# Health Information Technology Oversight Council

## August 5, 2010

**Meeting Agenda**

**1:00** **Opening and Welcome, Approval of minutes (June 3, June 17)** – Rick Howard
**1:10** **Meeting Overview and Outcomes** – Carol Robinson
**1:15** **Updates** –
- Meaningful Use Final Rule- Dave Witter
- Temporary Certification Final Rule- John Hall
- Program Information Notice (PIN)- Carol Robinson
- Office of Health Information Technology- Rick Howard

**2:00** **Ex-Officio Appointments** – Steve Gordon
**2:10** **Community Meetings and Public Input** – Carol Robinson
**2:20** **Advisory Panel Report**
**2:30** **Strategic and Operational Plan Presentation**
**3:00** **Public Comment regarding plans**
**3:15** **Break**
**3:30** **Discussion and Vote –** Rick Howard
**4:15** **Workgroups and Panels –** Chris Coughlin
**4:25** **Public Input**
**4:40** **Updates** – Carol Robinson
- Medicaid HIT Update
- Beacon

**4:50** **Closing Comments –** Steve Gordon and Rick Howard
**5:00** **Close**

# Meeting Outcomes

- Updates regarding Federal rules and other activities
- Ex-officio appointments to HITOC
- Orientation to public input, ONC Program Information Notice and plan implications and refinements
- Final discussion regarding strategic and operational plans
- Vote regarding plans
- Begin process for establishing workgroups
- Orientation regarding post-plan submission activities

# Updates

1. Office of Health Information Technology
2. Meaningful Use Final Rule
3. Temporary Certification Final Rule
4. Program Information Notice (PIN)

# Updates: CMS Meaningful Use Final Rule

- See handout

# Key Themes Guiding Changes from NPRM to Final Rule

Connecting America for Better Health

EHR INCENTIVE PROGRAM

- **Flexibility**
  - Moved away from all-or-nothing approach
- **Simplicity**
  - Feasibility: Easier to calculate & report HIT functionality measures (electr. denominator calculations)
- **Consistency**
  - Medicare-Medicaid; all start calendar year 2011
- **Quality**
  - MU principles of driving high-quality care intact

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

# Meaningful Use: Basic Overview of Final Rule

- Stage 1 (2011 and 2012)
  - To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
  - EPs have to report on 20 of 25 MU objectives
  - Eligible hospitals have to report on 19 of 24 MU objectives
  - Reporting Period – 90 days for first year; one year subsequently

# Notable Differences Between the Medicare & Medicaid EHR Programs

| Medicare | Medicaid |
|---|---|
| Federal Government will implement (will be an option nationally) | Voluntary for States to implement (may not be an option in every State) |
| Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use | No Medicaid payment reductions |
| Must demonstrate MU in Year 1 | A/I/U option for 1st participation year |
| Maximum incentive is $44,000 for EPs (bonus for EPs in HPSAs) | Maximum incentive is $63,750 for EPs |
| MU definition is common for Medicare | States can adopt certain additional requirements for MU |
| Last year a provider may initiate program is 2014; Last year to register is 2016; Payment adjustments begin in 2015 | Last year a provider may initiate program is 2016; Last year to register is 2016 |
| Only physicians, subsection (d) hospitals and CAHs | 5 types of EPs, acute care hospitals (including CAHs) and children's hospitals |

# Updates: ONC Temporary Certification Final Rule

- Sets initial standards, implementation specifications, and certification criteria for EHR technology under the incentive program.
- With these standards in place, providers can be assured that the certified EHR technology they adopt is capable of performing the required functions to comply with CMS' meaningful use requirements and other administrative requirements of the Medicare and Medicaid EHR incentive programs.
- Through the temporary certification program, new ONC-authorized organizations will be established: "ONC HIT Authorized Testing and Certification Bodies" (ONC-ATCBs). They will test and certify that complete EHRs and EHR modules are compliant with the standards, implementation specifications, and certification criteria now finalized.

# Updates: Program Information Notice ("PIN")

- Released by the ONC on July 6, 2010; first in a series to come
- The stated purpose of the PIN was to clarify required and recommended…
  1. Responsibilities of the state/SDE
  2. Roles of the HIT Coordinator
  3. Elements of the strategic and operational plans

# Program Information Notice ("PIN")

"Key Deliverables and Objectives for State HIE in 2011":

- States and SDEs shall outline in their Strategic and Operational Plans how they will enable eligible providers **to have at least one option for each** of these Stage 1 meaningful use requirements in 2011:
  1. E-prescribing
  2. Receipt of structured lab results
  3. Sharing patient care summaries across unaffiliated organizations

# Program Information Notice ("PIN")

Other key emphases of the PIN:

- Comprehensive and specific environmental scan
- Close coordination with Medicaid
- Close coordination with Public Health

# Office of Health Information Technology

## The Office of Health Information Technology will serve to:

- Accelerate state and federal health reform goals through organized support for adoption, implementation and integration of health information technologies,
- Increase and convert Health IT funding opportunities from federal agencies, philanthropic organizations and the private sector into results; and
- Increase collaboration and communication between state agencies and across programs for enhanced planning and share decision-making, leverage IT purchases and coordination of service delivery.

# Ex-officio appointments to HITOC

- Responding to PIN guidance:
  - "States and SDEs shall coordinate with Medicaid and public health programs to establish an integrated approach including having both programs represented in the state's governance structure and processes."

- *Action item*: The establishment of ex-officio HITOC appointments for the state directors of Medicaid and Public Health

# Community Meetings and Public Input

- From June 17 through July 14, 2010, the HIE Planning Team received, collected, reviewed, and analyzed **over 150 comments from more than 100 individuals and organizations** on the Draft HIE Strategic Plan.
- Feedback was received via **a diversity of forums**, including the HITOC Public Meeting in Portland (June 17), five community meetings held across the state, a public webinar (July 8), and via e-mail submitted to hitoc.info@state.or.us.
- **A full list of individual comments and feedback has been compiled**, is included with the materials for today's meeting, and will be made a public document after HITOC review.
- While **several public comments resulted in changes to the Strategic Plan,** others will be given to the appropriate workgroup, panel, or other forum to inform Phase 1 planning activities.
- An ad-hoc **Advisory Panel composed of 5 HITOC members reviewed the public input and gave feedback** to the HIE Planning Team on how to incorporate it into a revised Draft Strategic Plan.

# Strategic and Operational Plans

## Revisions to June 17 Draft Strategic Plan

- In response to:
  - Public input & HITOC Advisory Panel feedback
  - PIN
  - Suggestions from Planning Team
- All changes listed in Brief; some significant changes include:
  - New cover letter to address privacy and consumer/patient centrality
  - Expanded section on long term care
  - More detailed description of privacy & security framework
  - New language in response to PIN about the specific options for providers for secure connectivity to address MU in the 3 priority areas
  - Expanded section on education programs to include “legal toolkit”

# Operational Plan Overview

- Key Components:
  - Structure based on ONC guidance
  - Focus on objectives and deliverables by phase
  - Milestones
  - Budget
  - Detailed project management plan (“Project Plan”)
  - Coordination with other programs/entities

# Strategic and Operational Plans

**PIN Implications: Plan Adjustments**

- No significant changes to overall strategy.
- Primary impact is to timing.
  - Technology selection, purchasing, & some implementation activities now in Phase 1.
  - Service introductions begin earlier – Phase 1.
    - Services iteratively introduced, continuing into Phase 2.
    - Starts with those required for “push” capabilities to enable summary sharing and receipt of labs, progressing to “pull”.

# PIN Plan Adjustments: Technology procurement & timing

- Procurement
  - Initially through existing State-approved processes & methods
  - Dependent on requirements & specifications for services
- To meet PIN requirements, progressive introduction & rollout of central services starting Phase 1
  - Push Services
    - Base services required for “push” capabilities
    - Introduction & rollout in Phase 1
  - HIE Registry (Provider Registry)
    - Directory of HIE participants, such as providers, lab testing companies, state agencies, & others
    - Introduction & rollout in Phase 1 (first for “push”, extended as needed for “pull”)
  - Trust Services
    - Certificate authority & other “circle of trust” functions
    - Sufficient introduction & rollout in Phase 1 for “push”
    - Extensions introduced as needed for “pull” later in Phase 1, rollout continuing into Phase 2

# Workgroups and Panels

1. **Workgroups**: Legal and Policy, Technology, and Finance
   - Open application process in August, appoint members and launch in September

2. **Panels**: HIO Executive Panel and Consumer Advisory Panel
   - To be launched in Q3/4 2010

# Updates

1. Medicaid HIT Update
2. Beacon

# Updates: Medicaid HIT Update

- DHS/OHA Medicaid HIT Steering Committee formed; includes Rick Howard and Carol Robinson
- CMS expects majority of states to have incentive payment programs in place Summer 2011
- Oregon Medicaid HIT planning on track to meet that expectation
- 4 Public Health related Meaningful Use menu items states can move to list of Medicaid core objectives; process being developed to bring a recommendation to HITOC

# Updates: Beacon Community Grants

- The 2nd round of Beacon applications have been submitted, with 4 from Oregon:
  1. SACHIE/Physician's Choice Foundation
  2. Jefferson HIE/Asante Health System
  3. Cascade Healthcare Community/St. Charles Health System
  4. Community Health Alliance Rural Technological Synergy (Charts)
- Award decisions are expected in August

# Closing comments-Next steps

- Plans to Oregon Health Policy Board
- Approval by Director of Oregon Health Authority
- Plan submission
- Workgroup application process launched
- Workgroups commence
- Panels commence

