather than supporting e-prescribing as a central HIE service.

Summary of Care Record Exchange

Information on the current level of exchange of summary care records is not readily available. Feedback from local HIOs and health systems reflect that efforts to electronically exchange summary care records are just beginning. Two organizations (OCHIN and Douglas County IPA) are involved in the Social Security Administration pilot project to transmit electronic summary care records but are not expected to be active until early 2011. Two health systems (OCHIN and the Oregon Health & Science University) are exchanging clinical records through Epic CareEverywhere. As exchange of summary care records develops, it will involve direct provider-to-provider exchange, provider-to-provider through a shared service arrangement, or local HIO and provider-to-provider involving different HIOs. The initial focus of summary care record exchange between unaffiliated providers is at the local HIO and health system level. The SDE central HIE services will support exchange of summary care records initially by providing support to local HIOs with core central services that facilitate exchange as further described in the responses to Questions 11 and 12.

The technical architecture described in the Strategic Plan (pp. 49-51) contemplates the potential need for the equivalent of a local HIO that could be operated as a central HIE services if needed because of functional or geographic service gaps. Oregon's federated strategy emphasizes support of regional local HIOs, rather than duplicating similar services that are being developed by local HIOs. As further discussed in the responses to Questions 11 and 12 below, Oregon's "white space strategy" has several components that include (in ranked order):

- Encourage the market-driven approach that supports the provision of HIE services by local HIOs wherever possible.
- Encourage local HIOs to serve providers outside their primary service areas. Several HIOs are actively involved in discussion with providers in adjacent areas.
- Encourage local HIOs, health systems and commercial vendors to market exchange services that can support providers in areas without a local HIO using Direct Project, similar or other delivery models.
- Monitor the development of HIE service capabilities by EHR, HIE and other vendors.
- Provide basic necessary services through the SDE for secure message transport to allow providers to achieve Stage 1 Meaningful Use while local HIOs are developing their capabilities.
- Provide necessary (to meet meaningful use) services equivalent to a local HIO on a centralized basis through the SDE to providers or hospitals that are not part of an existing HIO as the "exchange of last resort."

Developments in the vendor marketplace as well as the continuing planning and evolving service models of Oregon's local HIOs may obviate the need to implement the final component in the above list.

ONC Question 3:

ONC encourages the focus on the simple interoperability during phase I and then work on the more advance interoperability that is consider in phase II, such as MPI, RLS, bi-directional public health exchange, etc. The plan currently contains, at least in ONCs view some ambiguity in the state plan on whether there will be potentially be more robust exchange services implemented in phase I. Please update the plan to clarify that the state will be focused on simple interoperability in the first phase of the project.

Oregon response

During Phase 1, the state/SDE will be focused on defining and developing the services necessary for messaging-based health information exchange: participant directories, Trust Services, standards, and HISP services. These services will be defined and an RFP developed for the procurement of technology and support needed for the implementation and operation of these services. Due to the timeline and need for all providers to have the capability to exchange information, all efforts will be focused on delivery of these core services. All efforts necessary to define and implement advanced HIE services, such as a master patient index, record locator service and query-based exchange, will be delayed until the core services that support message-based exchange are implemented and operational. These services will be operational in 2011, allowing for all eligible providers to qualify for meaningful use payments in the first year possible.

As Phase 1 of Oregon's Strategic and Operational Plans become operational and confidence in HIE grows on the part of both providers and patients, Oregon will embark on the next step to consider the additional value-added services to provide at the SDE level. Value-added services such as bi-directional, query-based exchange, the capability for providers to exchange public health and quality data with state and federal entities, a master patient index and record locator service for query-based, aka "pull," could be part of the Phase 2 offerings, provided there is support from the local and regional HIOs that those services would be useful. These services will start to be defined once the Phase 1 services are in place: targeting late 2011, and will be implemented throughout 2012 and 2013 in order for providers to meeting Stage 2 Meaningful Use.

The state understands that Stage 2 Meaningful Use criteria will likely change, and will employ its "monitor and adapt" philosophy to insure that the services it proposes to provide via the SDE are of value to the HIE participants.

Governance

ONC Question 4:

Oregon's plans include an accreditation of HIE participants in the state. However, ONC has questions about the program. Please address the following within the plan:

a. What are the goals and major business and/or policy drivers for the accreditation program?

Oregon response

There are two primary motivations and goals behind establishing Oregon's HIE Accreditation Program. First, it is critical to ensure that all entities providing or facilitating exchange services are held to the same standards in terms of protecting the privacy and security of protected health information (PHI). The HIPAA Security Rule specifies that entities must develop policies and procedures to protect the confidentiality, integrity, and availability of electronic PHI, but does not specify what those policies and procedures should be, nor does it have any systematic validation mechanisms in place to ensure that entities do, in fact, have the appropriate policies and procedures in place. Through Oregon's HIE Accreditation Program, mechanisms for affirmatively validating the existence and appropriateness of these policies and procedures, and for enforcing them when entities are found to be non-compliant will be established.

A second driver behind the Accreditation Program is to ensure interoperability and participation in statewide HIE. Oregon's approach to statewide exchange is a federated model, which relies to a great extent on the HIE activities and efforts the local health information exchange organizations (HIOs). For statewide HIE to thrive in Oregon, the local HIOs will not only need to facilitate exchange within their own communities, but will also need to communicate with one another, and with the statewide SDE. Oregon's HIE Accreditation Program will serve to ensure that the necessary technical standards, policies, and procedures are in place to facilitate exchange across HIOs and with the SDE.

b. Aside from following national standards, what other items will be included in the accreditation criteria?

Oregon response

Oregon's Health Information Technology Oversight Council (HITOC) is currently in the process of developing the framework and details around the HIE Accreditation Program, including the standards that will be required. On October 28, 2010, the HITOC HIO Executive Panel, composed of executives representing the local exchange efforts in Oregon, held a meeting to discuss and provide input on developing the Accreditation Program. An Accreditation Subcommitee, composed of volunteer members from the Legal and Policy Workgroup and the Technology Workgroup, also attended the Oct. 28 meeting to discuss accreditation. The questions that were raised pertaining to standards included:

1. Will the accreditation program take a phased approach, with more stringent standards, requirements, and validation methods phased in over time?
2. Will there be a different set of standards for core services and ancillary services?
3. Will there be a different set of standards for small-scale/regional HIOs and large-scale/statewide HIOs?

It was tentatively agreed that the Electronic Healthcare Network Accreditation Commission (EHNAC) criteria for HIE Accreditation is an adequate baseline standard for the Accreditation Program. However, the HIO Executive Panel members agreed to submit additional feedback and/or identify any concerns they may have about the criteria to HITOC staff for further review, and this process has been initiated. It was also noted that Oregon should adapt to federal standards as those become available.

The HIO Executive Panel members agreed that it will be important to pilot the standards chosen for the Accreditation Program. Self-assessment by one or more anel members using the EHNAC and any additional criteria was suggested and supported as an appropriate method for piloting the standards.

HITOC has formed an Accreditation Program "Tiger Team" composed of the workgroup members that volunteered for the Accreditation Subcommittee, to proceed in developing a proposal for the Accreditation Program. Staff will perform analysis of the questions and other issues raised at the October 28 and subsequent HITOC workgroup meetings, draft a proposal for review by the Tiger Team on December 3, 2010, and submit a revised proposal to the HIO Executive Panel on December 9, 2010. The revised proposal and feedback collected from the HIO Executive Panel members will then be reviewed by HITOC members at their retreat on January 20, 2011, which will make the final recommendation around Oregon's HIE Accreditation Program to the director of the Oregon Health Authority. Potential legislation for the implementation of an Accreditation Program has been drafted for consideration by the Oregon Legislature, and will be advanced if all of the steps outlined above are met. The Oregon Legislature meets from January 10, 2011 until late June. In the meantime, at least two regional HIOs have volunteered to participate in the EHNAC self-assessment to determine potential readiness for accreditation in 2011.

c. Please clarify how the HIE participants defined. Does it include HIOs, IDNs, Labs, pharmacies, and others?

Oregon response

HITOC is currently engaged in a process to develop the definitions for the entities that will be required to receive accreditation. The following draft language was discussed at the October 28, 2010, meeting of the HIO Executive Panel and Accreditation Subcommittee:

"Require all HIOs, community health data/network partnerships and other groups that promote data sharing across multiple, independent stakeholders to receive accreditation from the state within some specified time frame in order to continue operating in Oregon."

The panel and subcommittee members' input was that this definition needs more clarification and specificity, as some members were not able to determine whether their respective organizations would fall under this definition. This issue will be discussed further and the definition clarified during the development of the Accreditation Program framework by the Accreditation Tiger Team in early December 2010 as discussed above.

Medicaid Coordination

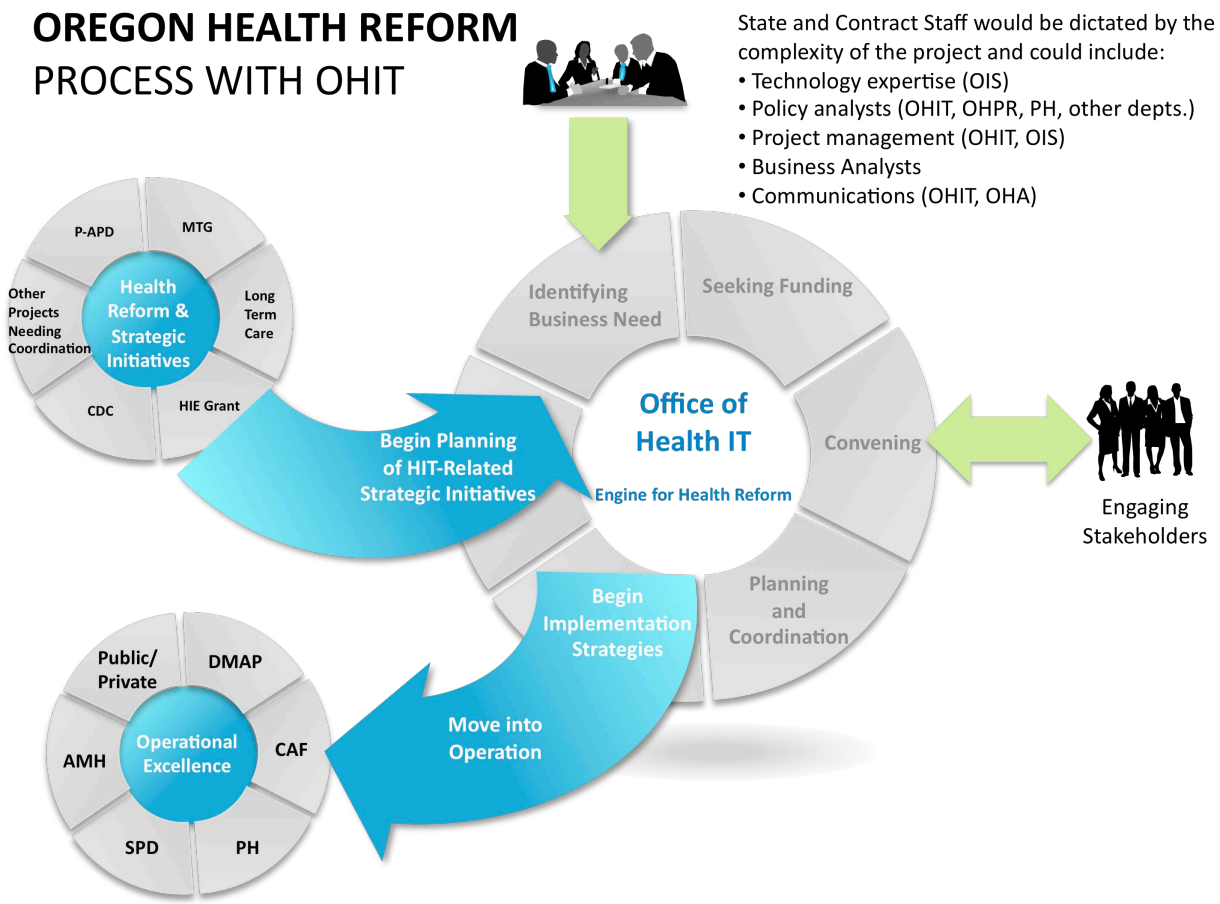
ONC Question 5:

While the Medicaid program has representation on Oregon's governance structure and the State HIE program and Medicaid have been working together on the various HIE and Medicaid planning activities, it would also be helpful to know whether the state HIE program and Medicaid have other joint efforts such as communication and outreach efforts, plans to leverage Medicaid matching funds for HIE or common health and health care goals. ONC requests evidence of ongoing Medicaid coordination efforts such as joint project plans, schedule of coordination meetings, discussions of joint goals and objectives, financial plans showing Medicaid's participation, etc.

Oregon response

Coordination Efforts:

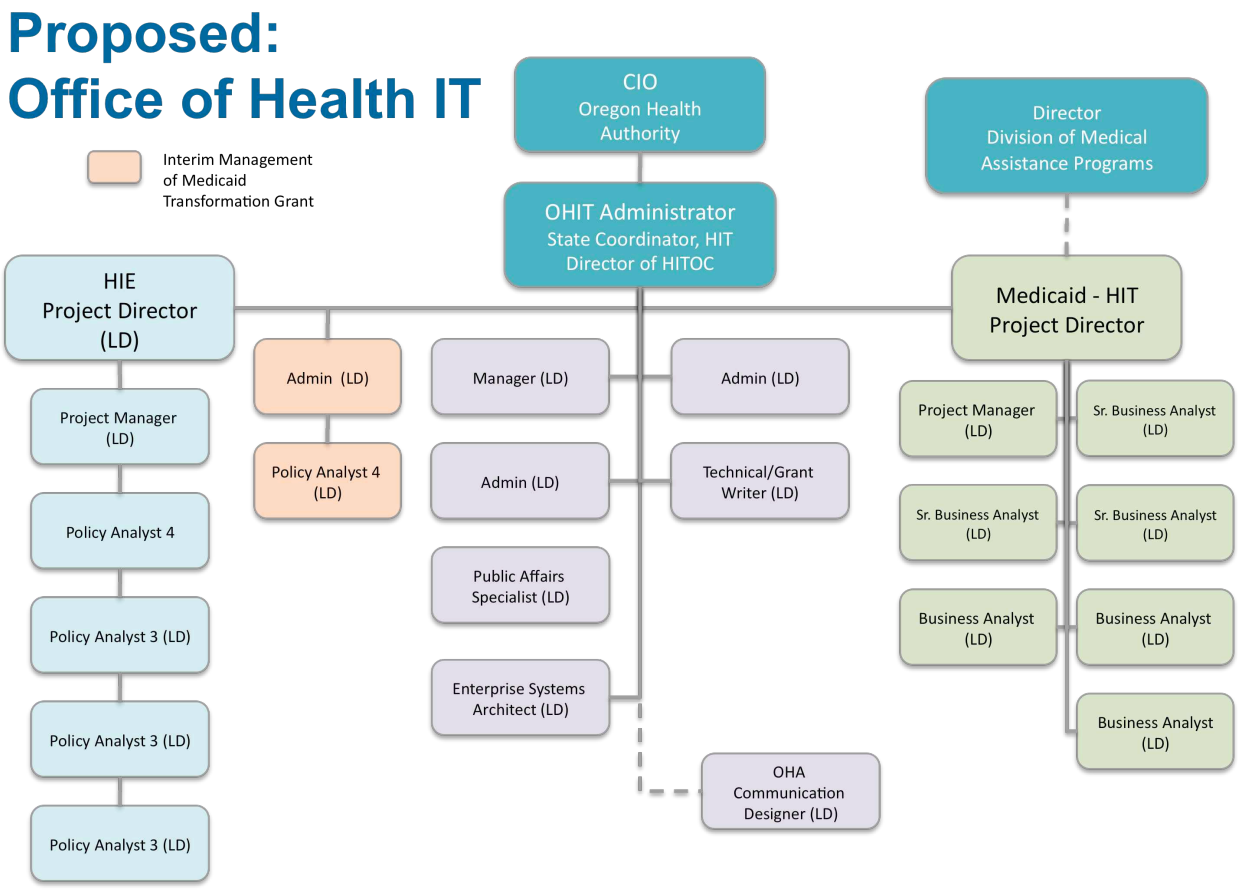
The planning for the Office of Health IT has progressed since the HIE Strategic and Operational Plans were submitted. On page 21 is a graphic conveying the role that the Office of Health IT will play in the coordination of all health IT planning processes as the new office is established. In the meantime, the HIE and the Medicaid HIT projects have moved forward under the new model of coordination.



Acronyms

AMH: Addictions and Mental Health
CAF: Children and Families
DMAP: Division of Medical Assistance Programs
MTG: Medicaid Transformation Grant
OHPR: Office for Health Policy and Research
OHA: Oregon Health Authority
OIS: Office of Information Services
PH: Public Health
P-APD: Planning-Advanced Planning Document
SPD: Seniors and People with Disabilities

The initial staffing plan for the Office of Health IT shows the organizational structure and shared staffing that will facilitate coordination between the HIE and Medicaid HIT projects:



Coordination meetings are happening on several levels. The State Medicaid Director is an ex-officio member of HITOC. In addition, the Medicaid HIT Project Director provides updates to HITOC at its monthly meetings. This allows an opportunity for HITOC to participate in discussions with the Medicaid leadership on joint goals and objectives.

On a staff level, there are coordination and program development meetings of core state staff at least twice a month. Participants include the State HIT Coordinator, the State Medicaid Director, the Interim CIO, the Deputy CIO of the Oregon Health Authority and the Department of Human Services, the Medicaid HIT Project Director and the Deputy Director of the Office of Health Policy and Research. These meetings are currently focused on the successful development of the Medicaid EHR Incentive Program, including the intersection and coordination with the HIE planning efforts. This is the core staff that is initiating and participating in the discussion around joint goals and objectives and determining how to deploy resources to successfully implement the work being done.

Beginning in January, the Medicaid HIT Steering Committee will resume meetings, with representation from both the HIE efforts and Medicaid, as well as Public Health, Addictions and Mental Health and other state agencies. This governance body will build on the coordination already occurring between Medicaid and HIE, and expand that across the other state agencies in the Oregon Health Authority and the Department of Human Services.

Both the Medicaid HIT Project and the HIE Project are in the process of expanding their project plans. There have

been some challenges in getting project managers on these efforts, so a decision was made several months ago to bring a consultant in to help expand the current staff capacities for the Medicaid HIT and HIE projects. To help ensure the necessary coordination between the two efforts, the same consultant is working on both projects, which has furthered the coordination that was already taking place. Both projects are in the process of filling positions, but the consultant will continue to work with both projects to help support the coordination.

Financial Plans:
Please see the Memorandum of Understanding (attached) between the Division of Medical Assistance Programs, Office of Information Services, and the Office of Health Policy and Research explaining the current funding support from Medicaid for the HIE planning efforts.

The Medicaid HIT project team is in the process of developing the SMHP and IAPD for submission to CMS in early 2011. In accordance with the State Medicaid Director's letter issued in August 2010, Oregon plans to request CMS 90/10 HIE funding to help support the development of the Medicaid portion of HIE.

Communications and Outreach:
The Oregon Medicaid Electronic Health Records Incentive Program Provider Communication Plan is in the final review stage before implementation begins. The scope of the communications plan, included below, indicates the fundamental coordination happening in the area of provider communications:

- The Medicaid Health Information Technology Program (HIT) is responsible for the development and implementation of Oregon's Medicaid Electronic Health Records (EHR) Incentive Program including provider communications. The critical timing of getting information to Oregon providers about the Medicaid EHR Incentive Program heightens the need for the immediate development of a communications plan for the Medicaid EHR Incentive Program. Therefore, this document will focus on the provider communications relating to the Medicaid and Medicare EHR Incentive Programs.
- The Office of Health IT will be working on the design, development, and related follow-up for an integrated external communications strategy, plan and approach for the implementation phase of statewide Health Information Exchange, including provider communications relating to the Medicaid and Medicare EHR Incentive Programs, consumer communications around personal health records, consent and privacy and security issues, state HIT planning for the Health Information Technology Oversight Council (HITOC) and any other related HIT statewide efforts including coordination with overall Oregon Health Authority (OHA) communications efforts.
- Once the overall HIT communications strategy is finalized by the Office of Health IT and the Oregon Health Authority in early 2011, this document could be expanded to include additional information for the messaging to providers about health information exchange and any programs that are developed to support broader adoption of electronic health records.

[excerpt from Oregon Medicaid Electronic Health Records Incentive Program Provider Communication Plan, page 2].

The Office of Health IT plans to hire a communications/public relations specialist who will provide communications support for both the Medicaid HIT project and the HIE efforts. Until that staff is brought on board both projects have contracted with the same consultant to provide communications support so that there can be maximum coordination. That consultant is also working closely with O-HITEC, Oregon's Regional Extension Center, to ensure coordination across programs.

Coordination with Other Federally Funded State Programs

ONC Question 6:

While Oregon's Plan describes several federally funded state initiatives and some coordinated efforts, the Plan does not provide a discussion of the formal mechanisms by which Oregon is coordinating their State HIE activities with these important initiatives. Please describe how OREGON is coordinating ongoing activities and efforts across important HIT and HIE-related federally funded state programs. Like with Medicaid, ONC requests evidence of ongoing coordination efforts, minimally with ONC funded REC and workforce recipients/sub recipients, such as joint project plans, schedule of coordination meetings, discussions of joint goals and objectives, specific roles and responsibilities between the partners, etc.

Oregon response

Oregon's HITOC and state HIT Coordinator, Carol Robinson, have made a concerted effort to establish ongoing coordination among the several federally funded state HIT and HIE-related programs, including ONC-funded REC and workforce recipients. Quarterly meetings have been scheduled with the following federally funded grantee "partner" organizations:

Oregon's Regional Extension Center (OCHIN/O-HITEC): Abby Sears, Chief Executive Officer of OCHIN; Clayton Gillett, Director of O-HITEC
Medicaid HIT Project (MHIT): Susan Otter, MHIT Project Director
Oregon Health and Science University (OHSU): Bill Hersh, MD, Professor and Chair of the Dept. of Medical Informatics and Clinical Epidemiology in the OHSU School of Medicine
Portland Community College (PCC): Paul Wild, Director of Customized & Workplace Training
Oregon Health Network: Kim Lamb, Executive Director
OCHIN (for HRSA HIT Adoption): Abby Sears, Chief Executive Officer
Children's Health Insurance Program Reauthorization Act Grant (CHIPRA): Nicole Merrithew, Director, Medicaid Advisory Committee
Quality Corp: Mylia Christensen, Executive Director; Lori Lambert, Data Project Manager
State Public Health Dept.: Rus Hargrave, Oregon Health Authority Information Technology Director
Safety Net Medical Home Project: Craig Hostetler, Executive Director, Oregon Primary Care Association

The first of these quarterly meetings was held on September 28, 2010, and was attended by the state HIT Coordinator, and the representatives from O-HITEC, MHIT, OHSU, PCC, OCHIN, and CHIPRA. Several coordination issues were discussed at that meeting, including:

- The importance of systematically tracking existing and new federally-funded HIT initiatives in Oregon.
- Synergies and coordination points around clinical research, including OHSU's capacity, the potential for HIE to facilitate data gathering and reporting for this purpose, and the potential benefits to the financial sustainability of the statewide HIE.
- Possible synergy and coordination opportunity between MHIT and CHIPRA in terms of potentially evaluating the providers who qualify for the Medicaid EHR Incentive Payment for CHIPRA quality improvement efforts.
- Holding a job fair or coordinating internships between the organizations represented at this meeting.
- The identification of volunteer clinics as a risk in terms of O-HITEC's ability to support them in meeting meaningful use (federal funding to O-HITEC does not provide for this), and the need for O-HITEC and MHIT to strategize around providing support and assisting volunteer clinics in reaching meaningful use.
- Suggestions regarding other partners that should potentially be included in these coordination meetings, including the Oregon Healthcare Quality Corporation (Quality Corp.), Public Health efforts, and the Safety Net Medical Home Project.

Subsequent meetings are scheduled for January 10, March 28, and June 27, 2011. The partners represented at the initial meeting, as well as those identified for inclusion (Public Health, Quality Corp., and the Safety Net Medical Home Project), have all been invited to attend these subsequent meetings.

The agenda for the next meeting on January 10, 2011, includes discussion of joint goals and objectives, and specific roles and responsibilities among the partners.

There are additional mechanisms in place for coordination with the Regional Extension Center. Representatives from OCHIN/O-HITEC are on all of the Phase 1 workgroups, as well as the HIO Executive Panel. The State HIT Coordinator and the Medicaid HIT Project Director have both been named to O-HITEC's Advisory Council. The first meeting of that council is scheduled for December 7. These meetings will be an opportunity for additional discussion about joint goals and objectives, including identification of those areas where joint project plans might be appropriate.

Project Schedule and Management Plan

ONC Question 7:

While Oregon has provided a project plan, the project plan does not identify resource assignments for specific tasks and does not identify interdependencies. Please include this information in an updated project plan as well as explicit identification of tasks essential for completion of priority stage 1 meaningful use requirements.

Oregon response

Since the submission of the Project Plan with the Operations Plan in July, the Project Plan has been migrated to Microsoft Project so it can be better used as a tool to inform the planning team. In moving the plan to Project, a full resource sheet has been added that includes Office of Health Information Technology staff, consultants, stakeholders and decision makers. Where staff members are not currently in future positions, it is indicated by their expected role and TBD (i.e. Contract Evaluator TBD). Dependencies on project tasks were added to the Predecessor column to show when tasks are dependent on each other and help guide the critical path activities. The contract Project Manager is meeting bi-weekly with OHIT staff to ensure the project is on track and the plan is being kept current. Within the coming months, OHIT will be transitioning the Project Plan from quarters to exact dates in order to provide specificity and as part of the monitor-and-adapt project approach.

The updated Project Plan is attached to this addendum.

ONC Question 8:

Please clarify the plan timeline which commences in Q1 of 2011 and doesn't seemed to be aligned with HHS timing requirements for achieving Meaningful Use by all Oregon eligible providers in 2011.

Oregon response

Oregon's HIE planning team has been monitoring activities through the HIO Executive Panel that was established in September 2010 and expect alignment for eligible providers to meet meaningful use in 2011 will be happening at local levels where HIOs are active. In addition the project plan reflects state-sponsored push services to help fill in potential gaps. Through the Technology Workgroup, the team will also be monitoring what is happening with electronic lab results, e-prescribing, and clinical summaries in the vendor solutions being deployed throughout the state.

The planning team will continue to monitor and adapt, have ongoing conversations with stakeholders including HIOs, O-HITEC (Oregon's Regional Extension Center) and the Medicaid Health Incentive Technology Program, while the marketplace evolves to meet the needs outlined now and in future releases of meaningful use and other relevant regulations.

ONC Question 9:

The Risk Assessment in the Strategic Plan didn't contain analysis of the severity of the risks or the likeliness of them happening as required in the PIN.

Oregon response

The analysis of risk severity and likelihood was carried out as part of the HIE planning process. Additional detail is provided here to expand on the risk and mitigation chart that was part of the Strategic and Operational Plans.

Method

Risks were initially identified and evaluated by the HITOC Workgroup in May of 2010, using a facilitated roundtable process. Workgroup members were asked to identify risks and post them to a shared collaboration space. The risks were discussed and defined in the workgroup setting, then documented by the support team staff. The staff then categorized and consolidated the list of risks into a non-redundant set, and listed the risks in a Risk Priority Number (RPN) calculator spreadsheet.

Each risk was assigned a severity and a likelihood of occurrence. The assignments were as follows:

- Severity: 1 = minor impact on time frame or deliverables; 2 = major impact; 3 = project will fail if not addressed.
- Likelihood: 1 not likely (<20%); 2 = medium probability; 3 = (>80%) very likely to occur in the designated timeframe.

The RPN score was calculated as Severity x Likelihood. A mitigation plan was developed for any risks with RPN scores > 5, i.e. risks considered as likely and/or severe enough to include. Additional risks were identified and added to this list as the planning process matured. For readability, the numeric scores for severity and likelihood have been transposed to qualitative designations of "High, Medium, Low" in the framework below.

Phase 1 Risks

Potential Risks	Mitigation	Severity	Likelihood
Opposition, disagreement and/or confusion among participants about state and/or federal standards could also result in a potential lack of interoperability.	HITOC and Phase 1 workgroups will focus on interoperability and communication standards based on national and federal standards; assist local HIO and provider adoption of interoperability standards; monitor interoperability barriers and issues, and coordinate technical approaches within Oregon.	Medium	Medium
Lack of participation among organizations and patients.	HITOC will monitor participation by local HIOs, providers and patients in local HIOs, along with HIE services and functions with attention to barriers and issues in adoption. HITOC will work cooperatively with O-HITEC to encourage provider participation in HIE services and achievement of meaningful use.	High	Medium
Local HIOs are weak and or failing	HITOC will monitor the scope of local HIO services, operations, participation and financial sustainability on an ongoing basis and assist local HIOs in developing strategies for success. The governance entity may have to provide additional services to support local HIOs.	High	Low
Consumer concerns about electronic health records, health information exchange and privacy/consent policies	HITOC will monitor the scope and effectiveness of the consumer engagement and communications program. The state, with input from the Consumer Advisory Panel, will implement a consumer engagement and	High	Medium

Potential Risks	Mitigation	Severity	Likelihood
	communication plan focused on educating consumers regarding the benefits of electronic records and information exchange in improving the quality and safety of healthcare services.		
Exclusion of specially protected health information (SPHI) in the consent model proves difficult to implement.	HITOC and Phase 1 workgroups will consider further evolution of the consent model and technologies including providing support and standardization for HIPAA/Privacy & Security approaches to facilitate exchange within and between local HIOs. The state will facilitate a consensus about what minimum data is transferred within and between HIEs, and treatment of specially protected health information. Legislation to clarify Oregon statues may be requested.	Medium	Medium
Consent policies vary between participants in the exchange, and this may impair the flow of information.	HITOC and Phase 1 workgroups will consider further evolution of the exchange-wide consent models and technologies as above	Medium	Medium
Legal inconsistencies may prove difficult to reconcile and harmonize.	HITOC and Phase 1 workgroups will consider legal and policy issues related to widespread HIE use both interstate and intrastate, HIO organizational development. Legislation to clarify Oregon statues may be requested.	Medium	Medium
Slow provider adoption of EHRs; general intransigence to change.	HITOC will monitor provider adoption of EHRs as well as provider achievement of meaningful use including HIE functions with attention to barriers and issues in adoption. HITOC will work cooperatively with O-HITEC to encourage EHR adoption and achievement of meaningful use. O-HITEC will assist providers with implementation and change management issues.	Medium	Medium
Insufficient technical infrastructure, such as broadband connectivity.	HITOC will monitor development of provider and local HIO technical infrastructure development issues, including broadband connectivity and other infrastructure elements. HITOC will work cooperatively with the Oregon Health Network to address broadband connectivity capabilities.	Medium	Low in Urban areas; Medium in rural areas & last mile
Unanticipated future policy or reform initiatives may influence HIE participation and participant connectivity.	HITOC and Phase 1 workgroups will monitor the possible impacts of federal and Oregon health reform efforts on HIE functions, services and participation. HITOC will consider adapting HIE strategies to take advantage of health reform efforts to maximize HIE participation and participant connectivity.	Medium	Low

Potential Risks	Mitigation	Severity	Likelihood
Reluctance to change standards or move to expected standards.	HITOC and Phase 1 workgroups will consider impacts of new standard specifications on existing systems along with implementation priorities and timeframes.	Medium	Medium
Evolution in the *NATIONAL* HIE Marketplace	Workgroups will monitor closely the following emerging HIE trends and recommend alternative technical approaches to the State, for evaluation. EHR vendors connecting customers; New/emerging alliances; HIE vendors evolving products and services; Mergers and acquisitions; Project DIRECT and similar vendor models.	Medium	Medium
Evolution in the *OREGON* HIE Marketplace	Workgroups will monitor closely the emerging HIE trends and recommend alternative technical approaches to the State, for evaluation. Local HIOs evolving around IDNs and collaborations; Epic dominance in Portland area (and Salem); Variable development of services (functions & scope); Direct services in planning.	Medium	Medium
Breach of personal health information	The State will develop consistent statewide guidance for local HIEs, about potential breaches involving the HIE, to supplement participants' existing contingency plans related to security violations, accidental disclosure, or theft of patient information.	High	Medium

Phase 2 Risks

Potential Risks	Mitigation	Severity	Likelihood
Lack of compliance due to changing legal/regulatory landscape.	HITOC and the SDE will monitor the impacts of any compliance issues due to a changing legal/regulatory landscape and develop strategies and recommendations related to the provision of HIE services.	Medium	Medium
Tension between local HIOs and SDE as the SDE expands its service offerings	HITOC will monitor the evolution of services by local HIOs and the SDE and develop strategies to minimize the impacts of tensions.	High	Medium
Legal obstacles in Phase 1 may create delays in legal/policy domain issues (i.e. interstate exchange)	HITOC, the SDE and workgroups will monitor the possible impacts of delays in addressing legal and policy issues and develop strategies and recommendations for minimizing adverse impacts.	High	Medium; Low if Phase 1 is successful