# Next meeting

- **Thursday, September 2, 2010**
- **1:00 pm – 5:00 pm Oregon State Library**

  **Rooms 102-103 250 Winter Street NE**

  **Salem, Oregon 97301**

Connecting America for Better Health

# Medicare & Medicaid EHR Incentive Program Final Rule

*Implementing the American Recovery & Reinvestment Act of 2009*

Dr. Joshua Seidman

Acting Director, Meaningful Use
Office of the National Coordinator
for Health Information Technology

CMS CENTERS for MEDICARE & MEDICAID SERVICES

# Key Themes Guiding Changes from NPRM to Final Rule

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- **Flexibility**
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CMS CENTERS for MEDICARE & MEDICAID SERVICES

# Meaningful Use: Changes from the NPRM to the Final Rule

| NPRM | Final Rule |
|---|---|
| Meet all MU reporting objectives | Must meet “core set”/can defer 5 from optional “menu set” |
| 25 measures for EPs/23 measures for eligible hospitals | 25 measures for EPs/24 for eligible hospitals |
| Measure thresholds range from 10% to 80% of patients or orders (most at higher range) | Measure thresholds range from 10% to 80% of patients or orders (most at lower to middle range) |
| Denominators – To calculate the threshold, some measures required manual chart review | Denominators – No measures require manual chart review to calculate threshold |
| Administrative transactions (claims and eligibility) included | Administrative transactions removed |
| Measures for Patient-Specific Education Resources and Advanced Directives discussed but not proposed | Measures for Patient-Specific Education Resources and Advanced Directives (for hospitals) included |

# Meaningful Use: Changes from the NPRM to the Final Rule, cont'd

| NPRM | Final Rule |
|---|---|
| States could propose requirements above/beyond MU floor, but not with additional EHR functionality | States' flexibility with Stage 1 MU is limited to seeking CMS approval to require 4 public health-related objectives to be core instead of menu |
| Core clinical quality measures (CQM) and specialty measure groups for EPs | Modified Core CQM and removed specialty measure groups for EPs |
| 90 CQM total for EPs | 44 CQM total for EPs – must report total of 6 |
| 35 CQM total for eligible hospitals and 8 alternate Medicaid CQM | 15 CQM total for eligible hospitals |
| 5 CQM overlap with CHIPRA initial core set | 4 CQM overlap with CHIPRA initial core set |

# Meaningful Use: Basic Overview of Final Rule

- Stage 1 (2011 and 2012)
  - To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
  - EPs have to report on 20 of 25 MU objectives
  - Eligible hospitals have to report on 19 of 24 MU objectives
  - Reporting Period – 90 days for first year; one year subsequently

# Meaningful Use: Core Set Objectives

- **EPs – 15 Core Objectives**
  1. Computerized physician order entry (CPOE)
  2. E-Prescribing (eRx)
  3. Report ambulatory clinical quality measures to CMS/States
  4. Implement one clinical decision support rule
  5. Provide Patients with an electronic copy of their health information, upon request
  6. Provide clinical summaries for patients for each office visit
  7. Drug-drug and drug-allergy interaction checks
  8. Record demographics
  9. Maintain an up-to-date problem list of current and active diagnoses
  10. Maintain active medication list
  11. Maintain active medication allergy list
  12. Record and chart changes in vital signs
  13. Record smoking status for patients 13 years or older
  14. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
  15. Protect electronic health information

# Meaningful Use: Core Set Objectives

- **Eligible Hospitals – 14 Core Objectives**
  1. CPOE
  2. Drug-drug and drug-allergy interaction checks
  3. Record demographics
  4. Implement one clinical decision support rule
  5. Maintain up-to-date problem list of current and active diagnoses
  6. Maintain active medication list
  7. Maintain active medication allergy list
  8. Record and chart changes in vital signs
  9. Record smoking status for patients 13 years or older
  10. Report hospital clinical quality measures to CMS or States
  11. Provide patients with an electronic copy of their health information, upon request
  12. Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request
  13. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
  14. Protect electronic health information

# Meaningful Use: Menu Set Objectives*

- Eligible Professionals
  - Drug-formulary checks
  - Incorporate clinical lab test results as structured data
  - Generate lists of patients by specific conditions
  - Send reminders to patients per patient preference for preventive/follow up care
  - Provide patients with timely electronic access to their health information
  - Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
  - Medication reconciliation
  - Summary of care record for each transition of care/referrals
  - Capability to submit electronic data to immunization registries/systems
  - Capability to provide electronic syndromic surveillance data to public health agencies

*At least 1 public health objective must be selected

# Meaningful Use: Menu Set Objectives*

- Eligible Hospitals
  - Drug-formulary checks
  - Record advanced directives for patients 65 years or older
  - Incorporate clinical lab test results as structured data
  - Generate lists of patients by specific conditions
  - Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
  - Medication reconciliation
  - Summary of care record for each transition of care/referrals
  - Capability to submit electronic data to immunization registries/systems
  - Capability to provide electronic submission of reportable lab results to public health agencies
  - Capability to provide electronic syndromic surveillance data to public health agencies

*At least 1 public health objective must be selected

# Meaningful Use: Stage 2

- Intend  to propose 2 additional Stages through future rulemaking. Future Stages will expand upon Stage 1 criteria.
- Stage 1 menu set will be transitioned into core set for Stage 2
- Will reevaluate measures – possibly higher thresholds

# Meaningful Use: Denominators

- Two types of percentage based measures are included to address the burden of demonstrating MU
  1. Denominator is all patients seen or admitted during the EHR reporting period
     - The denominator is all patients regardless of whether their records are kept using certified EHR technology
  2. Denominator is actions or subsets of patients seen or admitted during the EHR reporting period
     - The denominator only includes patients, or actions taken on behalf of those patients, whose records are kept using certified EHR technology

# Meaningful Use: Applicability of Objectives and Measures

- Some MU objectives are not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator. Exclusions count against the 5 deferred measures
- In these cases, the EP, eligible hospital or CAH would be excluded from having to meet that measure
  - Ex: Dentists who do not perform immunizations; Chiropractors do not e-prescribe

# States' Flexibility to Revise Meaningful Use

- States can seek CMS prior approval to require 4 MU objectives be core for their Medicaid providers:
  - Generate lists of patients by specific conditions for quality improvement, reduction of disparities, research or outreach (can specify particular conditions)
  - Reporting to immunization registries, reportable lab results and syndromic surveillance (can specify for their providers how to test the data submission and to which specific destination)

# Clinical Quality Measures (CQM) Overview

- 2011 – EPs, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States by attestation.
- 2012 – EPs, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States.

# CQM: Eligible Professionals

- Core, Alternate Core, and Additional CQM sets for EPs
  - EPs must report on 3 required core CQM, and if the denominator of 1or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures
  - EPs also must select 3 additional CQM from a set of 38 CQM (other than the core/alternate core measures)
  - In sum, EPs must report on 6 total measures:  3 required core measures (substituting alternate core measures where necessary) and 3 additional measures

# CQM: Core Set for EPs

| NQF Measure Number & PQRI Implementation Number | Clinical Quality Measure Title |
|---|---|
| NQF 0013 | Hypertension: Blood Pressure Measurement |
| NQF 0028 | Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment b) Tobacco Cessation Intervention |
| NQF 0421<br>PQRI 128 | Adult Weight Screening and Follow-up |

# CQM: Alternate Core Set for EPs

| NQF Measure Number & PQRI Implementation Number | Clinical Quality Measure Title |
|---|---|
| NQF 0024 | Weight Assessment and Counseling for Children and Adolescents |
| NQF 0041<br>PQRI 110 | Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older |
| NQF 0038 | Childhood Immunization Status |

# CQM: Additional Set for EPs

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
11. Anti-depressant medication management: (a) Effective Acute Phase Treatment,(b)Effective Continuation Phase Treatment
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
18. Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
19. Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

# CQM: Additional Set for EPs, cont'd

20. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
21. Smoking and Tobacco Use Cessation, Medical assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
22. Diabetes: Eye Exam
23. Diabetes: Urine Screening
24. Diabetes: Foot Exam
25. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
26. Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
27. Ischemic Vascular Disease (IVD): Blood Pressure Management
28. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
29. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
30. Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
31. Prenatal Care: Anti-D Immune Globulin
32. Controlling High Blood Pressure
33. Cervical Cancer Screening
34. Chlamydia Screening for Women
35. Use of Appropriate Medications for Asthma
36. Low Back Pain: Use of Imaging Studies
37. Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
38. Diabetes: Hemoglobin A1c Control (<8.0%)

# CQM: Eligible Hospitals and CAHs

1. Emergency Department Throughput – admitted patients Median time from ED arrival to ED departure for admitted patients
2. Emergency Department Throughput – admitted patients – Admission decision time to ED departure time for admitted patients
3. Ischemic stroke – Discharge on anti-thrombotics
4. Ischemic stroke – Anticoagulation for A-fib/flutter
5. Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
6. Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
7. Ischemic stroke – Discharge on statins
8. Ischemic or hemorrhagic stroke – Stroke education
9. Ischemic or hemorrhagic stroke – Rehabilitation assessment
10. VTE prophylaxis within 24 hours of arrival
11. Intensive Care Unit VTE prophylaxis
12. Anticoagulation overlap therapy
13. Platelet monitoring on unfractionated heparin
14. VTE discharge instructions
15. Incidence of potentially preventable VTE