Potential Risks	Mitigation	Severity	Likelihood
Unresolved legal and policy issue related obstacles in Phase 2.	HITOC, the SDE and workgroups will consider unresolved legal and policy issues related to widespread HIE use both interstate and intrastate along with HIO organizational development. Legislation to clarify Oregon statues may be requested.	Medium	Medium
Inadequate financial plan for sustainable non-profit SDE.	HITOC will monitor the scope of planned and operating SDE services, actual and projected financial performance and financial sustainability on an ongoing basis. HITOC will work with the SDE to maximize the financial and programmatic success of the SDE.	High	Medium
Accreditation program lacks enforcement or systems lack resources to meet standards.	HITOC and the SDE will monitor the effectiveness of the accreditation program in certifying and tracking HIO compliance with accreditation standards including issues encountered by HIOs in meeting accreditation program standards. HITOC will consider strategies for maximizing the success of HIOs in achieving accreditation.	Low	Medium
Early failures of HIE efforts and public support due to privacy and security breaches.	HITOC, the SDE and local HIOs are expected to make the protection of privacy and security a critical imperative in the design, implementation and operation of HIE services. The SDE and local HIOs will aggressively respond to any privacy and security breaches to maintain the trust and support of the public.	High	Medium
Failure to transition from "start-up" mode to on-going operation, resulting in unreliable services and unstable standards	HITOC and the SDE will closely monitor the establishment of the SDE, initial SDE operations including implementation of planned services, technical and performance standards to assure an effective transition to ongoing operations with reliable and stable services.	Medium	Medium
Consolidation in the provider markets may create changes for HIE.	HITOC and the SDE will monitor consolidations and changes in provider organization markets for possible impacts on the scope of local HIO services, operations, participation and financial sustainability and assist local HIOs in adapting strategies for success. The SDE may have to provide additional services to support local HIOs.	Medium	High

Potential Risks	Mitigation	Severity	Likelihood
Evolution in the *NATIONAL* HIE Marketplace	Workgroups will monitor closely the following emerging HIE trends and recommend alternative technical approaches to the State, for evaluation. EHR vendors connecting customers; New/emerging alliances; HIE vendors evolving products and services; Mergers and acquisitions; Project DIRECT and similar vendor models.	Medium	Medium
Evolution in the *OREGON* HIE Marketplace	Workgroups will monitor closely the emerging HIE trends and recommend alternative technical approaches to the State, for evaluation. Local HIOs evolving around IDNs and collaborations; Epic dominance in Portland area (and Salem); Variable development of services (functions & scope); Direct services in planning.	Medium	Medium
Breach of personal health information	The State will develop consistent statewide guidance for local HIEs, about potential breaches involving the HIE, to supplement participants' existing contingency plans related to security violations, accidental disclosure, or theft of patient information.	High	Medium

Technical Infrastructure

ONC Question 10:

The state plan must provide a more detailed description of the state's Nationwide Health Information Network Direct strategy. ONC needs a better understanding of the strategy as well as the tactical implementation. It may be helpful to tell "the story" from a provider point of view. The plan should include a full top-to-bottom description including requirements of the provider, requirements of the HISP, who is acting as the HISP, who is providing the directory, the authentication, the encryption, methodologies, etc.

Oregon response

While Oregon has a significant number of providers and hospitals with EHRs installed and geographic coverage of HIOs is quickly improving, there are still functional and geographic gaps. To fill these gaps, Oregon is investigating services that allow for messaging-based/"push" HIE for providers without access to a current or evolving local HIO. This service will be available to all providers/hospitals and HIOs, but should be considered as the "exchange of last resort" because Oregon's success in HIE is highly dependent on strong local HIO participation. NHIN Direct will not only be part of Oregon's white space strategy by tying together unaffiliated providers across the state, but will also be used to connect HIOs within the state.

Oregon's approach contemplates the SDE acting as a central HISP, facilitating communication between HIOs and unaffiliated providers, but does not preclude the formation and use of other HISPs. HIOs may themselves become HISPs, or engage third-party HISPs. However, if HIOs are engaging with a third-party HISP or acting as a HISP, a Trust Anchor relationship must be established with the SDE.

Requirements of the Providers/Hospitals
Providers/Hospitals must have the ability to connect to the Internet.
Providers/Hospitals must have patient information available via certified EHR technology.
Providers/Hospitals must have an active digital certificate that is recognized and trusted by the Trust Services provider.
Providers/Hospitals must be part of the HIE Participant directory.
Independent participants that are not affiliated with an accredited HIO, must demonstrate adherence to standards and policies necessary for secure health information exchange as defined by the Oregon Health Authority.

Requirements of the HISP
HISP must be connected to the Internet accessible via the SDE.
HISP must adhere to NHIN Direct/Direct Project standards and to standards and policies necessary for secure health information exchange as defined by the Oregon Health Authority. The determination of whether or how HISPs will be accredited is still under discussion within that planning process.

Technology and Services
Internet service – supplied by provider/hospital
Certified EHR – may be a local installation at the provider's office, or may be software as a service (SaaS) with access at the provider's office
Trust Services – provided by the SDE or local HIO, depending on whether it is internal to one HIO, or across HIOs
HIE Participant Directory – provided by the SDE or local HIO, depending on whether it is internal to one HIO, or across HIOs

The scenarios below envision various roles for the SDE and local HIOs; they do not cover every possibility and are included here strictly as examples.

Scenario #1 – Unaffiliated provider/hospital to unaffiliated provider/hospital
Provider A's HISP is the SDE
Provider B's HISP is the SDE

Provider A determines that it is clinically and legally appropriate to send a referral and summary of care to Provider B.
Provider A assembles patient information within its EHR in a standardized message format as defined by the HIE Participant Accreditation Program.
Provider A uses HIE Participant Directory provided by the SDE to find addressing information for Provider B.
Provider A uses its certificate granted by the HISP as part of the Trust Services to encrypt and sign patient information for transport to Provider B.
Provider A submits encrypted patient information to Provider B.
Provider B, through its EHR, is informed of incoming patient information.
Provider B notes that Provider A is part of the HIE Participant Directory (provided by the SDE) and uses its certificate, supplied by the HISP, to decrypt patient's information.

Scenario #2 – Unaffiliated provider/hospital to affiliated provider/hospital
Provider A's HISP is the SDE
Provider B's HISP is the HIO of which they are a member

Provider A determines that it is clinically and legally appropriate to send a referral and summary of care to Provider B.
Provider A assembles patient information within its EHR in a standardized message format as defined by the HIE Participant Accreditation Program.
Provider A uses HIE Participant Directory provided by the SDE to find addressing information for Provider B.
Provider A uses its certificate granted by the HISP as part of the Trust Services to encrypt and sign patient information for transport to Provider B.
Provider A submits encrypted patient information to Provider B.
Provider B, through its EHR, is informed of incoming patient information.
Provider B notes that Provider A is part of the HIE Participant Directory (provided by the SDE) and uses certificate, supplied by the HISP, to decrypt patient's information.

Scenario # 3 – Affiliated provider/hospital to affiliated provider/hospital – different HIO affiliations
Provider A's HISP is Provider A's HIO
Provider B's HISP is Provider B's HIO

Provider A determines that it is clinically and legally appropriate to send a referral and summary of care to Provider B.
Provider A assembles patient information within its EHR in a standardized message format as defined by the HIE Participant Accreditation Program.
Provider A uses HIE Participant Directory provided by the SDE to find addressing information for Provider B.
Provider A uses its certificate granted by the HISP as part of the Trust Services to encrypt and sign patient information for transport to Provider B.
Provider A submits encrypted patient information to Provider B.
Provider B, through its EHR, is informed of incoming patient information.
Provider B notes that Provider A is part of the HIE Participant Directory (provided by the SDE) and uses its certificate, supplied by the HISP, to decrypt patient's information.

Scenario # 4 – Affiliated provider/hospital to affiliated provider/hospital – same HIO affiliation
HISP services provided by the HIO of which both are members.
Providers may or may not use the statewide HIE Participant Directory, may have the option to use the local HIO directory.

Scenarios #3 and #4 are the ideal best case for Oregon's approach: strong local HIOs serving provider and hospital constituencies in their geographic regions, with facilitation of health information exchange provided by the SDE using a few key centralized services. While this is ideal, Oregon realizes that there may be gaps in this strategy, and will offer the basic necessary services for secure message transport to providers and hospitals to meet Stage 1 Meaningful Use.

ONC Question 11:

The plan should describe whether Oregon's statewide offering will compete with the many existing HIOs within the state. Additionally, the plan should describe how Oregon will leverage and build on any HIE services and resources already in place including those in existing HIOs.

Oregon response

Oregon's HIE strategy is built upon—and will leverage—the investments made by hospitals, providers and local HIOs both in technology purchases and in time spent building governance structures to allow for communication of health information across and within communities. Since the submission of the Strategic and Operational Plans, HITOC has convened a number of workgroups and panels to gain a deeper level of understanding of the capabilities and capacity of existing investments in HIE within the state of Oregon. One panel in particular, the HIO Executive Panel (comprised of CEO-level executives from the prominent HIOs within the state), was created to provide a forum for collaboration and information sharing among HIOs. The first two meetings of the HIO Executive Panel have been valuable for assessing the evolving HIO marketplace and gaining stakeholder support for the development of core services to be offered by the SDE

The SDE's technology-based service offerings will align with the market-driven approach as described in the original Strategic Plan. Based on the feedback from the HIO Executive Panel and other workgroups, the SDE will be offering centralized services that will allow HIOs to transmit health information between each other and other non-provider HIE Participants; e.g., laboratory testing companies, state agencies, and out-of-state participants that are not members of HIOs based in Oregon. These services include provider and participant directories, Trust Services to ensure the security and fidelity of exchanged information, interoperability services, and standards to provide the "rules of the road" by which participants will abide. Non-technology-based services that will be offered by the SDE will include accreditation of HIE participants, legal frameworks, and support services that will lower the operating costs incurred by the HIOs to allow for market growth. The SDE intends to leverage the existing local HIOs to get to the "last mile" of HIE and encourage providers and hospitals to join the membership ranks of the HIOs, rather than directly connecting to the SDE's services.

At this time, the SDE does not intend to directly engage with or market its services to providers or hospitals that are not able to join an HIO, but will provide those services to providers and hospitals as a means to meet Stage 1 Meaningful Use. These core HIE services will be offered as part of the SDE's mission of meeting the "public good need" as a public/private non-profit entity. This approach will best leverage existing investments in technology and services and will also allow the most flexible options for providers that are currently "in the white space."

As the marketplace evolves, the SDE will employ its "monitor and adapt" philosophy and intervene as issues are identified related to operational services or financial sustainability of local HIOs. The SDE and HITOC will work with eligible providers and hospitals to ensure their access to health information exchange. The monitoring will occur via ongoing environmental assessments, much like the assessments conducted for the creation of the Strategic and Operational Plans, and through ongoing engagement with the HIO Executive Panel. If exclusion or collapse is likely, the SDE will work with the HIOs to develop a response. This may include a franchise option for the local HIOs that take on the additional membership and operation of services, or the SDE could choose to expand its service offerings to cover the gaps. Additionally, the SDE may offer additional support to HIE participants for joining an existing HIO, or to a group wishing to develop or fund a new HIO.

ONC Question 12:

Please describe the extent of planned statewide service coverage and the plan for its roll as there were options discussed but the exact decision points and criteria were not given. Additionally, the plan wasn't clear about Oregon's approach to integrating with existing HIOs in the state.

Oregon response

Oregon's HIE Strategy is built upon—and will leverage—the investments made by hospitals, providers and local HIOs both in technology purchases and in time spent building governance structures to allow for communication of health information across and within communities. Since the submission of the Strategic and Operational Plans, HITOC has convened a number of workgroups and panels to gain a deeper level of understanding of the capabilities and capacity of existing investments in HIE within the State of Oregon.

The Oregon SDE will offer several services defined as "core:" necessary for the exchange of health information between health information organizations. These services include statewide provider and organizational HIE participant directories, a Trust Services framework to ensure the security and fidelity of exchanged information, and standards necessary to establish interoperability of exchange mechanisms between organizations. Core services may also include any other services to provide a message-based exchange capability to eligible providers. These services will be made available to local HIOs and providers and hospitals; however, unaffiliated providers and hospitals will be strongly encouraged to join an existing HIO rather than engaging directly with the SDE.

Through meetings of the HIO Executive Panel, the Technology Workgroup, and the Finance Workgroup it has become apparent that it will be a valued service for the SDE to provide a statewide directory of providers and non-provider participants for use by local HIOs. The local HIOs expressed strong interest in the availability of a statewide provider directory that would allow local HIOs to reduce the amount of work they'd have to do building such directories locally. These organizations also indicated that they would pay the SDE for the development and use of this service as it was one of the most expensive parts of their sustaining operational costs. The RFP for technology services will include the development and maintenance of a statewide participant directory.

Another technology-based service that was indicated to be of value was a Trust Services framework. While there was still some uncertainty regarding the exact implementation of such a framework, there was a general consensus on the need for Trust Services that would operationalize the framework. One option is that the SDE become a certificate-issuing authority and all HIOs and providers would obtain their Trust Services through the SDE; another option would be that the HIOs obtain Trust Services through the SDE acting as a Trust Anchor, and the HIOs would, in turn, provide Trust Services to their constituencies. Details of the implementation of the Trust Services will be discussed in upcoming meetings of the Technology and Finance Workgroups. The decision will be made before the development and issuance of the RFP for the technology services.

The core technology-based services under consideration are those necessary for message-based exchange of health information. These services are under much discussion as there is significant interest by the HIOs in providing these services to other HIOs and providers. While a final decision has not been made regarding the level of which services will be provided and by whom, there was general consensus that the SDE will offer inter-HIO messaging services, while the regional HIOs will offer internal messaging services to their constituencies.

These services will be rolled out in 2011, such that all eligible providers will have the ability to collect Stage 1 meaningful use payments. More details regarding the exact timing of the rollout of services can be found in the detailed project plan included with this addendum.

ONC Question 13:
While the plan expresses a commitment to adhere to national standards, the plan must describe the process and/or mechanism that ensures that the adoption of standards and policies will be aligned with national standards as they evolve

Oregon response

A core component of Oregon's Strategic and Operational Plans is a commitment to align with national and industry standards to maximize participation and minimize the operational support requirements for HIE. To this end, Oregon has convened a number of workgroups and subcommittees to address national and industry standards. Two in particular—the Legal and Policy Workgroup and Technology Workgroup—are working in concert to develop a standards recommendation for HIE participants. These "rules of the road" will lay the groundwork for an HIE Accreditation Program, by which all HIE participants within the state will be certified.

As the national standards landscape is evolving, especially in the realm of HIE standards, Oregon will extend its "monitor and adapt" philosophy to include a regular review and revision, if necessary, of its HIE Participant Accreditation program to consider and respond to any changes to national standards.

To support the workgroups and advance HIE within the state, HITOC has convened a special subcommittee to address the HIE Participant Accreditation program. The Accreditation subcommittee is a cross-functional group comprised of members of the HIO Executive Panel, Legal and Policy Workgroup and Technology Workgroup. Each workgroup will bring forth recommendations on standards for its area of expertise for review by the group. This group will provide a recommendation on the standards frameworks for use in the Accreditation Program. Each workgroup and panel will review these recommendations and present its findings to HITOC.

Finance

ONC Question 14:
The plan must address Oregon's mechanisms to ensure financial integrity and oversight, including financial policies and procedures.

Oregon response

Financial Accountability: State of Oregon Oversight, Policies and Procedures
The Oregon Health Authority (OHA) is a new state agency created by House Bill 2009. The OHA is being set up as an umbrella health agency with direct authority over those state agencies focusing on health, including the Division of Medical Assistance Programs, Office for Oregon Health Policy and Research (OHPR), Public Health Division, Addictions and Mental Health and a number of others. The new Department of Human Services (DHS) will include the Children, Adults and Families Division (CAF) and Seniors and People with Disabilities Division (SPD). The OHA is set to officially become separate from DHS in early July 2011, but shared services between the two agencies, including administrative services and information technology, are underway.

As Oregon's recipient for the State HIE Cooperative Agreement Program, the Office for Health Policy and Research (OHPR), an office within the OHA and DHS, will be the financing authority and serve as the single point of contact and fiscal agent to comply with all award requirements, provide active oversight and monitoring of the project, ensure accountability and ongoing auditing functions, and submit reports to ONC. The Oregon Health Authority will provide direct oversight and govern all State Cooperative Agreement funds including ongoing management and tracking. All federal funds will be processed through the State of Oregon Cash Management System and in accordance with all state and federal audit requirements. In addition, OHA operates and accounts for its activities according to relevant Federal Office of Management and Budget (OMB) circulars, including Circular A-122 and Circular A-133.

The Oregon DHS financial policies, procedures and controls are compliant with Generally Accepted Accounting Principles (GAAP) and Governmental Accounting Standards Board (GASB) accounting standards. Oregon DHS' existing systems and finance policies comply with federal requirements for cost reimbursement and grants

management (45 CFR Part 74 or 92) and will be used for tracking and reporting of all State HIE Program funds. The Department of Human Services participates, as required, in an annual independent single audit performed by the Oregon Secretary of State, Audits Division. The Single Audit Report describes procedures used by state auditors to ensure compliance with GAAP accounting standards and OMB circulars.