# Notable Differences Between the Medicare & Medicaid EHR Programs

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|---|---|
| Federal Government will implement (will be an option nationally) | Voluntary for States to implement (may not be an option in every State) |
| Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use | No Medicaid payment reductions |
| Must demonstrate MU in Year 1 | A/I/U option for 1st participation year |
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# Acronyms

- A/I/U – Adopt, implement, or upgrade
- CAH – Critical Access Hospital
- CCN – CMS Certification Number
- CHIPRA – Children's Health Insurance Program Reauthorization Act of 2009
- CMS – Centers for Medicare & Medicaid Services
- CNM – Certified Nurse Midwife
- CPOE – Computerized Physician Order Entry
- CQM – Clinical Quality Measures
- CY – Calendar Year
- EHR – Electronic Health Record
- EP – Eligible Professional
- eRx – E-Prescribing
- FFS – Fee-for-service
- FQHC – Federally Qualified Health Center
- FFY – Federal Fiscal Year
- HHS – U.S. Department of Health and Human Services
- HIT – Health Information Technology
- HITECH Act – Health Information Technology for Electronic and Clinical Health Act
- HITPC – Health Information Technology Policy Committee
- HIPAA – Health Insurance Portability and Accountability Act of 1996
- HPSA – Health Professional Shortage Area
- MA – Medicare Advantage
- MCMP – Medicare Care Management Performance Demonstration
- MU – Meaningful Use
- NCVHS – National Committee on Vital and Health Statistics
- NP – Nurse Practitioner
- NPI – National Provider Identifier
- NPRM – Notice of Proposed Rulemaking
- OMB – Office of Management and Budget
- ONC – Office of the National Coordinator of Health Information Technology
- PA – Physician Assistant
- PECOS – Provider Enrollment, Chain, and Ownership System
- PPS – Prospective Payment System (Part A)
- PQRI – Medicare Physician Quality Reporting Initiative
- Recovery Act – American Reinvestment & Recovery Act of 2009
- RHC – Rural Health Clinic
- TIN – Taxpayer Identification Number

## The Office of Health Information Technology will serve to:

- Accelerate state and federal health reform goals through organized support for adoption, implementation and integration of health information technologies;
- Increase and convert Health IT funding opportunities from federal agencies, philanthropic organizations and the private sector into results; and
- Increase collaboration and communication between state agencies and across programs for enhanced planning and share decision-making, leveraged IT purchases and coordination of service delivery.

| INTERNAL TO OHA/DHS | EXTERNAL |
|---|---|
| Convening:<br>• HITOC<br>• Workgroups as needed from both OHA and DHS departments<br><br>Coordinating with and sharing staff support with:<br>• Medicaid HIT Planning<br>• Medicaid Transformation Grant<br><br>Developing new processes for planning and decision-making of HIT purchases, integration of HIT into new grant opportunities | Convening:<br>• HITOC<br><br>Leading:<br>• Oregon statewide health information exchange (HIE) project |
| Coordinating with federally-funded HIT planning efforts:<br>• Medicaid HIT Planning<br>• Shared Services Architecture Planning<br>• Behavioral Health Integration Project<br>• Public Health and Long Term Care HIT planning<br>• Medicaid Transformation Grant | Coordinating with federally-funded HIT efforts in Oregon:<br>• O-HITEC the HIT Regional Extension Center (OCHIN)<br>• Broadband (Oregon Health Network)<br>• HIT workforce (Oregon Health & Science University, Portland Community College, Oregon Workforce Investment Board and the Healthcare Workforce Committee of the Policy Board)<br>• Telehealth<br>• Federal health care delivery systems including:<br>o Tribes<br>o Veterans Administration |
| Coordinating and communicating with state entities:<br>• Information Technology Governance Council (ITGC)<br>• OIS, OHPR, other OHA/DHS agencies<br>• Governor's Office<br>• Legislature<br>• Congressional delegation staff | Coordinating with external HIE-related entities:<br>• Local health information exchange organizations (HIOs)<br>• County and local health departments<br>• Health systems<br>• Neighboring states |
| Coordinating with state and federal health reform efforts with HIT components:<br>• Administrative simplification<br>• All Payer Data Reporting Program<br>• Patient-centered Primary Care Home pilots<br>• CHIPRA pilot programs<br>• Eligibility system streamlining<br>• Health Insurance Exchange | Coordinating with private stakeholders and private HIT efforts in Oregon:<br>• Providers and their associations<br>• Consumers and advocacy organizations<br>• Public and private sector quality initiatives such as Quality Corp., Acumentra, Oregon Patient Safety Commission<br>• Business associations and their members |

# Compilation of Public Comments
# Draft Oregon State HIE Strategic Plan
# June 17, 2010 – July 14, 2010

Following is a summary of comments received during the *Draft State HIE Strategic Plan* public comment period, June 17, 2010- July 14, 2010, and a brief response including whether there was a change needed to the Strategic Plan or if there was action required during Phase 1 implementation.

| Thematic area (-- sub-theme) | Comment | Forum: Name, Organization | Change to Plan needed? | Response including any actions required |
|---|---|---|---|---|
| Legal/Policy | | | | |
| --Privacy & Security, Patient rights | | | | |
| | I noted little focus on patient choice and patient rights. There is reference in some areas but I would appreciate it if the HITOC would consider expanding references to other what I would consider pertinent areas. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | HITOC cover letter to address underlying philosophy of plan. | Refer comments to Legal and Policy Workgroup and Consumer Advisory Panel. |
| | I would recommend taking into account additional HITECH Act requirements that impact the draft strategic plan –<br>1. HIOs and RHIOs are treated as business associates effective February 17, 2010<br>2. Business associates are required to adhere to the use and disclosure provisions of the HIPAA Privacy Rule and the complete HIPAA Security Rule effective February 17, 2010<br>3. Business associates have an equal responsibility to enter into a business associate contract with covered entities (all HIO and RHIO participants) effective February 17, 2010<br>4. Patients now have the right to require providers not disclose certain health information ("request for restriction") if the patient paid for services, treatment, a prescription, etc. "out of pocket" and the patient's data to the patient's health plan for payment and healthcare operations purposes; this is not the same as opt out with restrictions – this is specifically excluding health data that is not specially protected and the data cannot be included in an HIE (effective February 17, 2010)<br>5. The Office of the National Coordinator for Health Information Technology has been charged with managing and developing HIT/HIE technical and policy requirements including security technical and policy requirements effective February 17, 2009<br>6. State attorneys general (versus DCBS) now have the authority to enforce/file suit against, in the case of this draft plan, HIOs and RHIOs effective February 17, 2010 for violations of the HIPAA Privacy and Security Rules | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change: The Plan states that all applicable federal law will be followed and applied. | Refer to Legal and Policy Workgroup for discussion and include information in FAQs for providers and consumers. |
| | Medical information is arguably the most personal and private sources of data about us. While we appreciate efforts to hear consumer advocates, including the American Civil Liberties Union | June 17, 2010, HITOC Public | HITOC cover letter to address | Refer to Legal and Policy Workgroup and Consumer |

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| | of Oregon in this process, we strongly recommend strengthening the commitment to consumers as well as privacy, confidentiality and security in the Oregon Health Information Exchange (HIE) plans. Privacy must be a higher priority in Oregon's electronic health information system. The Plan must go further in demonstrating meaningful commitments to patients and consumers.<br><br>[Please see attached document for full submission of comments and suggestions.] | Meeting Attendee: Andrea Meyer, ACLU | underlying philosophy of plan. | Advisory Panel. |
| | We are a sole provider in a rural community and have been using EHRs for several years, but are having problems. One is that other organizations keep asking us to fax the records, even OHSU. And we want to get a new EHR system, but where are the security standards (for routers and firewalls) so we will be covered in terms of liability issues? For telemedicine, insurance will only cover it if they are in a "secured environment". When will those be ready? | July 13, 2010, Coos Bay Community Meeting attendee: Linda Gillehan, Dr. Reagan's office manager | No change: The Strategic and Operational Plan address the issue of using federal security standards. | Refer to Legal and Policy Workgroup. Include in information/education plan, work with O-HITEC to provide information to providers. |
| | All health records should belong to the patient.<br>There should be provisions made for the patient to correct doctor and hospital chart notes. The HIPPA law so provides, and a procedure should be developed for that within the electronic records.<br>There should also be some provision to be sure that if medical records are used for research purposes that they will be sterilized first. There should be records kept so that the patient can know which of her records have been mined for research purposes. Patients should have some recourse if those records are not properly sterilized first.<br>There is a wealth of concern below the surface of this project. | Public input submitted to hitoc.info@state.or.us: Karen Stolzberg, Disability Lawyer | No change: Patient rights to their own record, to correcting it, to protecting the privacy of it when used for secondary purposes, being notified of its use, and recourse for breach are all guaranteed by the HHS Privacy & Security framework and/or HIPAA. | Refer to Legal and Policy Workgroup. Include in consumer information/education strategies. |
| | First, the notion of a patient-centric model is critically important. In fact, in the summary provided at the June 2010 meeting of the OHPB, on page 2 of the HITOC report it states three goals for the Health Information Exchange:<br>• To ensure patients have safe, secure access to their personal health information and the ability to share that information with others involved in their care.<br>• To engage in an open, inclusive, and collaborative public process that supports widespread electronic health record (EHR) adoption and robust, sustainable statewide coverage.<br>• To improve health care outcomes and reduce costs.<br><br>In fact, we commend the first goal especially, as it puts patients at the center, but there is one critical missing piece of information in the report – naming the patient as the owner of the data. We | Public input submitted to hitoc.info@state.or.us: Community Leadership Council of the Archimedes Movement | No change: A patient's right to their own record is guaranteed by the HHS Privacy & Security framework and/or HIPAA. HITOC cover letter to address underlying | Refer to Consumer Advisory Panel. |