The State of Oregon, in accordance with Oregon Revised Statutes, requires all agencies, departments, divisions, boards, commissions and officers of the State to develop and implement financial policies and procedures for the receipt, deposit and disbursement of all federal funds. The Oregon Department of Human Services includes two Deputy Directors with one responsible for Operations and the other for Finance. The DHS Controller and Office for Financial services are responsible for financial systems management, financial reporting services for the entire Department of Human Services, including the Office for Health Policy and Research. The DHS Controller provides management in financial reporting, federal grant management and reporting, cash flow management, and works with state and federal auditors on all OHPR related projects, grants, and initiatives, including the ONC Cooperative Agreement. Other duties of the DHS Controller are to ensure compliance with financial policies and procedures in OMB circulars, GAAP and GASB. The Oregon Department of Human Services, Internal Audit and Consulting Services Division, performs an annual audit report as required by Oregon Administrative Rule (OAR 125-700-0050).

OHA will ensure prior to designation of the State Designated Entity (SDE) that an independent CPA firm audit and certify that the SDE's financial policies, procedures and controls are maintained in compliance with GAAP and relevant OMB guidelines. OHA will continue to serve as the single point of contact to submit all annual progress and financial reports to ONC as required by award stipulations. OHA will also ensure that all funded programmatic activities and sub-recipients using ONC Cooperative Agreement funds are in compliance with applicable state and federal audit standards throughout the duration of the project. The State Coordinator for HIT and State HIE Project Director will actively monitor program activities and sub-recipient activities on a quarterly basis throughout the project including requirements under the Recovery Act on the Schedule of Expenditures of Federal Awards (SEFA) to monitor expenditure of ONC funds. Additional monitoring mechanisms include phone contact, document review, ongoing meetings and other appropriate oversight and accountability methods. Monitoring will determine compliance with state plan and programmatic and financial requirements.

Privacy and Security

ONC Question 15:

While the Oregon Strategic Plan indicates that Oregon's strategy is to address all eight (8) principles of the HHS Privacy and Security Framework but there is not a description of how that will happen. The plan should describe Oregon's privacy and security framework, or if not complete, the process and timeline in which the framework will be complete.

Oregon response

HHS Privacy and Security Framework

1) Individual Access
2) Right to Dispute and Correction
3) Openness and Transparency
4) Individual Choice
5) Limitation on Collection, Use, and Disclosure to a specified purpose
6) Data Quality and Integrity
7) Safeguards
8) Accountability

Oregon will ensure that the entities participating in HIE in Oregon adhere to the principles outlined in the HHS Privacy and Security Framework through a combination of methods. First, Oregon will enforce compliance with existing federal regulations, particularly the HIPAA Privacy and Security Rules, which have existing provisions around HHS Principles (1), (2), (4), (5), (6), (7), and (8). Second, Oregon will leverage the meaningful use criteria where applicable, such as the stipulation that eligible providers wishing to receive incentive payments provide

patients an electronic copy of their medical record within a specified time frame of their request (addressing HHS Principle (1)). Third, Oregon is developing an HIE Accreditation Program, through which the state or SDE will validate and enforce the existence and appropriateness of the policies, procedures, and technical and other resources necessary to reliably implement and adhere to these principles. The Oregon HIE Accreditation Program will directly address HHS Principle (3) Openness and Transparency, and (8) Accountability, by using an open and transparent process by which HIE entities are evaluated and accredited, and by holding those entities accountable that are found to be non-compliant with the standards embodied in the program's requirements.

The process for developing Oregon's HIE Accreditation Program

HITOC has formed and staffed an Accreditation "Tiger Team" composed of the workgroup members that volunteered for the first Accreditation subcommittee meeting on October 28, 2010, to proceed in developing a proposal for the Accreditation Program. Staff will analyze the questions and other issues raised about accreditation at the HITOC workgroup meetings, draft a proposal for review by the Tiger Team on December 3, 2010, and submit a revised proposal to the HITOC HIO Executive Panel on December 9, 2010. The revised proposal and feedback collected from the HIO Executive Panel members will then be reviewed by HITOC members at their retreat on January 20, 2011, which will make the final recommendation around Oregon's HIE Accreditation Program to the director of the Oregon Health Authority. Potential legislation for the implementation of an Accreditation Program has been drafted for consideration by the Oregon Legislature, and will be advanced if all of the steps outlined above are met. The Oregon Legislature meets from January 10, 2011 until late June. In the meantime, at least two regional HIOs have volunteered to participate in the EHNAC self-assessment to determine potential readiness for accreditation in 2011.

HITOC Legal and Policy Workgroup

HITOC has also formed a Legal and Policy Workgroup to perform analysis and provide recommendations around a number of issues related to Oregon's HIE privacy and security framework. The Legal and Policy Workgroup is currently formulating its recommendations around a consent policy for Oregon HIE. The consent policy will address HHS Principle (4), Individual Choice, as appropriate. The workgroup is also discussing the privacy and security standards that will be required through the Accreditation Program and providing that input to the Accreditation Program Tiger Team to incorporate into its development of the program. Finally, the Legal and Policy Workgroup will discuss potential additional methods of validation and enforcement beyond the Accreditation Program, including but not limited to audit, breach remediation policies, and an ombudsman or patient advocate program for HIE in Oregon. These discussions within the Legal and Policy Workgroup around consent, privacy and security standards, and validation and enforcement mechanisms are taking place in November and December 2010, with formal recommendations going to HITOC on December 2, 2010 and January 20, 2011.

ONC Question 16:

The Operation Plan must indicate how Oregon will follow national standards and best practices for Privacy and Security, including digital certificates, encryption of data, unique user identifiers, role-based access and audit logs.

Oregon response

Adoption of national standards and best practices is a key component in Oregon's HIE strategy. Operationally, Oregon will approach ensuring adherence to such standards and practices in the realm of Privacy and Security through two mechanisms:

1. Incorporation of applicable standards within the framework of centralized services, and
2. Implementation of the Oregon HIE Accreditation Program.

National standards for Privacy and Security are being incorporated into the fabric of Oregon's statewide HIE standards framework and into the centralized services that enable and facilitate exchange. Non-adherence will prevent access to centralized services and an inability to exchange data. Such standards and best practices include:

- Transport Layer Security (TLS), for network-layer encryption to protect data in transit
- Digital certificates (X.509 PKI), for authentication, encryption of data in transit, data verification, and non-repudiation

Digital certificates will be issued only to entities that have successfully obtained accreditation through Oregon's HIE Accreditation Program. Building from EHNAC's Health Information Exchange Accreditation Program criteria, Oregon's HIE Accreditation Program will ensure that entities participating in health information exchange in Oregon are compliant with pertinent Privacy and Security regulations, such as the HIPAA Privacy and Security Rules, and have appropriate security and privacy policies with accompanying control programs to ensure privacy, information security, system availability, and other such concerns are addressed. Specifically, role-based access control, assignment of unique user identifiers, and audit trails are criteria within EHNAC's HIE Accreditation Program, and will also exist within Oregon's criteria.

Attachments:

1. Memorandum of Understanding for Medicaid HIE
2. Annotated and Updated Project Plan

Oregon Department of Human Services
Oregon Health Authority

Memorandum of Understanding Between the Division of Medical Assistance Programs, Office of Information Services, and the Office of Health Policy and Research

1. **Purpose**: Through this Memorandum of Understanding (MOU) the Division of Medical Assistance Programs (DMAP), Office of Information Services (OIS) and the Office of Health Policy and Research (OHPR), all divisions of the Oregon Department of Human Services (DHS)/Oregon Health Authority (OHA), agree to work together to strategize, plan, develop, and implement a statewide health information exchange (HIE).

   References: Centers for Medicare and Medicaid Services (CMS)
   Planning [Phase] Advance Planning Document (P-APD)

   Excerpt from P-APD:

   OR HIE Statewide HIE Planning: As mentioned throughout this document, the Medicaid Health Information Technology (MHIT) planning project will work closely to align and synchronize resources with the Health Information Technology Oversight Council's (HITOC) statewide HIE planning process. Medicaid HIT Planning team members and Medicaid subject matter experts will participate in the development of the Medicaid portion of the state HIE plan. Further the state HIE will support Medicaid providers and will connect DHS/OHA programs to providers to allow for the exchange of health-related data. Due to the direct benefits of the state HIE on Oregon's Medicaid HIT plans, Oregon is requesting Planning Advance Planning Document (P-APD) funding to include the Medicaid portion of Oregon's state HIE planning process. This proportion is estimated at 39% of state HIE planning costs, based on Oregon's federal financial participation (FFP) for health planning activities used by the OHPR. OHPR is the DHS/OHA office that staffs the HITOC as well as the health reform efforts and other health policy and planning efforts.

2. **Background**: DMAP, Oregon's Medicaid agency, received approval of the P-APD by CMS February 2010 to complete the objectives set forth in the P-APD. Part of the P-APD described the use of P-APD funding to cover the Medicaid portion of Oregon's state HIE planning process that will be conducted by HITOC, being operated within OHPR. This approval by CMS of the P-APD provides for OHPR the ability to charge the P-APD budget for the proportional HITOC costs. This MOU outlines processes, procedures, and permission for OHPR to do so.

3. **Schedule Restrictions**: The approved P-APD has a current end date of October 31, 2010. The budgeted funds and the services provided with these funds must be completed and allocated by the end of the P-APD. It is anticipated that a P-APD Update (P-APDU) will be submitted to CMS during the P-APD time frame that will request an extension of time to continue the P-APD scope of work and funding beyond the October 2010 date. This MOU will automatically extend in accordance with any extensions authorized by CMS from P-APDU(s).

4. **Agreements**:

- Aaron Karjala, Deputy CIO – OIS, will be responsible for the management of this agreement for OIS.
- Judy Mohr Peterson, Assistant Director – DMAP, will be responsible for the management of this agreement for DMAP.
- Sean Kolmer, MPH – Deputy Administrator, will be responsible for management of this agreement for OHPR.
- Carol Robinson, State Coordinator – HITOC, will be responsible for management of this agreement for HITOC.
- Douglas A. Jones, P-APD/MHIT Project Manager, will be responsible for the overall facilitation of this agreement for the P-APD and will coordinate and develop any amendments as necessary.
- Activities performed and expenditures charged under this MOU shall conform to the scope, time lines and milestones in the P-APD or the subsequent P-APDU submitted to and approved by CMS. The P-APD project team will include HITOC/OHPR in negotiations with CMS where changes to scope, time lines, and milestones that impact the work being conducted by HITOC/OHPR under the P-APD.
- HITOC/OHPR may NOT use the allocated and budgeted funds to deploy direct staff to manage or perform activities as required by, and in accordance with, the HITOC portion of the P-APD, unless otherwise amended in a CMS approved P-APDU or other form of approval.
- HITOC/OHPR may engage the services of its vendor(s) to manage or perform activities as required by, and in accordance with, the HITOC portion of the P-APD.
- HITOC/OHPR will submit periodic reports to the P-APD project supplying information necessary for the required CMS reporting as it relates to the HITOC portion of the P-APD.

5. CMS Guiding Principles for use of P-APD Funds

Per (t)(9)(C), CMS will consider approval for 90/10 FFP for States' proposed initiatives that will meet the following criteria:

- Serve as a direct accelerant to the success of the State's Medicaid Electronic Health Records (EHR) Incentive Program and facilitate the dispersion and use of certified EHRs.
- Will, in most cases, be normalized and integrated into the Medicaid business enterprise (an example of an exception is point-in-time technical assistance), such as technical bridges between Medicaid and statewide HIEs.
- Are designed to be well-defined projects with specific goals that would enhance the capability of the Medicaid program to exchange health information necessary allowing providers to be meaningful users of certified EHRs.
- Cannot otherwise be funded by the CMS MMIS matching funds.
- Are a complement to Office of the National Coordinator (ONC) funding for HIE (that is inclusive of Medicaid) - following the fair share principle across all payers.
- Are working in concert, and to a satisfactory performance level, with the ONC HIE activities in the State, as the HIE work under those cooperative agreements is viewed by CMS as an integral piece of a successful Medicaid EHR Incentive Program.
- Are not duplicating technical assistance efforts conducted by the ONC funded Regional Extension Centers to the same specific providers.
- Are procured following the principles of free and open competition for all contracts unless waived by CMS.
- Are developmental and/or time-limited in nature, and not part of on-going operational activities (an example of what would not meet this standard would be paying for providers' HIE transaction fees).
- Are cost-allocated where part of a multi-payer enterprise, using a methodology that identifies Medicaid's pro-rated share where the denominator is either the total patient volume or total patient cost, adjusted by an estimation of Medicaid provider participation in the state EHR Incentive Program over the next five years.
    - Cost allocation should involve the timely and assured financial participation of all parties so that Medicaid funds are not the sole contributor at the onset.
    - CMS views the Medicaid share as appropriate only for a governmental or non-profit utility, not privately-held and for-profit.
    - CMS is open to considering other cost allocation methodologies, subject to prior review and approval.
- Are not intended to be permanent initiatives, however will, in most cases, lead to a permanent and sustainable outcome.
- Are described and integrated into the State Medicaid HIT Plan.

6. **Budget and Financial Obligations**: According to the terms of the P-APD, Oregon is required to fund 10% of the overall project expenditures, with the remaining 90% to be covered by a federal CMS match. The budget provided in the approved P-APD projected only costs for contractors and did not allocate any costs for state staff. The terms to utilize this budget for staff costs may be allowed upon notification to CMS. The HITOC/OHPR portion of the P-APD budget is as follows:

HITOC Staff Costs	$ 0.00
HITOC Contractor Costs	$ 472,788.00
HITOC P-APD Budget Total	**$ 472,788.00**
State Share of Costs (OHPR)	$ 47,279.00
Federal Share of Costs	$ 425,509.00
Total Share of Costs	$ 472,788.00

The agreements made as part of the development of the P-APD indicate that HITOC/OHPR will provide the State Share of Costs for the HITOC portion of the P-APD. The full P-APD budget is managed by OIS, therefore it is agreed that HITOC/OHPR will transfer the HITOC portion of the P-APD State Share in the amount of $47,279.00 to OIS to be incorporated into the overall P-APD State Share.

7. **Budget Projection and Actual Expenditures**:

DHS/OHA Budget Projects and Revisions
DHS/OHA requires the MHIT Project to estimate expenditures by budget category on a month-by-month basis for the life of the project. As actual expenditures are paid, revisions to the future budget months must be made. For example, if an expenditure is budgeted for the month of March, but the cost will not occur until April, adjustments to the budget must be made to reflect the change.

Federal Reporting Requirements
CMS requires the MHIT Project to submit quarterly cost reports that outline expenditures occurred by budget category. The MHIT Project team will be responsible to compile this report with the assistance of the DHS/OHA Accounting Office. This report is derived by the actual expenses as coded in the accounting system, so accuracy at the time of processing payments is crucial.

Charge Corrections
If a correction needs to be made to a payment already made (coding change, incorrect amount, etc.), HITOC/OHPR must communicate the change in writing (email accepted) to the MHIT Project, so that a proper record and understanding of the change will be provided.

8. **Expenses and Accounting Requirements**: The P-APD MHIT Project has allocated a not-to-exceed amount of $472,788 for the purpose of the HITOC activities as described in the P-APD. HITOC/OHPR will be responsible to issue payments for expenditures as outlined in the MOU. HITOC/OHPR will provide the appropriate designated accounting codes (Index, PCA, AOBJ) as defined by the MHIT Project. HITOC/OHPR will be responsible to maintain the appropriate recordkeeping as required by DHS/OHA, state laws, and federal requirements. The MHIT Project will monitor the budget against the not-to-exceed amount as described in this MOU.

   Accounting Codes:
   HITOC/OHPR will be assigned and utilize the following accounting codes:

   MHIT Project **INDEX**: **05420**

   HITOC **In-House PCA**: **08616** (Not allowed unless CMS Notified)

   HITOC **Private** (Contractors) **PCA**: **08617**

   Agency Object Code (**AOBJ**): **See *AY 11 OIS Agency* List** (Appendix A)

9. **Effective Date**: This agreement becomes effective upon signature of the parties.

10. **Retroactive Billing:** According to CMS Communications, CMS may allow for retroactive billing and contractor approvals. Based upon the final rules approved by CMS, the effective date for payments and contract approvals will follow these final publish rules.

11. **Termination**: This agreement expires upon completion of the project and formal delivery of the final report to CMS, termination of the P-APD from CMS, or by written notice by either party.

The signatures provided below indicate the approval and agreement to execute this agreement and comply with the terms and conditions as stated within.

_____

For the Division of Medical Assistance Programs Date
Judy Mohr Peterson, Ph.D., Assistant Director

_____

For the Health Information Technology Oversight Council — Date
Carol Robinson, Director

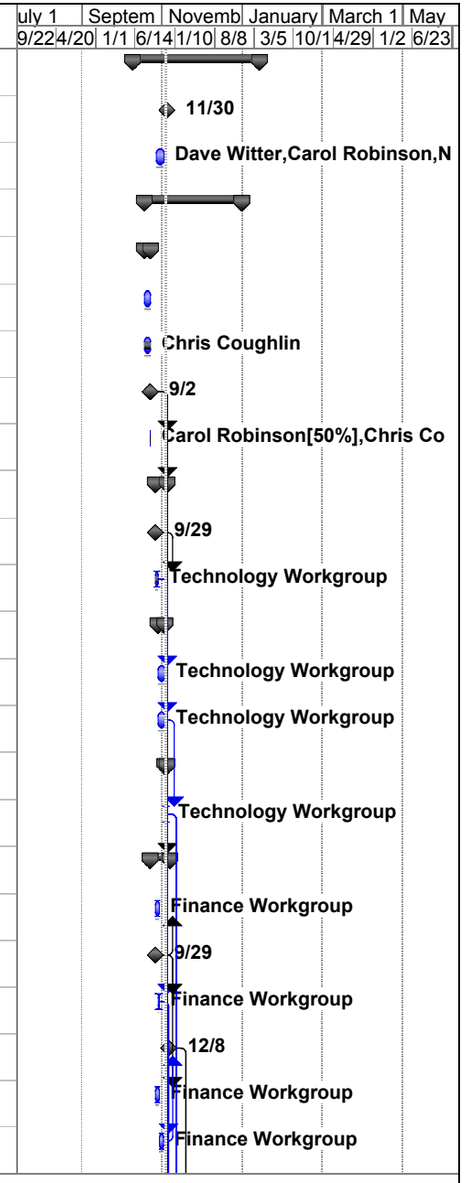
_____

For the Office of Information Services — Date
Aaron Karjala, Deputy Chief Information Officer

_____

For the Oregon Health Policy and Research — Date
Sean Kolmer, Deputy Administrator

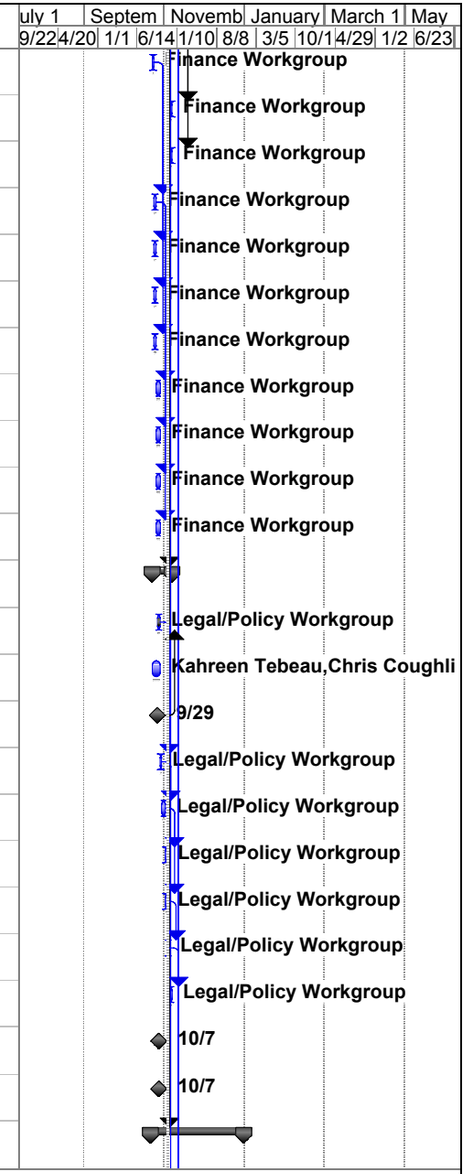
ID	Task Name	Duration	Start	Finish	Predecesso	Resource Names
1	**1 Phase 1**	**481 days**	**Tue 6/1/10**	**Tue 4/3/12**		
2	1.1 ONC Approval of Strategic and Operational Plan	0 hrs	Tue 11/30/10	Tue 11/30/10		ONC[0%]
3	1.2 Respond to ONC feedback on Strategic and Operational Plan	30 days	Mon 10/4/10	Fri 11/12/10		Dave Witter,Carol Robinson,Nan Robertson,John Hall,Jan Green
4	**1.3 Establishment of workgroups and stakeholder engagement**	**370 days**	**Mon 8/2/10**	**Sat 12/31/11**		
5	**1.3.1 HITOC workgroups and panels created and approved**	**25 days**	**Mon 8/2/10**	**Fri 9/3/10**		
6	1.3.1.1 Create workgroups and panels	24 days	Mon 8/2/10	Thu 9/2/10		
7	1.3.1.2 Write workgroup and panel charters	24 days	Mon 8/2/10	Thu 9/2/10		Chris Coughlin
8	1.3.1.3 HITOC approves workgroup and panel members	0 hrs	Thu 9/2/10	Thu 9/2/10		HITOC[0%]
9	1.3.1.4 Send workgroup members invitations welcoming them and giving 9/29 date	2 days	Thu 9/2/10	Fri 9/3/10	8	Carol Robinson[50%],Chris Coughlin[50%]
10	**1.3.2 Technology Workgroup established**	**44 days**	**Wed 9/29/10**	**Mon 11/29/10**	**8**	
11	1.3.2.1 Orientation	0 hrs	Wed 9/29/10	Wed 9/29/10		Technology Workgroup[0%]
12	1.3.2.2 Gather feedback on HIE Core Services Requirements	10 days	Wed 9/29/10	Tue 10/12/10	11	Technology Workgroup
13	**1.3.2.3 Confirm HIE Core Services Requirements**	**27 days**	**Wed 10/13/10**	**Thu 11/18/10**		
14	1.3.2.3.1 Gather feedback on prelimianry HIE Core Services specifications	27 days	Wed 10/13/10	Thu 11/18/10	12	Technology Workgroup
15	1.3.2.3.2 Understand changes and impacts from other workgroups (if any) and any possible course adjustments	27 days	Wed 10/13/10	Thu 11/18/10	12	Technology Workgroup
16	**1.3.2.4 Confirm Final HIE Core Services requirements and specifications**	**7 days**	**Fri 11/19/10**	**Mon 11/29/10**		
17	1.3.2.4.1 Understand changes and impacts from other Workgroups (if any) with possible course adjustment identified (if any)	7 days	Fri 11/19/10	Mon 11/29/10	15	Technology Workgroup
18	**1.3.3 Finance Workgroup established**	**74 days**	**Thu 9/2/10**	**Tue 12/14/10**	**8**	
19	1.3.3.1 1st Meeting-Review sustainability goals and timelines	15 days	Wed 9/29/10	Tue 10/19/10	20	Finance Workgroup
20	1.3.3.2 Orientation-overview financing components, and phasing and scheduling for WGs	0 hrs	Wed 9/29/10	Wed 9/29/10		Finance Workgroup[0%]
21	1.3.3.3 Core and potential HIE services	4 days	Thu 10/14/10	Tue 10/19/10	12,20	Finance Workgroup
22	1.3.3.4 Bring cost and revenue projections, financing options and issues for discussion at Jan HITOC meeting	0 hrs	Wed 12/8/10	Wed 12/8/10	24	HITOC[0%]
23	1.3.3.5 Review value propositions, other state financing examples, financing options/issues	15 days	Wed 9/29/10	Tue 10/19/10	20	Finance Workgroup
24	1.3.3.6 2nd Meeting-Prioritize HIE services, start-up financing, services vs. utility financing	16 days	Wed 10/20/10	Wed 11/10/10	21	Finance Workgroup



Project: HITOC_111710
Date: Fri 11/19/10

Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

ID	Task Name	Duration	Start	Finish	Predecesso	Resource Names
25	1.3.3.7 4th Meeting-Updated projections based on Tech/Legal WGs	6 days	Thu 9/2/10	Thu 9/9/10		Finance Workgroup
26	1.3.3.8 Address HITOC comments	4 days	Thu 12/9/10	Tue 12/14/10	22	Finance Workgroup
27	1.3.3.9 Frame timing/phasing for financing plan	4 days	Thu 12/9/10	Tue 12/14/10	22	Finance Workgroup
28	1.3.3.10 5th Meeting-Review feedback from HIO Exec panel, Legal/Policy and Technology WG's	8 days	Fri 9/10/10	Tue 9/21/10	25	Finance Workgroup
29	1.3.3.11 Pricing proposals to support financing plan	8 days	Fri 9/10/10	Tue 9/21/10	25	Finance Workgroup
30	1.3.3.12 Review financing susatainability options and recommendations for discussion at Jan 6th HITOC meeting-possible legislation	8 days	Fri 9/10/10	Tue 9/21/10	25	Finance Workgroup
31	1.3.3.13 Sustainability Plan Framework	8 days	Fri 9/10/10	Tue 9/21/10	25	Finance Workgroup
32	1.3.3.14 6th Meeting-HITOC feedback on financial sustainability options, issues, plans	17 days	Wed 9/22/10	Thu 10/14/10	28	Finance Workgroup
33	1.3.3.15 Review feedback from the HIO Executive Panel, Legal/Policy and Technology WG's	17 days	Wed 9/22/10	Thu 10/14/10	28	Finance Workgroup
34	1.3.3.16 Review services planning schedule	17 days	Wed 9/22/10	Thu 10/14/10	28	Finance Workgroup
35	1.3.3.17 Review fianncing sustainability options and recommendations	17 days	Wed 9/22/10	Thu 10/14/10	28	Finance Workgroup
36	**1.3.4 Legal and Policy Workgroup established**	**75 days**	**Thu 9/2/10**	**Wed 12/15/10**	**8**	
37	1.3.4.1 Consent and SPHI-look at impact of various consent models on tech and finance	10 days	Wed 9/29/10	Tue 10/12/10	39	Legal/Policy Workgroup
38	1.3.4.2 Prepare consent scenarios for meeting	29 days	Thu 9/2/10	Tue 10/12/10		Kahreen Tebeau,Chris Coughlin
39	1.3.4.3 Orientation-Review legal and policy decisions and scope of work for workgroup	0 hrs	Wed 9/29/10	Wed 9/29/10		Legal/Policy Workgroup[0%]
40	1.3.4.4 Oregon's Consent Model-Arrive at Consensus on long-term consent model	6 days	Wed 10/13/10	Wed 10/20/10	37	Legal/Policy Workgroup
41	1.3.4.5 Accountability and Oversight-Privacy and Security Standards	14 days	Thu 10/21/10	Tue 11/9/10	40	Legal/Policy Workgroup
42	1.3.4.6 Prepare for Inter-workgroup committee on Accreditation program standards and details	6 days	Wed 11/10/10	Wed 11/17/10	41	Legal/Policy Workgroup
43	1.3.4.7 Accountability and Oversight-Monitoring and Enforcement	6 days	Wed 11/10/10	Wed 11/17/10	41	Legal/Policy Workgroup
44	1.3.4.8 Meeting -TBD	10 days	Thu 11/18/10	Wed 12/1/10	43	Legal/Policy Workgroup
45	1.3.4.9 Meeting-TBD	10 days	Thu 12/2/10	Wed 12/15/10	44	Legal/Policy Workgroup
46	**1.3.5 Consumer Advisory Panel established**	**0 days**	**Thu 10/7/10**	**Thu 10/7/10**		
47	1.3.5.1 HITOC approves Consumer Advisory Panel nominations	0 hrs	Thu 10/7/10	Thu 10/7/10		HITOC[0%]
48	**1.3.6 HIO Executive Panel established**	**354 days**	**Tue 8/24/10**	**Sat 12/31/11**	**8**	



Project: HITOC_111710
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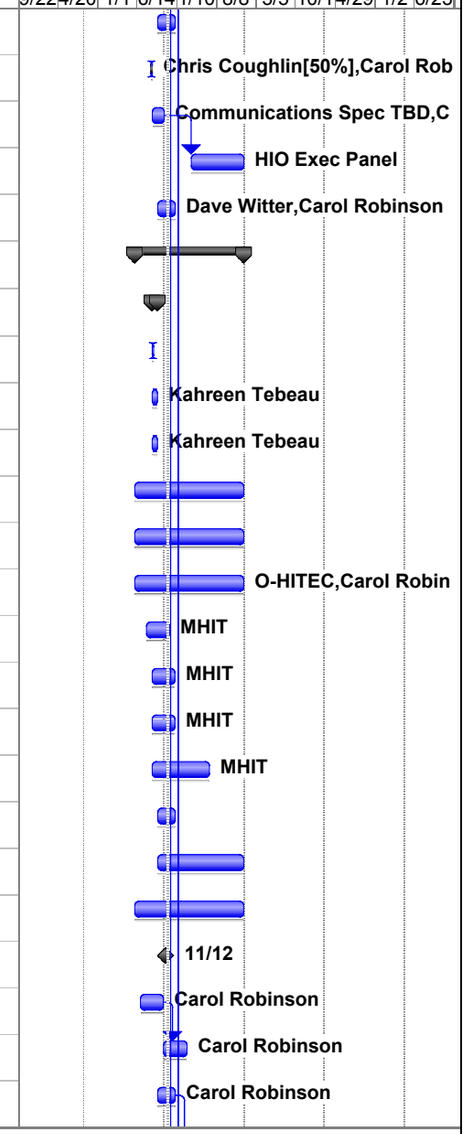
Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

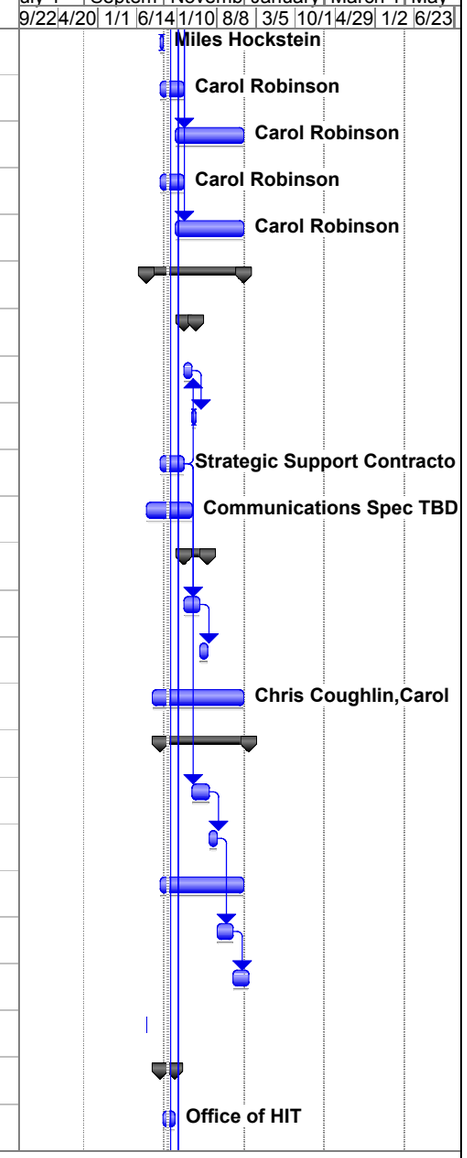
ID	Task Name	Duration	Start	Finish	Predecesso	Resource Names
49	1.3.6.1 Local HIOs - establish coordination process with existing and planned HIO efforts	66 days	Fri 10/1/10	Fri 12/31/10		
50	1.3.6.2 Draft email to HIO contact list inviting them to identify their participants in HIO Advisory Panel	7 days	Tue 8/24/10	Wed 9/1/10		Chris Coughlin[50%],Carol Robinson[50%]
51	1.3.6.3 Local HIOs - develop communications plan with local HIOs	45 days	Thu 9/2/10	Wed 11/3/10		Communications Spec TBD,Chris Coughlin
52	1.3.6.4 Local HIOs - ongoing process with existing and planned HIO efforts	200 days	Mon 3/28/11	Sat 12/31/11	51	HIO Exec Panel
53	1.3.6.5 Develop plan for working with all HIOs and how they will communicate with providers on OHIT's behalf	66 days	Fri 10/1/10	Fri 12/31/10		Dave Witter,Carol Robinson
54	**1.4 Ongoing coordination with other programs**	**414 days**	**Tue 6/1/10**	**Fri 12/30/11**		
55	**1.4.1 Prepare for First Federal Grantee Meeting**	**20 days**	**Wed 9/1/10**	**Tue 9/28/10**		
56	1.4.1.1 Attendees invited	6 days	Wed 9/1/10	Wed 9/8/10		
57	1.4.1.2 Agenda	20 days	Wed 9/1/10	Tue 9/28/10		Kahreen Tebeau
58	1.4.1.3 Handouts	20 days	Wed 9/1/10	Tue 9/28/10		Kahreen Tebeau
59	1.4.2 Oregon Health Network - broadband deployment	414 days	Tue 6/1/10	Fri 12/30/11		
60	1.4.3 Workforce Development	414 days	Tue 6/1/10	Fri 12/30/11		
61	1.4.4 O-HITEC - EHR adoption and MU attainment	414 days	Tue 6/1/10	Fri 12/30/11		O-HITEC,Carol Robinson
62	1.4.5 Medicaid SMHP - planning (PAPD)	88 days	Mon 8/2/10	Wed 12/1/10		MHIT
63	1.4.6 Medicaid SMHP implementation (IAPD)	87 days	Wed 9/1/10	Thu 12/30/10		MHIT
64	1.4.7 Medicaid - review Oregon application of meaningful use objectives/measures	87 days	Wed 9/1/10	Thu 12/30/10		MHIT
65	1.4.8 Medicaid - incentive program policies coordination/implementation	218 days	Wed 9/1/10	Fri 7/1/11		MHIT
66	1.4.9 State of Oregon-Public Health Division	66 days	Fri 10/1/10	Fri 12/31/10		
67	1.4.10 Other data providers and data consumers	326 days	Fri 10/1/10	Fri 12/30/11		
68	1.4.11 Process for coordination with and consideration of existing and planned HIE efforts - other states	414 days	Tue 6/1/10	Fri 12/30/11		
69	1.4.12 Submit application for RTI funding	0 hrs	Fri 11/12/10	Fri 11/12/10		Miles Hockstein[0%]
70	1.4.13 Pacific NW Health Policy Consortium - identify and establish collaborations	87 days	Thu 7/1/10	Fri 10/29/10		Carol Robinson
71	1.4.14 Pacific NW Health Policy Consortium - develop plan for directly connecting to other state HIOs	90 days	Mon 11/1/10	Fri 3/4/11	70	Carol Robinson
72	1.4.15 Federal Agencies - develop coordination process for state/local HIE/HIO and federal agencies/programs	66 days	Fri 10/1/10	Fri 12/31/10		Carol Robinson