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| | believe that this is essential to moving forward with the system implementation, and that acknowledging this ownership will heavily influence decisions along the way. | | philosophy of plan. | |
| | I do not believe a statewide health information exchange is a good idea. It will not be as private as you think. The only one that it will be beneficial for is maybe the Dr. I know I don't want my information out there. One reason is staff. I have heard many comments and information leaked by staff. Who would be able to get the info. Dr., staff etc? Anyone in the state? Too much info is out on the net and I know it is not accurate by any means. I am sure others feel the same way I do. | Public input submitted to hitoc.info@state.or.us: Della Mattingly | No change: The Strategic and Operational Plan address the issue of using federal security standards. | Refer to Legal and Policy Workgroup. |
| | Trying to figure out how they are going to keep all this information secure. Without security, this is not valuable. The larger the integration of a health information exchange system, what does that mean in terms of security of personal information? | July 13, 2010, Roseburg Community Meeting Attendee | No change: The Strategic and Operational Plans address the issue of using federal security standards. | Refer to Legal and Policy Workgroup. |
| | What about coding of patient information sent to India? | July 13, 2010, Roseburg Community Meeting Attendee | No change: The Strategic and Operational Plan address the issue of using federal security standards. | Refer to Legal and Policy Workgroup. |
| --Consent | | | | |
| | Also, it's insufficient to ask people if they consent, because they don't have enough information to understand what they're consenting to. | June 28, 2010, Medford Community Meeting attendee | No change. | Refer to Consumer Advisory Panel; Consumer education program around consent will be developed during Phase 1. |
| | PHI being shared without the patient's consent. Too often I see a consent statement buried in a consent for services rendered. | June 28, 2010, Medford Community Meeting attendee: Joyce Hane, Asante | No change. | Refer to Consumer Advisory Panel and Legal and Policy Workgroup. Consumer education program around consent will be developed during Phase 1. |
| | How will patient choice regarding Opt Out work? | July 13, 2010, Coos Bay Community Meeting attendee: Barbara, Bay Area Hospital | No change. | Refer to Consumer Advisory Panel and Legal and Policy Workgroup; Plan addresses how consent process and consumer education approach will be determined during |

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| | | | | Phase 1. |
| | Please define opt out versus opt in, and full opt out? | July 13, 2010, Coos Bay Community Meeting attendee | No change: The recommended consent policy is clearly defined in the Plan. | Refer to Consumer Advisory Panel Consumer education program around consent will be developed during Phase 1. |
| | The constitution guarantees life, liberty, and the pursuit of happiness. And the liberty piece is being taken away with opt out for patients, and providers having to do something they don't get a choice about. | July 13, 2010, Coos Bay Community Meeting attendee: Dean Smith, local oral surgeon | No change r: The recommended consent policy in the Plan explicitly addresses and incorporates patient choice. | Refer to Consumer Advisory Panel; Consumer/patient communication and education will focus on the existence of choice and the importance of and mechanisms for exercising it. |
| | The OMA supports the "opt out" system for use and disclosure of protected health information in an EHR. While we fully support patient privacy, the best quality health care relies on ready access to all relevant health information about the patient. As use of an interoperable EHR becomes more prevalent, we are open to evaluating patient privacy issues to determine if the opt out system remains appropriate. | Public input submitted to hitoc.info@state.or.us: Gwen Dayton, JD, General Counsel, Oregon Medical Association | No change | Refer to Legal and Policy Workgroup. |
| | Has the state decided upon an opt-in or opt-out model for patient consent? | July 13, 2010, Roseburg Community Meeting Attendee | No change: The Plan explains the recommended consent policy. | Consumer/patient education will clearly explain Oregon's consent policies.. |
| | Question about opt-in and opt-out. If an individual initially opts-in and then decides to opt-out, how does this work? | July 13, 2010, Roseburg Community Meeting Attendee | No change:. | Refer to Legal and Policy Workgroup and Consumer Advisory Panel. The Plan includes developing a consumer education program around consent during Phase 1. |
| | Comment: want to avoid a Facebook syndrome in that individuals didn't really understand what is implied in terms of consent. When developing a communication strategy, we need to understand that and communicate this understanding to consumers. | July 13, 2010, Roseburg Community Meeting Attendee | No chang | Refer to Consumer Advisory Panel. The Plan states that a consumer education program around consent will be developed during Phase 1. |
| | There is a legal difference between "consent" and authorization" pursuant to state and federal law. | Public input | No change | The Plan states that all |

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| | I would appreciate it if that distinction would be made in the strategic plan and the fact that, pursuant to Oregon law, authorizations have a limited life. | submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | | applicable federal and state laws, including those related to consent/ authorization, will be examined during Phase 1, and any necessary changes made. Refer to Legal and Policy Workgroup. |
| --Specially Protected Health Information (SPHI) | | | | |
| | I don't believe that medical record professionals are being involved enough and they are the people who are "in the trenches" who understand and deal with the logistics of how to share some information and not all, i.e. HIV, mental health, etc. People at the 30,000 foot level have a different perspective than those who are working with PHI daily. All perspectives are critical to the process. | June 28, 2010, Medford Community Meeting attendee: Joyce Hane, Asante | No change | Refer to Legal and Policy Workgroup. The feasibility of segregating/ excluding SPHI from exchange will be explored in depth during Phase 1, and the expertise of hands-on practitioners will be sought during that process. |
| | Regarding the privacy and confidentiality of patient information, Planned Parenthood is concerned that because all reproductive and sexual health information is of such a personal nature, it needs to be called out for special protection. My understanding that the current draft plan only addresses these concerns for minors. Indeed, this is a special subset of the population that deserves attention. However, information relating to sexually transmitted diseases/infections, the number of pregnancies and terminations, partner information, etc. needs to be protected for all patients, not just minors. Planned Parenthood would like to see greater protections for reproductive and sexual health PHI. | Public input submitted to hitoc.info@state.or.us: David Greenberg, Ph.D. President and CEO, Planned Parenthood Columbia Willamette | No change | Refer to Legal and Policy Workgroup. The Plan states that all categories of SPHI, including current and potential, will be explored in depth and possible legislative changes made during Phase 1. |
| | We also strongly share HITOC's concerns regarding the difficulties posed by specially protected records.<br>Request: Please include Gwen Dayton, OMA General Counsel, in any subcommittees or other groups formed for the purpose of evaluating and developing solutions to the problem associated with specially protected records. We also urge you to include her in other groups formed to consider legal and policy issues. | Public input submitted to hitoc.info@state.or.us: Gwen Dayton, JD, General Counsel, Oregon Medical Association | No change | All interested persons are welcome to apply during the Workgroup nomination process. |
| --Liability | | | | |
| | And who's going to handle the risk associated with security leaks? And the cost of that risk/liability? Is it really practical for small clinics to bear these costs? | July 13, 2010, Coos Bay Community Meeting attendee: | No change. | Refer to Legal and Policy Workgroup. Plan addresses how liability issues will be addressed during Phase 1. |

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| | | Dean Smith, local oral surgeon. | | |
| | There are always inherent and unavoidable risks in providing medical care. These new risks and liabilities associated with HIE are no different. | July 13, 2010, Coos Bay Community Meeting attendee: Dean Smith, local oral surgeon | No change<br>The Strategic Plan addresses potential risks and mitigation strategies. | HITOC has and will continually assess HIE risks, liabilities, and mitigation strategies. |
| | A lot of time, money and energy is going into how to move information. What I have not heard discussed is the operationalization of "now what do we do with it?". For example, two areas that I have not seen addressed which I think are critical at some level are HIM management and provider responsibility.<br><br><u>Provider responsibility</u><br><br>I think a large assumption has been made, that being that providers want, and so will use, this information. I would be very interested to know how often the information is accessed by providers in States such as Indiana which have the history of HIO/HIE. From a provider's perspective, this introduces new workflow, and at least the perception of new risk. If the information is available, am I negligent if I don't access it? If I do access it, how much do I need to review? What are my liabilities if the information is incorrect and I make a medical decision based on it? How do I reconcile disparate pieces of information?<br><br>Frequently scenarios drawn around HIE involve having the information needed in an emergency. While this is a great concept, if I am the physician attempting to stabilize you in an "emergency", if I have time to log into a RLS, request, receive, review and reconcile the information available prior to providing your care, it probably truly was not an emergency. If I am not understanding how this would function, please educate me.<br><br><u>Health Information Management (HIM) responsibility</u><br><br>If I as the above provider, use "outside" information in my medical decision making, how do I document that? Do I download this information into my own EMR? Do I now "own" this information? Do I release this information with a release of records request from an attorney? Is this all now part of my organizations legal medical record? Do I as an organization now assume the risk of this information? What are the rules, if any, regarding how I can use this information in the future? | Public input submitted to hitoc.info@state.or.us: Elizabeth Lincoln, CMIO, Samaritan Health Services | No change | Refer to Legal and Policy Workgroup and HIO Executive Panel. The Plan states that liability issues will be explored and addressed during Phase 1. |
| --Legal Guidance | | | | |
| | In terms of financial sustainability, the state should incorporate the costs of ongoing legal advisory services; a lot of organizations are paying a lot of money to get legal advice, and if the state could coordinate that it would be very helpful. | June 28, 2010, Medford Community | Strategic Plan revised to explicitly include | Legal "Toolkit" will be developed in Phase 1. |