Project: HITOC_111710
Date: Fri 11/19/10

Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

ID	Task Name	Duration	Start	Finish	Predecesso	Resource Names
73	1.4.16 Draft application for RTI funding	12 days	Thu 10/14/10	Fri 10/29/10		Miles Hockstein
74	1.4.17 Interstate coalitions - identify and establish collaborations	90 days	Thu 10/14/10	Wed 2/16/11		Carol Robinson
75	1.4.18 VA - coordination on local/state interaction and VistA connections	260 days	Mon 1/3/11	Fri 12/30/11	72	Carol Robinson
76	1.4.19 Interstate coalitions - develop plan for directly connecting to other state HIOs	90 days	Thu 10/14/10	Wed 2/16/11		Carol Robinson
77	1.4.20 IHS - coordination with tribal programs on HIT/HIE services	260 days	Mon 1/3/11	Fri 12/30/11	72	Carol Robinson
78	**1.5 Consumer, provider and HIO education programs defined and documented, including topics and timelines**	**370 days**	**Mon 8/2/10**	**Fri 12/30/11**		
79	**1.5.1 Develop relationships with provider associations**	**45 days**	**Thu 2/17/11**	**Wed 4/20/11**		
80	1.5.1.1 Provider and HIO education program materials developed	30 days	Thu 2/17/11	Wed 3/30/11	82	
81	1.5.1.2 Provider and HIO education program materials made final	15 days	Thu 3/31/11	Wed 4/20/11	80	
82	1.5.2 External communication strategy developed	90 days	Thu 10/14/10	Wed 2/16/11		Strategic Support Contractor TBD
83	1.5.3 Stakeholder annual forums planned and held	175 days	Mon 8/2/10	Fri 4/1/11		Communications Spec TBD
84	**1.5.4 Identify consumer materials/programs to be developed**	**90 days**	**Thu 2/17/11**	**Wed 6/22/11**		
85	1.5.4.1 Market research to support consumer communication & education	60 days	Thu 2/17/11	Wed 5/11/11	82	
86	1.5.4.2 Consumer education program materials developed	30 days	Thu 5/12/11	Wed 6/22/11	85	
87	1.5.5 Communicate various HIT/HIE program opportunities at HITOC meeting	347 days	Thu 9/2/10	Fri 12/30/11		Chris Coughlin,Carol Robinson
88	**1.6 Objective: Provider and HIO education sessions have been conducted and programs are in review based on feedback**	**336 days**	**Thu 10/14/10**	**Thu 1/26/12**		
89	1.6.1 Assess stakeholder feedback, identify education program needs	65 days	Fri 4/1/11	Thu 6/30/11	82	
90	1.6.2 Update provider materials/programs based on feedback	30 days	Fri 7/1/11	Thu 8/11/11	89	
91	1.6.3 Continued stakeholder engagement	317 days	Thu 10/14/10	Fri 12/30/11		
92	1.6.4 Consumer education program materials made final and distribute	60 days	Fri 8/12/11	Thu 11/3/11	90	
93	1.6.5 Update consumer materials/programs based on feedback	60 days	Fri 11/4/11	Thu 1/26/12	92	
94	1.7 Continued refinement of HIE Approach	1 day	Mon 8/2/10	Mon 8/2/10		
95	**1.8 Objective: Strategic and operational plan reviews and adjustments**	**56 days**	**Thu 10/14/10**	**Thu 12/30/10**		
96	1.8.1 Review Stage 1 meaningful use criteria and develop a strategy to adjust course as needed	45 days	Fri 10/29/10	Thu 12/30/10		Office of HIT



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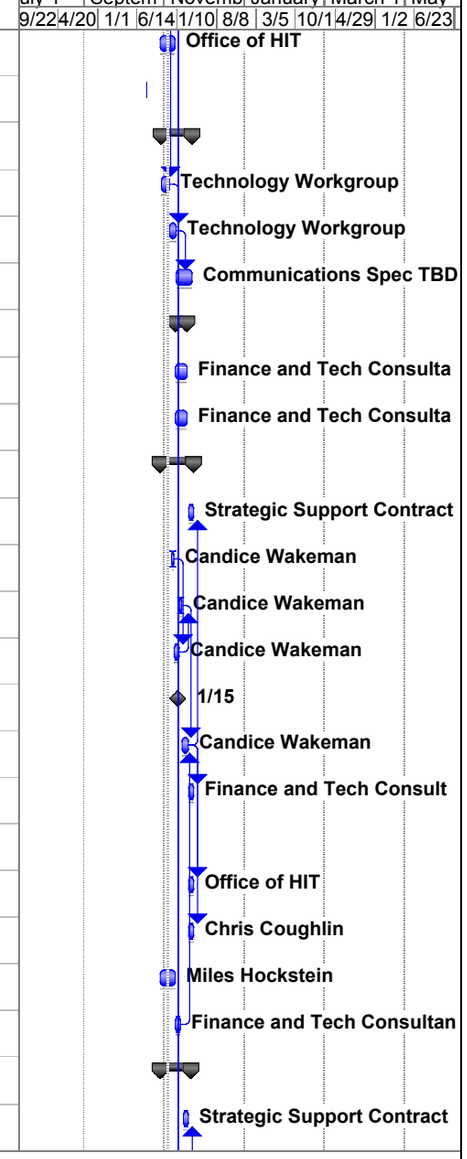
Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

ID	Task Name	Duration	Start	Finish	Predecesso	Resource Names
97	1.8.2 Course corrections based on future PINs	56 days	Thu 10/14/10	Thu 12/30/10		Office of HIT
98	1.9 Establishment of HIE Services Starting with Three Priority Areas	1 day	Mon 8/2/10	Mon 8/2/10		
99	**1.10 Objective: HIE services reviewed, finalized and communicated to stakeholders**	**117 days**	**Wed 10/20/10**	**Thu 3/31/11**		
100	1.10.1 Plan central HIE services	31 days	Wed 10/20/10	Wed 12/1/10	21	Technology Workgroup
101	1.10.2 Select standards for central HIE technical services	26 days	Thu 12/2/10	Thu 1/6/11	100	Technology Workgroup
102	1.10.3 Communication of planned technical architecture to stakeholders	60 days	Fri 1/7/11	Thu 3/31/11	101	Communications Spec TBD
103	**1.11 Facilitate services that support the secure exchange of health information between providers and hospitals in 3 core areas.**	**45 days**	**Mon 1/3/11**	**Fri 3/4/11**		
104	1.11.1 Identify and contact providers and hospitals	45 days	Mon 1/3/11	Fri 3/4/11		Finance and Tech Consultantant
105	1.11.2 Define outcomes and success metrics	45 days	Mon 1/3/11	Fri 3/4/11		Finance and Tech Consultantant
106	**1.12 Laboratory Reporting**	**127 days**	**Thu 10/14/10**	**Fri 4/8/11**		
107	1.12.1 Develop marketing plan to reach out to providers not currently receiving lab reports electronically	20 days	Mon 3/14/11	Fri 4/8/11	112	Strategic Support Contractor TBD
108	1.12.2 Develop survery on e-lab reporting capabilities/LOINC	10 days	Mon 12/13/10	Fri 12/24/10		Candice Wakeman
109	1.12.3 Summarize results of e-lab reporting capabilities/LOINC	10 days	Mon 1/24/11	Fri 2/4/11	110	Candice Wakeman
110	1.12.4 Field e-lab reporting capabilities/LOINC	20 days	Mon 12/27/10	Fri 1/21/11	108	Candice Wakeman
111	1.12.5 Laboratory Stakeholder Group Convened	0 hrs	Sat 1/15/11	Sat 1/15/11		Laboratory Working Group[0%]
112	1.12.6 Create Laboratory Stakeholder Group Action Plan	25 days	Mon 2/7/11	Fri 3/11/11	118,109	Candice Wakeman
113	1.12.7 Develop a migration program flow (no capability->labs only->full-fledged EHR) and cost model including incentive payments and	20 days	Mon 3/14/11	Fri 4/8/11	112	Finance and Tech Consultantant
114	1.12.8 Monthly Laboratory Stakeholder group meeting	1 day	Mon 1/17/11	Mon 1/17/11		
115	1.12.9 Develop collateral to support providers' decision making	20 days	Mon 3/14/11	Fri 4/8/11	112	Office of HIT
116	1.12.10 Coordinate with REC regarding messaging and communication/education	20 days	Mon 3/14/11	Fri 4/8/11	112	Chris Coughlin
117	1.12.11 Analyze electronic rates and monitor non-e-lab providers	57 days	Thu 10/14/10	Fri 12/31/10		Miles Hockstein
118	1.12.12 Investigate push capabilities for electronic receipt of lab reports	20 days	Mon 1/3/11	Fri 1/28/11		Finance and Tech Consultantant
119	**1.13 Electronic Prescribing**	**117 days**	**Thu 10/14/10**	**Fri 3/25/11**		
120	1.13.1 Develop marketing plan to reach out to providers/pharmacies not currently supporting e-prescribing	20 days	Mon 2/14/11	Fri 3/11/11	128	Strategic Support Contractor TBD



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Task | Progress | Summary | External Tasks | Deadline
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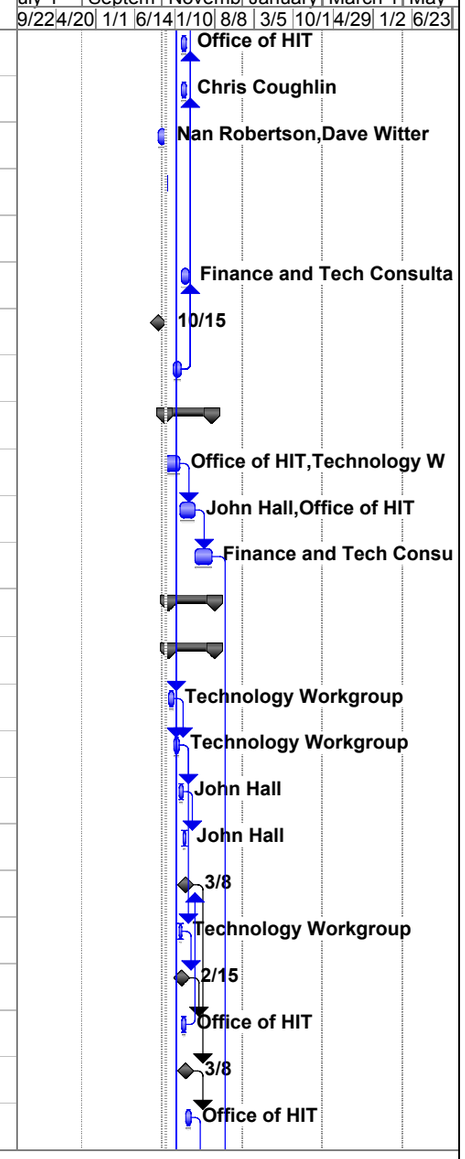
ID	Task Name	Duration	Start	Finish	Predecesso	Resource Names
121	1.13.2 Develop collateral to support providers' decision making (possibly a how-to on signing up for NEPSI)	20 days	Mon 2/14/11	Fri 3/11/11	128	Office of HIT
122	1.13.3 Coordinate with REC regarding messaging and communication/education	20 days	Mon 2/14/11	Fri 3/11/11	128	Chris Coughlin
123	1.13.4 Analyze eRx rates and monitor non-e-prescribing providers and pharmacies	28.5 days	Thu 10/14/10	Tue 11/23/10		Nan Robertson,Dave Witter
124	1.13.5 Second eRx Stakeholder Group Meeting	1 day	Thu 12/2/10	Thu 12/2/10		
125	1.13.6 Third eRx Stakeholder Group Meeting	1 day	Mon 1/17/11	Mon 1/17/11		
126	1.13.7 Determine a migration program flow (no eRx->eRx only->full-fledged EHR) and cost model including incentive payments and penalties	30 days	Mon 2/14/11	Fri 3/25/11	128	Finance and Tech Consultantant
127	1.13.8 eRx Stakeholder Group Convened	0 hrs	Fri 10/15/10	Fri 10/15/10		
128	1.13.9 Develop eRx Action Plan	30 days	Mon 1/3/11	Fri 2/11/11		
129	**1.14 Clinical Summaries**	**178 days**	**Thu 11/18/10**	**Mon 7/25/11**		
130	1.14.1 Develop program scope timeline	57 days	Thu 11/18/10	Fri 2/4/11		Office of HIT,Technology Workgroup
131	1.14.2 Investigate push capabilities for Clinical Summaries	57 days	Mon 2/7/11	Tue 4/26/11	130	John Hall,Office of HIT
132	1.14.3 Define and finalize parameters for clinical summaries program	64 days	Wed 4/27/11	Mon 7/25/11	131	Finance and Tech Consultantant
133	**1.15 Objective: Service requirements definition process is completed**	**175 days**	**Wed 12/8/10**	**Tue 8/9/11**		
134	**1.15.1 HIE Registry**	**175 days**	**Wed 12/8/10**	**Tue 8/9/11**		
135	1.15.1.1 Specifications developed	20 days	Wed 12/8/10	Tue 1/4/11	17	Technology Workgroup
136	1.15.1.2 Requirements definition	20 days	Wed 1/5/11	Tue 2/1/11	17,135	Technology Workgroup
137	1.15.1.3 Distribute draft requirements document to and solicit feedback from customer base	15 days	Wed 2/2/11	Tue 2/22/11	136	John Hall
138	1.15.1.4 Incorporate feedback	10 days	Wed 2/23/11	Tue 3/8/11	137	John Hall
139	1.15.1.5 RFI/RFP issued for selection of technology solution	0 hrs	Tue 3/8/11	Tue 3/8/11	142	Office of HIT[0%]
140	1.15.1.6 Finalize requirements document	10 days	Wed 2/2/11	Tue 2/15/11	136	Technology Workgroup
141	1.15.1.7 HITOC approval of requirements	0 hrs	Tue 2/15/11	Tue 2/15/11	140	HITOC[0%]
142	1.15.1.8 RFI/RFP developed for selection of technology solution	15 days	Wed 2/16/11	Tue 3/8/11	141	Office of HIT
143	1.15.1.9 Award technology solution contract	0 hrs	Tue 3/8/11	Tue 3/8/11	139	Office of HIT[0%]
144	1.15.1.10 Contract negotiation with Technology Solution provider	20 days	Wed 3/9/11	Tue 4/5/11	143	Office of HIT



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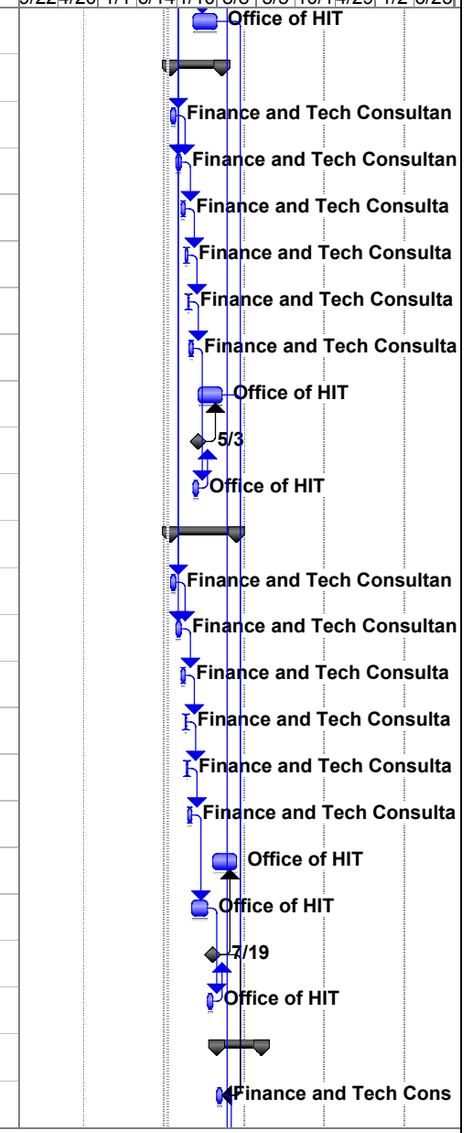
145	1.15.1.11 Purchase/implement technology solution	90 days	Wed 4/6/11	Tue 8/9/11	144	Office of HIT
146	**1.16 Trust Services**	**195 days**	**Wed 12/8/10**	**Tue 9/6/11**		
147	1.16.1 Specifications developed	20 days	Wed 12/8/10	Tue 1/4/11	17	Finance and Tech Consultantant
148	1.16.2 Requirements definition	20 days	Wed 1/5/11	Tue 2/1/11	17,147	Finance and Tech Consultantant
149	1.16.3 Distribute draft requirements document to and solicit feedback from customer base	15 days	Wed 2/2/11	Tue 2/22/11	148	Finance and Tech Consultantant
150	1.16.4 Incorporate feedback	10 days	Wed 2/23/11	Tue 3/8/11	149	Finance and Tech Consultantant
151	1.16.5 Finalize requirements document	5 days	Wed 3/9/11	Tue 3/15/11	150	Finance and Tech Consultantant
152	1.16.6 RFI/RFP for developed for selection of technology solution	15 days	Wed 3/16/11	Tue 4/5/11	151	Finance and Tech Consultantant
153	1.16.7 Purchase/implement technology solution	90 days	Wed 5/4/11	Tue 9/6/11	154	Office of HIT
154	1.16.8 Award technology solition contract	0 hrs	Tue 5/3/11	Tue 5/3/11	155	Office of HIT[0%]
155	1.16.9 Contract negotiation with technology solution provider	20 days	Wed 4/6/11	Tue 5/3/11	152	Office of HIT
156	**1.17 Push Services**	**250 days**	**Wed 12/8/10**	**Tue 11/22/11**		
157	1.17.1 Specifications developed	20 days	Wed 12/8/10	Tue 1/4/11	17	Finance and Tech Consultantant
158	1.17.2 Requirements definition	20 days	Wed 1/5/11	Tue 2/1/11	157,17	Finance and Tech Consultantant
159	1.17.3 Distribute draft requirements document to and solicit feedback from customer base	15 days	Wed 2/2/11	Tue 2/22/11	158	Finance and Tech Consultantant
160	1.17.4 Incorporate feedback	5 days	Wed 2/23/11	Tue 3/1/11	159	Finance and Tech Consultantant
161	1.17.5 Finalize requirements document	5 days	Wed 3/2/11	Tue 3/8/11	160	Finance and Tech Consultantant
162	1.17.6 RFI/RFP for developed selection of technology solution	15 days	Wed 3/9/11	Tue 3/29/11	161	Finance and Tech Consultantant
163	1.17.7 Purchase/implement technology solution	90 days	Wed 7/20/11	Tue 11/22/11	165	Office of HIT
164	1.17.8 Selection technology solutions provider	60 days	Wed 3/30/11	Tue 6/21/11	162	Office of HIT
165	1.17.9 Award technology solution contract	0 hrs	Tue 7/19/11	Tue 7/19/11	166	Office of HIT[0%]
166	1.17.10 Contract negotiation with technology solution provider	20 days	Wed 6/22/11	Tue 7/19/11	164	Office of HIT
167	**1.18 Integrated Services Rollout: Registry, Trust, Push**	**170 days**	**Wed 8/10/11**	**Tue 4/3/12**		
168	1.18.1 Define and finalize program rollout parameters	20 days	Wed 8/10/11	Tue 9/6/11	153FF,145F	Finance and Tech Consultantant



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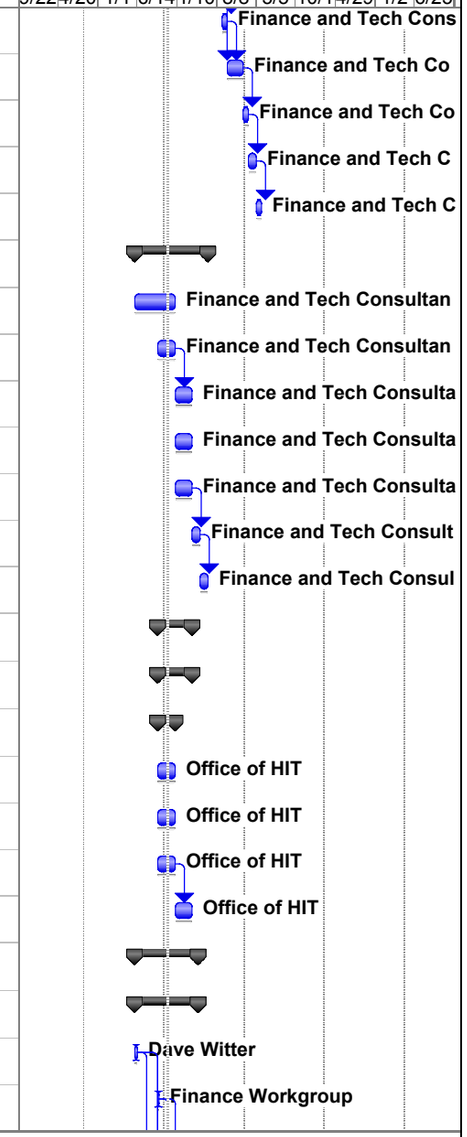
169	1.18.2 Enroll initial rollout program participants	20 days	Wed 9/7/11	Tue 10/4/11	168	Finance and Tech Consultantant
170	1.18.3 Rollout program to initial participants	60 days	Wed 10/5/11	Tue 12/27/11	169,132	Finance and Tech Consultantant
171	1.18.4 Assess rollout program results	20 days	Wed 12/28/11	Tue 1/24/12	170	Finance and Tech Consultantant
172	1.18.5 Plan for extensions of the registry, trust and push services	30 days	Wed 1/25/12	Tue 3/6/12	171	Finance and Tech Consultantant
173	1.18.6 Start rollout of extended trust services	20 days	Wed 3/7/12	Tue 4/3/12	172	Finance and Tech Consultantant
174	**1.19 Plan to leverage current HIE capacities**	**278 days**	**Tue 6/1/10**	**Thu 6/23/11**		
175	1.19.1 Analysis of existing HIO services carried out	154 days	Tue 6/1/10	Fri 12/31/10		Finance and Tech Consultantant
176	1.19.2 Planning for Phase 1 HIE services and offerings	66 days	Fri 10/1/10	Fri 12/31/10		Finance and Tech Consultantant
177	1.19.3 Planning process for non-technical services to be offered in Phase 2	64 days	Mon 1/3/11	Thu 3/31/11	176	Finance and Tech Consultantant
178	1.19.4 Process for assessment of additional services to be offered in Phase 2	64 days	Mon 1/3/11	Thu 3/31/11		Finance and Tech Consultantant
179	1.19.5 Prioritization of services to be offered	64 days	Mon 1/3/11	Thu 3/31/11		Finance and Tech Consultantant
180	1.19.6 Gather and define requirements of services to be offered in Phase 2	30 days	Fri 4/1/11	Thu 5/12/11	179	Finance and Tech Consultantant
181	1.19.7 Finalize and communicate services to be offered in Phase 2	30 days	Fri 5/13/11	Thu 6/23/11	180	Finance and Tech Consultantant
182	**1.20 Assessment of Underserved and Unserved Areas**	**130 days**	**Fri 10/1/10**	**Thu 3/31/11**		
183	**1.20.1 Objective: Strategy for meeting the HIE needs of underserved areas is approved**	**130 days**	**Fri 10/1/10**	**Thu 3/31/11**		
184	**1.20.1.1 Identification of underserved providers**	**66 days**	**Fri 10/1/10**	**Fri 12/31/10**		
185	1.20.1.1.1 Talk to Office of Rural Health and/or ORPRN to determine what HIE/HIO activity is happening in hard to reach	66 days	Fri 10/1/10	Fri 12/31/10		Office of HIT
186	1.20.1.2 Prioritization of underserved providers	66 days	Fri 10/1/10	Fri 12/31/10		Office of HIT
187	1.20.1.3 Review findings/prioritization and set strategy	66 days	Fri 10/1/10	Fri 12/31/10		Office of HIT
188	1.20.1.4 Communicate with and assist underserved providers to connect with HIO or SDE offered services	64 days	Mon 1/3/11	Thu 3/31/11	187	Office of HIT
189	**1.21 SDE Sustainable Business Plan**	**240 days**	**Tue 6/1/10**	**Mon 5/2/11**		
190	**1.21.1 Objective: Sustainable business plan for SDE developed, reviewed and approved**	**240 days**	**Tue 6/1/10**	**Mon 5/2/11**		
191	1.21.1.1 Identify potential SDE services and revenue opportunities	10 days	Tue 6/1/10	Mon 6/14/10		Dave Witter
192	1.21.1.2 Prioritization of potential SDE services	5 days	Fri 10/1/10	Thu 10/7/10		Finance Workgroup



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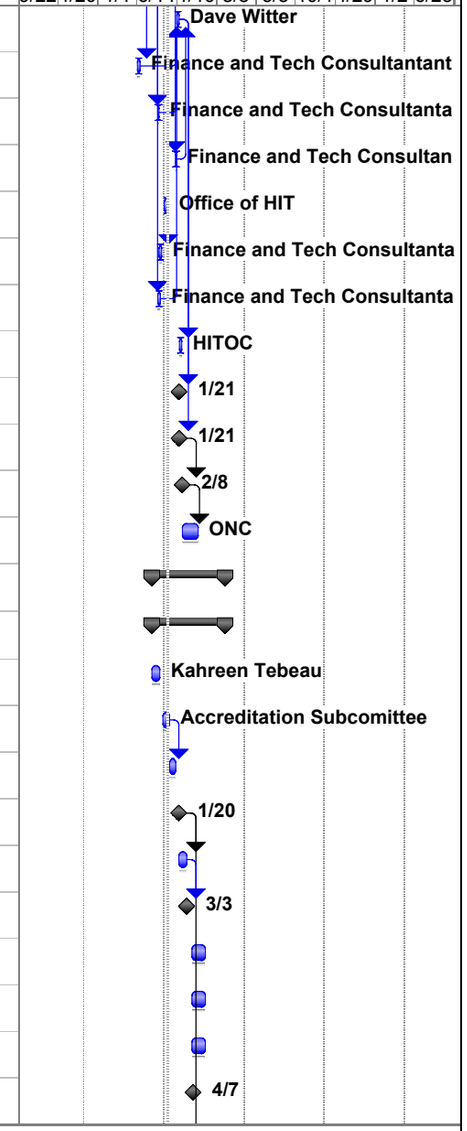
193	1.21.1.3 Prepare business plan document and supporting artifacts	10 days	Mon 1/10/11	Fri 1/21/11	196,194,19	Dave Witter
194	1.21.1.4 Financing plan & business model made final	10 days	Tue 6/15/10	Mon 6/28/10	191	Finance and Tech Consultantant
195	1.21.1.5 Staffing plan developed	5 days	Fri 10/1/10	Thu 10/7/10	191	Finance and Tech Consultantant
196	1.21.1.6 Implementation plan for core services	5 days	Mon 1/3/11	Fri 1/7/11	192	Finance and Tech Consultantant
197	1.21.1.7 Financial tracking in place	15 days	Thu 11/4/10	Wed 11/24/10		Office of HIT
198	1.21.1.8 Analysis of costs of providing services in Phase 2	10 days	Fri 10/8/10	Thu 10/21/10	192	Finance and Tech Consultantant
199	1.21.1.9 Finalize finance and business model for sustainable HIE	10 days	Fri 10/1/10	Thu 10/14/10	191	Finance and Tech Consultantant
200	1.21.1.10 HITOC and Health Policy Board Review	10 days	Mon 1/24/11	Fri 2/4/11	193	HITOC
201	1.21.1.11 HITOC Approval	0 hrs	Fri 1/21/11	Fri 1/21/11	193	HITOC[0%]
202	1.21.1.12 OHA Approval	0 hrs	Fri 1/21/11	Fri 1/21/11	193	Director of OHA[0%]
203	1.21.1.13 Submit final business plan to ONC	0 hrs	Tue 2/8/11	Tue 2/8/11	202	Carol Robinson[0%]
204	1.21.1.14 Sustainable business plan approved	60 days	Tue 2/8/11	Mon 5/2/11	203	ONC
205	**1.22 First use of HIE Participant Accreditation**	**278 days**	**Tue 8/31/10**	**Thu 9/22/11**		
206	**1.22.1 Objective: HIE Participant Accreditation Project Started**	**278 days**	**Tue 8/31/10**	**Thu 9/22/11**		
207	1.22.1.1 Research other states accreditation programs-Minnestota	30 days	Tue 8/31/10	Mon 10/11/10		Kahreen Tebeau
208	1.22.1.2 HIE Participant Accreditation Program project developed	26 days	Thu 10/28/10	Thu 12/2/10		Accreditation Subcomittee
209	1.22.1.3 Standards and policies for project developed and proposed to HITOC/OHA	22 days	Fri 12/3/10	Mon 1/3/11	208	
210	1.22.1.4 Standards and policies approved by HITOC/OHA	0 hrs	Thu 1/20/11	Thu 1/20/11		Director of OHA[0%],HITOC[0%]
211	1.22.1.5 Sites selected	30 days	Fri 1/21/11	Thu 3/3/11	210	
212	1.22.1.6 Objective: HIE Participant Accreditation project started	0 hrs	Thu 3/3/11	Thu 3/3/11	211	
213	1.22.1.7 Measure-At least one HIE participant completes the project	50 days	Fri 4/1/11	Thu 6/9/11		
214	1.22.1.8 Permanent HIE Participant Accreditation Program designed	50 days	Fri 4/1/11	Thu 6/9/11		
215	1.22.1.9 Standards and policies developed and proposed to HITOC/OHA based on initial results	50 days	Fri 4/1/11	Thu 6/9/11		
216	1.22.1.10 Standards and policies approved by HITOC/OHA	0 hrs	Thu 4/7/11	Thu 4/7/11		HITOC[0%],Director of OHA[0%]



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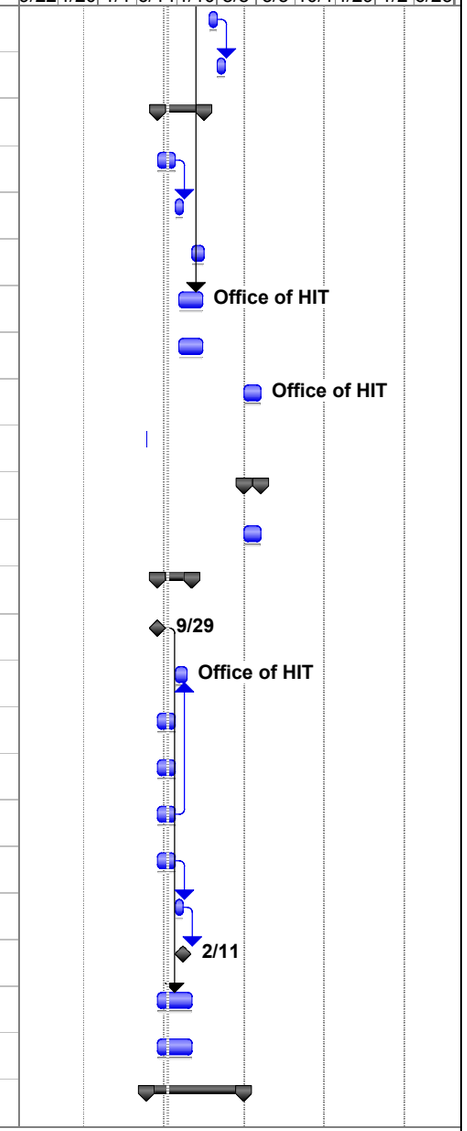
217	1.22.1.11 HIE Participant Accreditation Program announced	30 days	Fri 7/1/11	Thu 8/11/11		
218	1.22.1.12 HIE Participant Accreditation Program implemented	30 days	Fri 8/12/11	Thu 9/22/11	217	
219	**1.23 Objective: At least one intrastate and one interstate DURSA are executed**	**175 days**	**Fri 10/1/10**	**Thu 6/2/11**		
220	1.23.1 Development of DURSA	66 days	Fri 10/1/10	Fri 12/31/10		
221	1.23.2 Review of DURSA by involved parties' attorneys	30 days	Mon 1/3/11	Fri 2/11/11	220	
222	1.23.3 DURSAs finalized and executed	45 days	Fri 4/1/11	Thu 6/2/11		
223	1.24 Objective: One HIE participant exchanges data with another HIE participant	90 days	Fri 1/21/11	Thu 5/26/11	210	Office of HIT
224	1.25 Measure: At least one HIE participant exchanges data with an external HIE participant within Oregon	90 days	Fri 1/21/11	Thu 5/26/11		
225	1.26 Objective: At least one additional HIE participant applies for accreditation, and at least one HIE participant is accredited.	65 days	Mon 1/2/12	Fri 3/30/12		Office of HIT
226	1.27 Privacy and security issues addressed through legislative and other changes	1 day	Mon 8/2/10	Mon 8/2/10		
227	**1.28 Measure: At least one HIE participant has begun the accreditation process through the HIE Accreditation Program**	**65 days**	**Mon 1/2/12**	**Fri 3/30/12**		
228	1.28.1 Update Accreditation to match any federal standards changes	65 days	Mon 1/2/12	Fri 3/30/12		
229	**1.29 Objective: Legislative changes necessary to implement consent model are identified and bills drafted**	**132 days**	**Wed 9/29/10**	**Thu 3/31/11**		
230	1.29.1 Establish Legal and Policy Workgroup	0 hrs	Wed 9/29/10	Wed 9/29/10		Chris Coughlin[0%],Kahreen Tebeau[0%]
231	1.29.2 Possible creation of ombudsman position	45 days	Mon 1/3/11	Fri 3/4/11	234	Office of HIT
232	1.29.3 Identification of legislative changes related to privacy	68 days	Wed 9/29/10	Fri 12/31/10		
233	1.29.4 Examination of state barriers to meaningful use	68 days	Wed 9/29/10	Fri 12/31/10		
234	1.29.5 Review of privacy, security and legal risks/mitigations	68 days	Wed 9/29/10	Fri 12/31/10		
235	1.29.6 Draft relevant bills	68 days	Wed 9/29/10	Fri 12/31/10		
236	1.29.7 Legislation consideration for privacy/security	30 days	Mon 1/3/11	Fri 2/11/11	235	
237	1.29.8 Legislative approval of privacy/security changes	0 hrs	Fri 2/11/11	Fri 2/11/11	236	
238	1.29.9 Assess NHIN Connect/Direct privacy/security issues	132 days	Wed 9/29/10	Thu 3/31/11	230	
239	1.29.10 Coordination with HHS Privacy and Security Framework	132 days	Wed 9/29/10	Thu 3/31/11		
240	**1.30 Designation of a governance entity to carry out HIE in Phase 2**	**370 days**	**Mon 8/2/10**	**Fri 12/30/11**		