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| | | Meeting attendee | the development of a legal resource guide or "toolkit". | |
| | Also, training her staff to be conversant with the constantly changing legal issues of exchanging clinical info is very burdensome for a single provider. | June 28, 2010, Medford Community Meeting attendee | No change | Provider and business associate HIPAA training strategies will be addressed during Phase 1. |
| | Our hospitals stressed the need for clear, consistent and comprehensive legal guidance as they move toward planning and implementation of health information exchange. Hospitals will look to HITOC for legal interpretation of salient HIE issues, written in language understandable and actionable for developing health information exchange programs. Such legal guidance is critical to defining how Oregon's medical consent laws shape HIE operations. It will also be necessary as health care entities write information-sharing agreements, or DURSAs, that are local or that cross state lines. Failure to swiftly identify and resolve legal issues will retard local action and jeopardize hospital and provider ability to meet expected meaningful use criteria for health information exchange. Without clear legal guidance on HIE, hospitals and providers face increased administrative burden to launch health information organizations, and they open themselves to legal risks. Oregon hospitals appreciate HITOC's plan to appoint a legal and policy work group to address these matters, but are concerned that the group's guidance may not be delivered quickly enough. Perhaps HITOC could tap the expertise of a national legal expert on HIE who could quickly draft and disseminate an initial report to address the most pressing legal questions. | Public input submitted to hitoc.info@state.or.us: Robin Moody, Oregon Association of Hospitals and Health Systems | Strategic Plan revised to explicitly include the development of a legal resource guide or "toolkit". | Legal "Toolkit" will be developed in Phase 1. Refer to Legal and Policy Workgroup. Development of DURSAs to be addressed in Phase 1. |
| --Legislative changes | | | | |
| | I would appreciate the HITOC review my notes regarding what may be actions proposed that are either already mandated by federal statute and rule, state statute and rule and proposed actions that appear to violate federal statute. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change. | Expert advice will be sought and research conducted into harmonizing state and federal law during Phase 1. |
| | I would recommend not proposing legislation defining "consent" as it relates to HIT/HIE in Oregon. Federal and state laws already exist and federal standards already exist regarding "consent" as it relates to HIT/HIE. Statute is difficult to change and I do not believe it is the appropriate vehicle to use for the articulation of standards. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change | All solutions, including legislative solutions, will be explored during Phase 1 for implementing a statewide consent framework. |
| | Meaningful use requires that PHI be shared w/patient upon request, but Oregon has rules that if the patient requests their lab results, there's a 7 day wait to give those to them. This conflicts with MU. Are there plans to re-evaluate this OAR? | June 28, 2010, Medford Community Meeting attendee: E. Susan Cease, Asante | No change | The Plan addresses how legislative/ administrative barriers to HIE and potential solutions will be explored in depth during Phase 1. |
| --Interstate | | | | |

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| exchange | | | | |
| | Here in the Gorge she sees patients on both sides of the river, and she sees some mention in the plan of working with border states, but she hopes to see more of that. | June 30, 2010, The Dalles Community Meeting attendee | No change | The Plan states that inter-state exchange issues and agreements will be addressed and developed during Phase 1. |
| | We also have out-of-state patients and being able to exchange information outside of the state will be important as well. | July14, 2010, Bend Community Meeting Attendee | No change | The Plan states that interstate exchange will be a priority and related issues addressed during Phase 1. |
| Data Quality, Accuracy, Integrity | | | | |
| | Concerned about errors in her patient's EHR and how to make sure the info is correct. | June 28, 2010, Medford Community Meeting attendee | No change | The plan addresses how policies & procedures to ensure data accuracy/ integrity will be developed during Phase 1. |
| | As we get all these records linked together, is there going to be a verification of the accuracy of the record? What is the one true record? And who's liable for inaccuracies in the record(s)? | July 13, 2010, Coos Bay Community Meeting attendee: Dr. Bill Moriarty, CMO, Bay Area Hospital | No change | The Plan addresses how issues of data accuracy, integrity, and liability will be addressed during Phase 1. |
| Meaningful Use | | | | |
| | I would recommend noting that "meaningful use" is not a national mandate. If a qualified health care professional (which does not necessarily include all health care professionals who would be good candidates to take advantage of EHR implementation) elects not to take advantage of the incentive dollars, they are not required to meet "meaningful use" requirements. Also, if a qualified health care professional does not see Medicare patients, the "stick" associated with the incentives never comes into play (it is associated with a reduction in Medicare reimbursement). I would recommend other incentives. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change | Strategies to encourage EHR adoption and HIE for both eligible and ineligible providers will be explored continuously. |
| | Are there provisions in the Plan to help providers upgrade their EHR security software and/or hardware? | June 28, 2010, Medford Community Meeting attendee | No change: Already included through references to loan program under Medicaid P-APD. | There will be provider education and outreach through O-HITEC and the Medicaid HIT Planning efforts. |
| | Who can we contact or where do we go to initiate the process to get the incentive payments? | June 28, 2010, Medford Community | No change | There will be provider education and outreach through O-HITEC and the |

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| | | Meeting attendee | | Medicaid HIT Planning efforts. |
| | While payments for Medicare and Medicaid for meaningful use can be made as early as 2011 what is the cash flow and what is the process? E.G., what is the first month that a payment request can be made. Also is this calendar year or fiscal year based? Please elaborate? | Public input submitted to hitoc.info@state.or.us: Bob McGuirk | No change: Not directly related to Plan content; requested information is available through CMS. | There will be provider education and outreach through O-HITEC and the Medicaid HIT Planning efforts. |
| | What are the options/timeframe to exchange clinical care summaries with outside providers? | Northwest Portland Area Indian Health Board Meeting, July 12, 2010: Board member | No change: Refer to Operational Plan based on ONC PIN guidance. | Will be explained in Communications Plan through FAQs and other communication strategies. |
| | It appears that CMS changed the timeline for MU payments for Medicare. Where are you in terms of a timeline for determining Medicaid incentive payments? | July14, 2010, Bend Community Meeting Attendee | No change : Refer to timeline for Medicaid Payments as part of the P-APD MHIT planning process currently underway. | Will be explained in Communications Plan through FAQs and other communication strategies. |
| | For us, who provide commercial transportation for Medicaid clients, we need to verify that it is a Medicaid billable service for individual clients. | July14, 2010, Bend Community Meeting Attendee | No change : Refer to MHIT project. | No action required. |
| --e-Prescribing | | | | |
| | Another piece of the ePrescribing puzzle is that the pharmacies need to be participating in a drug data warehouse for the ability of a medication fill history to be possible (p 49). We have been pursuing this and even though all of the pharmacies, with few homegrown owned establishments, communicate electronically, they do not aggregate this data or share it externally. | Public input submitted to hitoc.info@state.or.us: Mary Moore, BACIA Liaison | No change. | As we address future MU criteria in Phase 2+, this is something we'll have to analyze and scope. |
| Finance | | | | |
| | He'd like to applaud Oregon for their HIMSS award. He sees a trend like in Utah A 35 A 37 claims processing- he encourages us to look at that as a potential source of financing. Look at the all payer claims database- they feel it will be a powerful transformative tool set. | June 17, 2010, HITOC Public Meeting Attendee: Tristan VanHorne, Ingenix | No change: This issue is adequately addressed in the AP section in Strategic Plan. | Refer to Finance Workgroup |
| | In terms of financial sustainability, the state should incorporate the costs of ongoing legal advisory | June 28, 2010, | No change. | HITOC staff will create a |

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| | services; a lot of organizations are paying a lot of money to get legal advice, and if the state could coordinate that it would be very helpful. | Medford Community Meeting attendee | | Legal Resource Toolkit during Phase 1. |
| | How do we reach out to other entities within our geographic community who don't have the resources to tie in with us, if we don't have the funds to provide to them? They are part of our community, so how do we address this? | July 13, 2010, Coos Bay Community Meeting attendee: Bob Adams, Bay Area Hospital | No change. | During Phase 1, HITOC will explore potential sources of funding (including a loan program) to assist with the costs of EHRs and interfaces. |
| | I don't have a clear picture of how the money flows and suggest that a diagram or further description be included. | Public input submitted to hitoc.info@state.or.us: Rod Meyer | No change. | Finance plan is being developed and will be proposed to ONC in February 2011. |
| | We are concerned regarding the discussion of financial sustainability. While we completely support the notion that any entity responsible for facilitating HIE must be financially sustainable, we are worried by the mention of potential fees and assessments on hospitals and other providers. We also note that the plan indicates the SDE will charge for some services. We certainly understand there is no free lunch, so to speak, but urge HITOC to consider other emerging administrative changes and financial burdens on health care providers, and avoid imposing fees or charges that serve as a disincentive for physicians to adopt and fully use an electronic health record (EHR) and participate in HIE. For many physicians, an electronic health record is a new and significant expense. The OMA fully supports these physicians obtaining an EHR but hope that any fees imposed will be either insignificant or tied to significant value back for the physician.<br>Request: We respectfully request that Betsy Boyd Flynn, OMA Deputy Executive Director, be invited to participate in any committees charged with evaluating the financial sustainability issue. | Public input submitted to hitoc.info@state.or.us: Gwen Dayton, JD, General Counsel, Oregon Medical Association | No change. | This issue is to be addressed by the Finance Workgroup and in the planning process for financial sustainability. |
| | On the finance piece, what amount are you contemplating will be needed? | July 8, 2010, Public Webinar Participant Input | No change Will be addressed by budget documents. | No action required. |
| | We strongly support the incorporation of the HB 2009 All-Payer, All Claims (APAC) Database into the Oregon HIE as mentioned on p. 27 of the HIE Strategic Plan Draft. We feel that the HIE Strategic Draft Plan would benefit by expanding its description of how OHA and HITOC will incorporate the APAC data. Part of the expanded description of APAC data use should consider how analytics drives value-add services for HIE stakeholders—in fact, we recommend this be added as a new topic to the "Potential HIE Funding Sources" section on p. 40-41.<br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Tristan Van Horne, Ingenix | No change<br>. | Refer to Finance Workgroup. |
| | We strongly support Oregon's goal to look beyond short-term funding sources and search for long-term sustainability solutions. Although short-term funding is advantageous for initial HIE implementation costs, long-term funding will enable the Oregon HIE to become financially independent and self-sustaining. We believe that Oregon should add "Evaluation of fees associated with administrative transactions between payers and providers and how this income/expense can be redirected" to its suggestions for specific financing sources for HIE:<br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Tristan Van Horne, Ingenix | No change. | Refer to Finance Workgroup. |

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| EHR | | | | |
| --Selection/ adoption | | | | |
| | I recommend grant or loan programs be implemented to assist small to medium sized providers (and rural providers) in the adoption of EHRs that meet the now finalized meaningful use requirements. Especially small practices are faced with paying for the software, the implementation, the conversion and staff training before realizing any benefit from the ARRA Medicare/Medicaid EHR implementation incentives. The lack of funds has already been noted as a barrier even with the availability of incentive dollars later this year and the beginning of 2011. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change . | During Phase 1, HITOC will investigate a potential loan program and will work with the philanthropic community to explore other assistance programs as part of our gaps strategy |
| | He's increasingly concerned about how this is evolving. The current system here is becoming voluminous- too much data, lots of useless data camouflaging useful data. Lots of errors. There are 200 certified products- Is there going to be any kind of uniformity of EHRs so that when you get that information it's useful? There's no data to support our lofty dreams, and you're asking providers to put in 14-16 hours of uncompensated time a week to enter that data. His concern is that he as a provider has no say with the vendor- once you buy a system you own it, and to change and buy another is to go bankrupt. Does the state have any sway or say with these vendors?- to tell them, if your product is no good we won't support this? | June 30, 2010, The Dalles Community Meeting attendee | No change: This issue will be partially addressed by the O-HITEC, and providing recommended /preferred lists of EHR vendors/ products. | Will require continued coordination with O-HITEC. |
| | She started a clinic from scratch 3 years ago; they changed their first EMR system. They're being dinged with costs constantly, such as paying for training sessions on still undefined MU requirements. She doesn't see any progress in vendor selection by O-HITEC. | June 30, 2010, The Dalles Community Meeting attendee | No change : This issue will be partially addressed by the O-HITEC, and providing recommended /preferred lists of EHR vendors/ products. | Will require continued coordination with the O_HITEC. |
| | They also just purchased a brand new system that was $15k, and have 2 medical providers. As the office administrator she doesn't see any benefit to the system. She doesn't think it has a great impact on the patient. She doesn't know how it's going to educate the patient. She's not bought on it, at all. | June 30, 2010, The Dalles Community Meeting attendee | Nochange. | Will require continued coordination with the O-HITEC, and the benefits of EHR/HIE will be part of the Communications Plan. |
| | The number one reason why we're trying to do what we're doing is because out of 8 industrialized nations, we're the lowest in terms of quality of care. He looked at the EMR system in Argentina and what great results they've had. | June 30, 2010, The Dalles Community Meeting attendee | No change. | No action required. |
| | 1. The specifics of a plan of technology from a provider of EMRs would help.<br><br>2. I represent employers in purchasing health insurance. I wish you could comment on cost of | June 30, 2010, The Dalles Community | No change. | The impact of EHR/HIE on reducing healthcare costs will be part of communications |

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| | EMRs to help bring down healthcare cost. We have fewer insureds again this year in Oregon. We will have higher costs for insurance each year forward. I would refer you to a study done by Deloitte CPAs on where funding for health reform is coming from – Medicare tax and health provider tax is 75% of funding. | Meeting attendee: Bob Beswick | | plan. |
| | Document is focused on current Adopters and does not seem to address the Individual Practitioner. However, the implicit expectation is that Individual Practitioners will adopt an EHR. Problems: Costs of EHR acquisition, support, maintenance and usage are high and likely to get higher.<br>If it is a goal for Individual Practitioners to have access to, use, maintain and integrate Patients into an EHR (e.g., Patient-Centric Healthcare), then the low-cost, commonly-available EHR is a necessity. 'Ability-to-pay-for-services' is not an appropriate basis for a 'commonly-available EHR'.<br><br>Suggestion: Two-track system:<br>1)Provider-backed EHR system that integrates Provider-specific EHR products and Services<br>2)Low-cost State financed basic EHR system covering basic services.<br>Decoupling allows Providers to modify and upgrade existing systems while retaining their desired features, functions and specialties. The State-backed system can be developed as a cost-efficient EHR covering basic care. The State Universities have abundant personal resources to accomplish this task. Both systems can be integrated efficiently at low-cost. Both can be available State-wide. The State system can service rural areas and Patients not serviced by Healthcare-Providers. | Public input submitted to hitoc.info@state.or.us: Dr Thomas Clark, Patient Measurement and Monitoring Corporation | No change | During Phase 1, HITOC will investigate a potential loan program to assist with the costs of EHRs and interfaces. |
| --Implementation | | | | |
| | There's been a report that says staffing efficiencies are not gained through the use of EMR. Staff need to be trained to effectively use an EMR. There is no way she can sit down and try to train her staff individually and teach them how to best use an EMR, and she can't afford to hire anyone to do it. She was reading the draft plan, and she doesn't see the practicality. | June 30, 2010, The Dalles Community Meeting attendee | No change | O-HITEC to provide support services in terms of training and optimization of EHR use. |
| | I do not believe the current data available supports claims made in the draft plan regarding the number of practices in Oregon actually utilizing an EHR. The data only indicates that an EHR has been purchased. It does not indicate it is currently being used or, as an example, only being used to schedule patient appointments. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change | Environmental scan will be updated periodically. |
| | He doesn't believe that we don't know if the incentive payments are adequate or not- don't we know the costs? He's been to a number of meetings where he's heard a decrease in actual patient care while they're implementing the EMR, but some say they don't recover even after 5 years. Why is this the time when we're trying to push forward a system when it's not ready? The products that are being produced haven't been designed with the physician in mind. Why can't we wait another 3-5 years until some of these products have worked through the bugs, instead of pushing | June 30, 2010, The Dalles Community Meeting attendee | No change Federal policy has directed that we move forward now. | Will require continued coordination with the O-HITEC. |

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| | them on doctors who are really trying to see patients. And we've already figured out really good [paper] methods and systems that work currently. He thinks now is a good time to work through the concepts, but not to push the products into the field before the beta testing is done. | | | |
| | Here in the US we don't invest much in primary care- they don't get compensated as well as specialty care, so if we invested more in primary care then we could invest more in EMRs and do all this. There are things HITOC/OHITEC can help with- how to take the money being provided and train staff- this is going to require more staff, not less staff. If HITOC could fund implementation training, that would be really helpful. You have all these millions to implement HIE. HITOC wants to build a net (the HIE), but the first step is helping providers effectively implement their EMR and train them to use them. We have to do that before we focus on casting the net. | June 30, 2010, The Dalles Community Meeting attendee | No change | HITOC is and will continue to coordinate with O-HITEC to ensure providers have sufficient training resources with and Workforce efforts through PCC and OHSU. |
| | It's not just the [EHR] system that you have to purchase; it's the security and firewalls as well that cost significantly more. Is it going to be useful to get a system, and is it going to be secure? | July 13, 2010, Coos Bay Community Meeting attendee: Tim Salsberry, CFO at the Bay Area Hospital | No change | Certified products will use federal security standards. |
| --Interfaces, connectivity, OHN/ Broadband | | | | |
| | He's had difficulty downloading information from his own EHR system- basic patient information. They don't have the technology to transfer images electronically. To meet the security and HIPAA requirements, you need a direct fiber link, which is expensive, and very burdensome on a small clinic. | July 13, 2010, Coos Bay Community Meeting attendee: Dean Smith, local oral surgeon | No change Broadband access via OHN is addressed in the Plan. | HITOC will continue to coordinate with OHN. |
| | Are we going to connect with OHN's hub in Portland? | July 13, 2010, Coos Bay Community Meeting attendee: Curt Carpenter, I.S. Director, Coquille Valley Hospital | No change | HITOC will continue to coordinate with OHN. |
| | The local Tribe just got an EHR and wants to exchange patient information with the Medical Center, but it's going to cost additional money to share it with Medicity [to interface]. Has the state moved to bring down interface costs with the vendors, or is there grant seed money to begin an exchange? The cost is prohibitive for the smaller, especially non-profit, organizations. | July 13, 2010, Coos Bay Community Meeting attendee: Bob Schmidt, Medical Center | No change | Will be examined as a possible Phase 2 service/offering. The Medicaid HIT project is exploring the possibility of some grant funding within their proposed plan to CMS |