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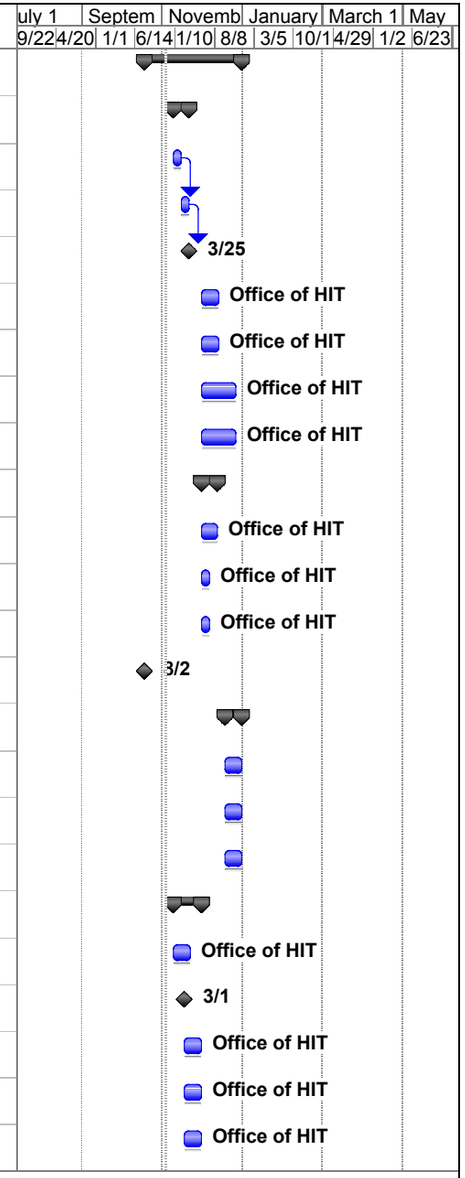
241	**1.30.1 Objective: Define and begin transition of HIE operations to SDE**	**370 days**	**Mon 8/2/10**	**Fri 12/30/11**		
242	**1.30.1.1 Sub-objective: Legislation enabling SDE**	**60 days**	**Mon 1/3/11**	**Fri 3/25/11**		
243	1.30.1.1.1 Develop legislative proposals needed for HIE and SDE designation	30 days	Mon 1/3/11	Fri 2/11/11		
244	1.30.1.1.2 Legislation consideration enabling SDE designation	30 days	Mon 2/14/11	Fri 3/25/11	243	
245	1.30.1.1.3 Legislative approval of SDE enabling legislation	0 hrs	Fri 3/25/11	Fri 3/25/11	244	
246	1.30.1.2 Sub-objective: Implement the SDE framework (for issues not addressed in legislation)	65 days	Wed 6/1/11	Tue 8/30/11		Office of HIT
247	1.30.1.3 Finalize type of non-profit organization	65 days	Wed 6/1/11	Tue 8/30/11		Office of HIT
248	1.30.1.4 Finalize roles/responsibilities of SDE, HITOC, other entities	130 days	Wed 6/1/11	Tue 11/29/11		Office of HIT
249	1.30.1.5 Develop policies and participation framework for SDE	130 days	Wed 6/1/11	Tue 11/29/11		Office of HIT
250	**1.30.1.6 Develop contractual elements to transfer authority to SDE**	**60 days**	**Wed 6/1/11**	**Tue 8/23/11**		
251	1.30.1.6.1 Issue RFP for SDE to be named	60 days	Wed 6/1/11	Tue 8/23/11		Office of HIT
252	1.30.1.6.2 Draft RFP	30 days	Wed 6/1/11	Tue 7/12/11		Office of HIT
253	1.30.1.6.3 Award RFP	30 days	Wed 6/1/11	Tue 7/12/11		Office of HIT
254	1.30.1.7 Designation or creation of SDE	0 hrs	Mon 8/2/10	Mon 8/2/10		OHA[0%]
255	**1.30.1.8 Sub-objective: Transition Implementation to SDE for Phase 2**	**65 days**	**Mon 10/3/11**	**Fri 12/30/11**		
256	1.30.1.8.1 Review of services/architecture during Phase 2	65 days	Mon 10/3/11	Fri 12/30/11		
257	1.30.1.8.2 Assessment of participation in services	65 days	Mon 10/3/11	Fri 12/30/11		
258	1.30.1.8.3 Transition of operational and technology services	65 days	Mon 10/3/11	Fri 12/30/11		
259	**1.31 Objective: HIE participation survey/study initiated**	**107 days**	**Mon 1/3/11**	**Wed 6/1/11**		
260	1.31.1 Create participation assessment criteria and plan	65 days	Mon 1/3/11	Fri 4/1/11		Office of HIT
261	1.31.2 Contract with independent evaluator	0 hrs	Tue 3/1/11	Tue 3/1/11		Office of HIT[0%]
262	1.31.3 Survey process initiated	65 days	Tue 3/1/11	Mon 5/30/11		Office of HIT
263	1.31.4 Ongoing assessment of HIE participation	65 days	Tue 3/1/11	Mon 5/30/11		Office of HIT
264	1.31.5 Determine frequency of survey	65 days	Tue 3/1/11	Mon 5/30/11		Office of HIT



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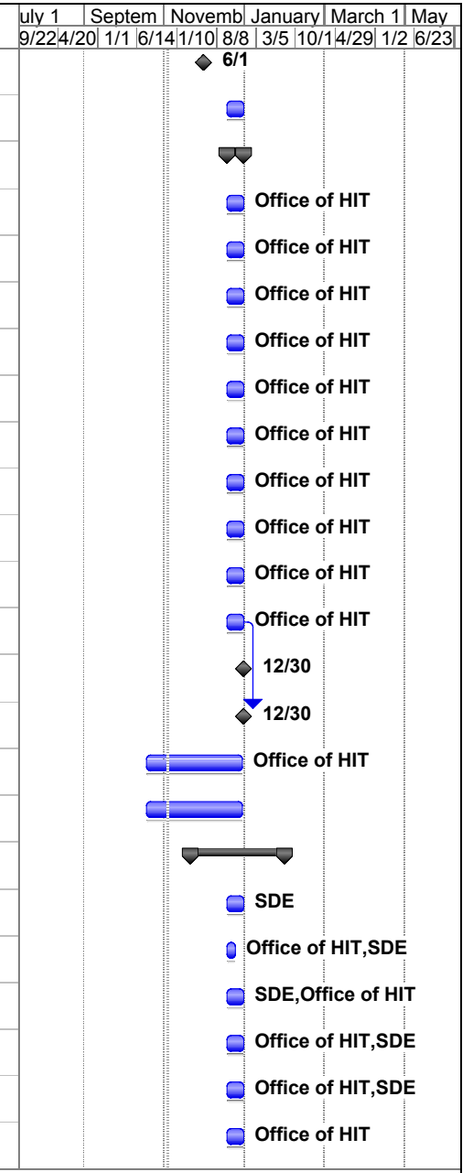
265	1.31.6 Survey Administered	0 hrs	Wed 6/1/11	Wed 6/1/11		Office of HIT[0%]
266	1.32 Evaluation of HIE success	65 days	Mon 10/3/11	Fri 12/30/11		
267	**1.33 Objective: Success metrics for HIE participation defined**	**65 days**	**Mon 10/3/11**	**Fri 12/30/11**		
268	1.33.1 Assess participation in HIE-enabled state-level technical services	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
269	1.33.2 Process for assessing use of HIE services defined	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
270	1.33.3 Analysis of barriers, resources and opportunities for overcoming low participation in HIE	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
271	1.33.4 Privacy, security, and related legal and policy risks to be identified in Phase 1	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
272	1.33.5 Ombudsman for SDE-operated services, privacy and security possibly appointed	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
273	1.33.6 Steps to implement policies and protocols for how the HIE will foster compliance with applicable federal and state legal and policy requirements	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
274	1.33.7 Plans for privacy and security harmonization and compliance drafted	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
275	1.33.8 Processes, timelines, etc. for ongoing development in response to federal requirements	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
276	1.33.9 Implementation of legislative or consent policy changes as developed in Phase 1	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
277	1.33.10 Process to monitor, measure and assess gradual attainment of benchmarks identified in Phase 1	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT
278	**1.34 Success of Health Information Exchange evaluated**	**0 days**	**Fri 12/30/11**	**Fri 12/30/11**		
279	1.34.1 Objective: HIE participation survey/study initiated	0 hrs	Fri 12/30/11	Fri 12/30/11	277	Contract Evaluator[0%]
280	1.35 Continued Refinement of HIE Approach	365 days	Mon 8/2/10	Fri 12/23/11		Office of HIT
281	1.36 Objective: Strategic and Operational plan reviews and adjustments	365 days	Mon 8/2/10	Fri 12/23/11		
282	**2 Phase 2**	**358 days**	**Wed 3/23/11**	**Fri 8/3/12**		
283	2.1 SDE assumes HIE Governance	65 days	Mon 10/3/11	Fri 12/30/11		SDE
284	2.2 Objective: Complete transition of HIE services and programs operation to the SDE	32.5 days	Mon 10/3/11	Wed 11/16/11		Office of HIT,SDE
285	2.3 Implement policies for HIE developed by HITOC and approved by OHA	65 days	Mon 10/3/11	Fri 12/30/11		SDE,Office of HIT
286	2.4 Review policies and procedures	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT,SDE
287	2.5 Ensure policies and procedures meet generally accepted accounting principals (GAAP)	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT,SDE
288	2.6 Continuation of educational programs	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT



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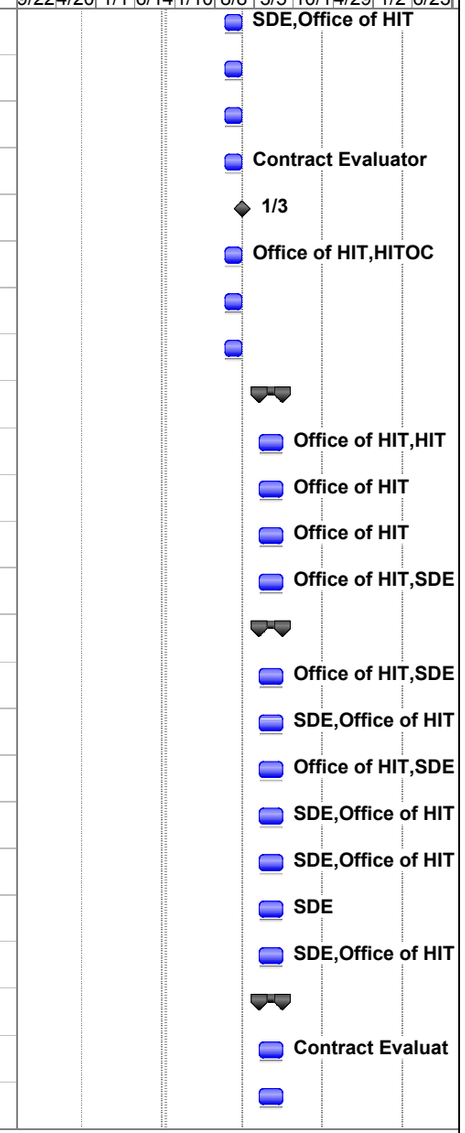
289	2.7 Development and rollout of Phase 2 services	65 days	Mon 10/3/11	Fri 12/30/11		SDE,Office of HIT
290	2.8 Objective: Consumer, provider and HIO education sessions have been conducted and programs are in review based on feedback	65 days	Mon 10/3/11	Fri 12/30/11		
291	2.9 Continued stakeholder engagement	65 days	Mon 10/3/11	Fri 12/30/11		
292	2.10 Evaluation of HIE success	65 days	Mon 10/3/11	Fri 12/30/11		Contract Evaluator
293	2.11 Objective: Phase 2 services start	0 hrs	Tue 1/3/12	Tue 1/3/12		
294	2.12 Develop Oregon specific Objectives for Phase 2	65 days	Mon 10/3/11	Fri 12/30/11		Office of HIT,HITOC
295	2.13 Evaluation of Phase 2	65 days	Mon 10/3/11	Fri 12/30/11		
296	2.14 Develop Phase 2 evaluation criteria	65 days	Mon 10/3/11	Fri 12/30/11		
297	**2.15 Ongoing**	**90 days**	**Mon 4/2/12**	**Fri 8/3/12**		
298	2.15.1 Monitor and Adapt	90 days	Mon 4/2/12	Fri 8/3/12		Office of HIT,HITOC
299	2.15.2 Perform a set of environmental assessments across the state to determine HIE availability, HIE impact and other factors.	90 days	Mon 4/2/12	Fri 8/3/12		Office of HIT
300	2.15.3 Develop a plan to address any areas not meeting desired thresholds defined by its governance	90 days	Mon 4/2/12	Fri 8/3/12		Office of HIT
301	2.15.4 Initiate plan, which may involve the creation of new services and offerings that require operation	90 days	Mon 4/2/12	Fri 8/3/12		Office of HIT,SDE
302	**2.16 Enter a Continuous Monitor and Adapt Cycle**	**90 days**	**Mon 4/2/12**	**Fri 8/3/12**		
303	2.16.1 Services and offerings created and/or modified to reflect the output of assessments	90 days	Mon 4/2/12	Fri 8/3/12		Office of HIT,SDE
304	2.16.2 Services and offerings become operational	90 days	Mon 4/2/12	Fri 8/3/12		SDE,Office of HIT
305	2.16.3 Determine that operations of services and offerings are mature	90 days	Mon 4/2/12	Fri 8/3/12		Office of HIT,SDE
306	2.16.4 New assessments conducted	90 days	Mon 4/2/12	Fri 8/3/12		SDE,Office of HIT
307	2.16.5 New plan would be drafted and set in motion	90 days	Mon 4/2/12	Fri 8/3/12		SDE,Office of HIT
308	2.17 Continued Operation	90 days	Mon 4/2/12	Fri 8/3/12		SDE
309	2.18 Continued Refinement of HIE Approach	90 days	Mon 4/2/12	Fri 8/3/12		SDE,Office of HIT
310	**2.19 Evaluation**	**90 days**	**Mon 4/2/12**	**Fri 8/3/12**		
311	2.19.1 Ongoing evaluation of project milestones, state specific goals and objectives, and key performance measures will continue beyond Phase 2	90 days	Mon 4/2/12	Fri 8/3/12		Contract Evaluator
312	2.20 Objective: Strategic and Operational plan reviews and adjustments	90 days	Mon 4/2/12	Fri 8/3/12		



Project: HITOC_111710
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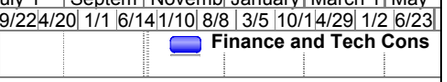
Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

ID	Task Name	Duration	Start	Finish	Predecesso	Resource Names
313	2.21 Investigate pull capabilities/requirements	114 days	Wed 3/23/11	Mon 8/29/11		Finance and Tech Consultantant



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Task
Split
Progress
Milestone
Summary
Project Summary
External Tasks
External Milestone
Deadline