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| | I am new with Intechgra and am working to better understand these concepts. Intechgra Database Solutions provides HL7 interfaces and integration engines for health care providers. We want to stay on top of new regulations. | July 13, 2010, Coos Bay Community Meeting attendee: Heather Borland, Intechgra | No change | Will be addressed by Communications Plan. |
| | I have some edits to the broadband section on page 77. I only had the PDF, so instead of tracking changes – retyped. I apologize if this makes it difficult to track the current version and one proposed. I've updated some information, and also clarified and connected some of the dots (I hope) a bit better – to make the story/message stronger and clearer.<br><br>Thanks for your consideration and offer to ask for input. | Public input submitted to hitoc.info@state.or.us: Kim Lamb, Oregon Health Network | Revisions have been made. | No action required. |
| | I'm located at the furthest South/West point in Oregon and come from the Medical Electronics Field and I am very interested in joining any group that's involved in covering the exchange and repository of Medical Records. We are already tied into high speed cable through Charter and also have access to faster fiber links that run up and down Hwy 101. | Public input submitted to hitoc.info@state.or.us: Bill Andrews Parameter Developments | No change | HITOC will continue to engage all Stakeholders in further planning and implementation phases. |
| | Our members raised the concern that the draft plan does not adequately address how to connect hospitals and clinics with long term care facilities, with tribal health centers, and with ancillary providers such as vision and dental clinics. We ask also HITOC to strengthen its commitment to providing a connection to state agencies requiring the submission of clinical data. Our members emphasized the great import of HITOC's support for and inclusion of small, independent hospitals and medical practices, and those in rural and remote communities lacking access to high-speed broadband connections. These entities face unique barriers to connecting to health information exchange, and could use HITOC's help in the form of outreach, education and technical assistance. | Public input submitted to hitoc.info@state.or.us: Robin Moody, Oregon Association of Hospitals and Health Systems | No change | Gap strategies will be addressed in ongoing planning. |
| | It is a financial burden on organizations to have vendors build these bridges. If we can adopt a collaborative approach that allows organizations to work with vendors to minimize the need to build interfaces. | July 13, 2010, Roseburg Community Meeting Attendee | No change | HITOC will continue to coordinate with the O-HITEC regarding purchasing strategies. |
| | My question is about practical ways to help medical providers refer their patients to evidence-based community resources related to chronic disease management programs and chronic disease prevention programs. Among community based providers, peer-lead programs, will EHR systems be structured so that a medical provider can refer to a community-based service and in which a community-based service can provide information back to provider(s)? Can you talk about that? | July 13, 2010, Roseburg Community Meeting Attendee | No change | In order for the patient to get the data, it needs to be able to be exchanged. PHRs become morepractical once the data is flowing. Phase 2+ and later MU criteria will drive toward this. |
| Technical Infrastructure | | | | |
| | Why don't we just use NHIN since it's already underway, rather than re-creating the wheel and developing our own HIE here in Oregon? | June 28, 2010, Medford Community | No change:: NHIN is a set of standards, | Refer to Technology Workgroup. |

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| | | Meeting attendee | services, and polices enabling the secure exchange of health information over the Internet. Health Information Organizations (HIOs) across the nation will use these standards and policies for connectivity with federal agencies and, likely, between states. Oregon's Strategic Plan aligns well with NHIN standards, and wherever possible, those standards will be adopted for intrastate HIE as well as for federal and state-to-state connectivity. | |
| | Standardize systems or have centralized exchange that will work with systems already in place. | June 30, 2010, The Dalles Community Meeting attendee | No change : The Strategic Plan outlines an approach based on adopting national, industry-accepted standards. Vendors have incorporated or are in the | Refer to Technology Workgroup. |

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| | | | process of incorporating these standards into their offerings. | |
| | Does/will HIE Strategic Plan address how statewide HIE will exchange health data with regional and provider HIE's and other health systems? This is critical. | July 8, 2010, Public Webinar Participant Input | No change. This is covered in the Strategic and Operational plans. | Refer to Technology Workgroup. |
| | Is the state working on developing its own IT solutions or vendor driven solutions? | July 13, 2010, Roseburg Community Meeting Attendee | No change. | Refer to Technology Workgroup. |
| | Some states have accomplished what we are talking about with technology by choosing a single vendor, who then brokers information among multiple organizations. In Oregon, there are three information exchange technologies that we are beginning to follow. How do you see this playing out in a competitive fashion with existing investments? | July14, 2010, Bend Community Meeting Attendee | No change. | Oregon's approach has been developed to support the investments made to the greatest extent possible. This will continue to be discussed in the Technology Workgroup. |
| | We've talked about this can be a workable system. The dynamic is about syncing local and community nodes with the state, and as we architect this system out, as long as the local nodes can communicate with other nodes, and the state nodes, we will be okay. | July14, 2010, Bend Community Meeting Attendee | No change. | Refer to Technology Workgroup. |
| | Are you looking at the state helping facilitate exchange across local HIOs? | July14, 2010, Bend Community Meeting Attendee | No change. This is covered in the Strategic and Operational plans. | Refer to Technology Workgroup. |
| Stakeholders | | | | |
| | The strategic plan does not define who the stakeholders are. There are references to different participants but no definition of stakeholder (who were explicitly defined as part of the HISPC project). | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change : The term "stakeholder" is used as a general term in the Plan, and is defined by common usage. | HITOC will continue to communicate and coordinate with all Stakeholders into further planning and implementation phases. |
| --Dentists | | | | |
| | Have dentists been left out of the Plan? Will there be any provisions to help them access the HIE or adopt/upgrade their systems? | June 28, 2010, Medford Community Meeting attendee | Language has been added to the plan to indicate the | HITOC will continue to look for opportunities to engage and support all providers with the long-term goal of bringing |

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| | | | ongoing need for coordination with many groups, including dentists and dental associations. | all providers in the state into the statewide HIE. |
| | One of our concerns is where does dental fit into this plan. How are rural dental providers going to be including into this process? What does this look like? | July14, 2010, Bend Community Meeting Attendee | Language has been added to the plan to indicate the ongoing need for coordination with many groups, including dentists and dental associations. | HITOC will continue to look for opportunities to engage and support all providers, with the long-term goal of bringing all providers in the state into the statewide HIE. |
| | What facilities are out there to support dentists? | July14, 2010, Bend Community Meeting Attendee | Language has been added to the plan to indicate the ongoing need for coordination with many groups, including dentists and dental associations. | HITOC will continue to look for opportunities to engage and support all providers , with the long-term goal of bringing all providers in the state into the statewide HIE. |
| --Long Term Care | | | | |
| | He's been involved in long term care for the last 30 years in Oregon. He's a consultant to the Oregon Healthcare Association. But he's coming here as an individual. He has personal concerns. He's delighted to hear that the feds see we're a progressive and innovative state. We are innovative in two important ways- as a demonstrator of sound planning processes- the phased approach and the recognition of differences across provider types and density across the state. However, his feeling is that the broad and robust planning process needs to give more attention to substantive priorities about providers and patient care, in addition to methodologies. Considering Blumenthal's priorities- he feels we haven't given full attention to the values stated- care coordination- we've omitted a substantial sector, the sector that can do the most to save lives and promote cost effectiveness, that is Long Term Care. The potential cost effectiveness and saved lives from facilitating proper patient transitions- consider what EMRs can do to reduce the | June 17, 2010, HITOC Public Meeting Attendee: Mike Saslow | The Strategic Plan has been revised to better reflect the importance of and incorporate long term care. | Continued communication and coordination with all Stakeholders, including the LTC community, will continue into further planning and implementation phases. |

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| | admissions from prevention programs and chronic long term care programs. Think what can be done to reduce hospital admissions. Think of what EMRs can do to reduce hospital readmissions. Long term care- nursing homes, foster care, in home care, etc. The third reduction- EMRs has the potential to reduce hospital lengths of stay, if there were information garnered prior to hospitalization. These are some of the cheapest ways to cut costs. But the planning process hasn't talked about this. There has not been anywhere near adequate participation by long term care providers and associations, it doesn't need to continue that way. Some things can be done relaitvely soon: the active participation of long term care providers/associations, along with the HIOs, providers, and hospitals, in surveying the current EMR utilization in both directions. We could do that relatively soon. Having explicit plans to do this would add attractiveness at the federal level. And we need to do that. We need to submit an innovative proposal, in terms of phasing and working with a diverse group of stakeholders. But we also have an asset in Oregon- a highly innovative system of LTC, only 1/3 of our medicaid clients that are eligible are in nursing homes, 2/3 are in the community. We have providers that are sensitive to the need to prolong independence or minimize dependence for as long as possible. It's time for us to think constructively and collectively on how best to maximize savings and saved lives, and attractiveness to the federal government. His wife recently had a stroke and is recuperating and as she moves around in care around the system, it's amazing how much hand carrying of information has to be done. So much time is spent getting the information to where it needs to be. | | | |
| | Also, a really important group that has been left out of the federal money is nursing homes, adult foster care [LTC] and they are having to cover the costs of EMRs all by themselves, and as we moved forward we need to strategize how to address that. | June 30, 2010, The Dalles Community Meeting attendee | The Strategic Plan has been revised to better reflect the importance of and incorporate long term care. | There is some money now available through the federal Patient Protection and Affordable Care Act. Continued communication and coordination with all Stakeholders, including the LTC community, will continue into further planning and implementation phases. |
| | First and foremost among OHCA's concerns with the Strategic and Operational Plan is the lack of discussion or consideration of LTC providers. OHCA strongly encourages the HITOC to attempt to incorporate some discussion of the long term care system in Oregon and how it can be incorporated into the Strategic and Operational plan. OHCA believes that long term care providers can be a key player in assisting HITOC and the SDE in achieving its goals for healthcare system improvement. In order to assist the HITOC in its efforts to develop material on LTC providers in Oregon, I have drafted the following short narrative on the background of leading innovation undertaken by Oregonians in the private and public sectors which has caused Oregon to be a national leader in the LTC marketplace. [Please see attachment for further details]<br><br>In addition to urging the HITOC to include LTC as a coequal provider in its proposal to the ONC, OHCA would also like to submit some concepts for how it and its Membership can be directly involved in Oregon's Strategic and Operational Plan. OHCA hopes to be directly involved as a partner in the effort to leverage all of the various public and private resources which will encourage all providers throughout the healthcare continuum to adopt inoperable HIT and ultimately | Public input submitted to hitoc.info@state.or.us: Joe Greenman, Oregon Health Care Association | The Strategic Plan has been revised to better reflect the importance of and incorporate long term care. | Continued communication and coordination with all Stakeholders, including the LTC community, will continue into further planning and implementation phases. |

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| | participate in Oregon's HIEs.<br><br>[Please see attached document for full submission of comments and suggestions.] | | | |
| | We appreciate the wealth of information, summary of issues, and thoughtful strategies that are contained in the plan particularly given the extreme complexity of the effort ahead for the exchange of information to improve the health and health care of Oregonians. It is our strong belief that the long term care providers and stakeholders need to play a strong role in those efforts. Just as Congress recognized the importance of including long term care (LTC) as part of the nation's health care reform efforts in passage of the Patient Protection and Affordable Care Act, we believe long term care needs to be at the table in the planning and development of activities related to Health Information Technology, Health Information Exchanges and Electronic Health Records in Oregon.<br>The case for including long term care is well articulated in the *Roadmap for Health IT in Long Term and Post Acute Care (LTPAC)1*, published by the LTPAC HIT Collaborative that includes our national organization the American Association of Homes and Services for the Aging and the Center for Aging Services Technologies.<br><br>We believe that:<br>▯ LTC should be included in state HIT policies and programs designed to expand the adoption, use and exchange of health information for Oregonians.<br>▯ LTC providers should be supported in the adoption and use of HIT, EMRs and EHRs including grants and no to low-interest loans for HIT planning and implementation.<br>▯ LTC providers and vendors should be included and participate in Oregon HIEs<br>▯ Care coordination and continuity of care should be promoted through the use of HIT during transition of care periods and for electronic prescribing (e-prescribing)<br><br>The Alliance and our members stand ready to participate in such efforts. We are forming a technology committee to focus on provider HIT, EHR needs, readiness, and for continued involvement/sharing of information related state/regional HIE activities. Please let us know what planning groups/initiatives are being formed in the next phase of your planning efforts and who/how we may contribute to the process. Thank you for the opportunity to comment. We look forward to working with you on this important endeavor.<br><br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Ruth Gulyas, Executive Director, Oregon Alliance of Senior & Health Services | The Strategic Plan has been revised to better reflect the importance of and incorporate long term care. | Continued communication and coordination with all Stakeholders, including the LTC community, will continue into further planning and implementation phases. |
| --Tribes | | | | |
| | In the Strategic Plan, it mentions the Tribes having sites in 11 counties in Oregon, but the Tribes provide services in many more than 11 counties- this should be noted. | Northwest Portland Area Indian Health Board Meeting, July 12, 2010: Board member | Revisions have been made according to the suggestion. | No action required. |
| --Payers | | | | |
| | Please take into account the legitimate business needs of the various stakeholders. Unless and until there is high-quality government-provided healthcare, we need insurers and brokers. Previously, | Public input submitted to hitoc.info@state.or | No change. | HITOC will continue to communicate and coordinate with all Stakeholders into |

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| | pharmaceutical companies were in the hot seat. In the current climate, it seems to be the insurers. Just as drug companies will not take the enormous risks necessary to develop a drug unless they have a reasonable hope of profit, neither will insurers provide coverage at a loss.<br>The trick is managing the needs of all stakeholders in our for-profit system.<br>Besides asking that you keep all stakeholder needs in mind, I have no specific suggestion. But I thank you for the honest effort you are making to be proactive, and hope it will be successful. | .us: Sandra Shotwell | | further planning and implementation phases. |
| | Ensuring that health plans and other payers are equal partners in access for care management purposes to clinical information being exchanged could accelerate Oregon's attainment of its goals…"<br><br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Michael Cochran | No change. | HITOC will continue to communicate and coordinate with all Stakeholders into further planning and implementation phases. |
| --Patients | | | | |
| | In reviewing the draft plan and listening to the conversation at the last HITOC meeting, it is clear that the plan has been drafted without enough attention paid to the needs and concerns of people served by our health and provider systems. While I understand the need to address the Federal priorities first, I think that the plan can be strengthened by creating "place-holders" for the additional planning work that needs to be done around patient-centered care. | Public input submitted to hitoc.info@state.or.us: David Greenberg, Ph.D. President and CEO, Planned Parenthood Columbia Willamette | No change. | Refer to Consumer Advisory Panel. |
| --Foster Children | | | | |
| | Comment: another potential for health IT is with Oregon's foster children. Being able to access, locate, and retrieve medical information on foster children from parents, care givers, and other would be really valuable as well. Especially as these children move in-and-out of the foster system. | July 13, 2010, Roseburg Community Meeting Attendee | No change. | This is a central aim of the Medicaid Transformation Grant, with which HITOC is closely coordinating. |
| --Rural providers | | | | |
| | 1. For rural providers, what is the plan to help provide administrative support? Is it in the incentive plan or something separate? Rural providers are already overwhelmed and this is going to be very difficult.<br><br>2. Also, what is the plan for dissemination of this information into rural areas? | July 13, 2010, Roseburg Community Meeting Attendee | No change. | HITOC will continue to communicate and coordinate with all Stakeholders, including rural providers, into further planning and implementation phases. Coordination with O-HITEC on technical assistance services and provider |

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| | | | | outreach will be ongoing. |
| --Other organizations | | | | |
| | What attempt is going to be made to partner with the Oregon HIMSS? | June 28, 2010, Medford Community Meeting attendee | No change. | HITOC will continue to communicate and coordinate with all Stakeholders into further planning and implementation phases. |
| | Are you here to represent school-based health centers? Have you been meeting with these organizations as well? | July14, 2010, Bend Community Meeting Attendee | Strategic Plan has been revised to explicitly make reference to coordination with SBHCs. | HITOC will continue to communicate and coordinate with all Stakeholders into further planning and implementation phases. |
| --The VA | | | | |
| | Are we seeing any greater willingness on the part of the VA to share information? | July 13, 2010, Coos Bay Community Meeting attendee: Dr. Bill Moriarty, CMO, Bay Area Hospital | No change : Coordination with the VA and other federal agencies and programs is addressed in the Plan. | HITOC will continue to communicate and coordinate with all Stakeholders, including the VA, into further planning and implementation phases. |
| --HIOs | | | | |
| | I also wanted to correct a typo on the HIE Strategic Plan Draft. On page 27 the list of HIOs had BACIA as Bay Area Community *Health* Agency. It is Bay Area Community *Informatics* Agency. Just thought you would like to know of this correction. | Public input submitted to hitoc.info@state.or.us: Mary Moore, BACIA Liaison | Revision has been made accordingly. | No action required. |
| | Kaiser has been working on this technology for quite some time. Have you worked or consulted with Kaiser on how they have done what they have been able to accomplish? | July14, 2010, Bend Community Meeting Attendee | No change : All operational HIOs have been consulted and will be part of the ongoing HIO Executive Panel. | HITOC will continue to communicate and coordinate with all Stakeholders, including HIOs, into further planning and implementation phases. |
| --Public Safety | I was happy to see that the plan encourages both public and private entities to participate in the information exchanges. There was really no mention of the public safety partners anywhere in the document, however. Without the inclusion of jails and prison, you may not get all the information you want. | Public input submitted to hitoc.info@state.or.us: Liv Jenssen, Multnomah County, Dept. of | No change. | HITOC will continue to communicate and coordinate with all Stakeholders, including Public Safety partners, into further planning and implementation phases. |

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| | | Community Justice | | |
| PHRs | | | | |
| | We also encourage HITOC to adopt the notion of a web-centric model. This would allow patients to access their own personal health records, research health related issues from "trusted" websites, and allow the patient to partner with their health provider in developing their own treatment plan. This would not necessarily require additional software, and could be fee-based or free.<br><br>We urge HITOC to consider the patient as the repository of their health data. Large organizations, such as Google, are providing free tools for patient to access their personal health records. The challenge that we see, is that by allowing these kinds of relationships, we leave patient data open to data mining if we are not explicitly clear that the patient owns the data. Patients could decide whether to hold their personal health records individually, or to store them with a private or public entity. It would be the patient's choice – similar to setting up a bank account.<br><br>One additional option to consider is the use of a "Smart Card." We think that the Military is using these now. It includes the Patient's ID plus a summary of issues the provider needs to know (like drug allergies, current prescriptions, past surgeries and treatments, etc.). This could be rolled out on a State level, Regional level or Federally. It would be like carrying a credit card with additional healthcare information. | Public input submitted to hitoc.info@state.or.us: Community Leadership Council of the Archimedes Movement | No change : PHRs are addressed on page 91 of the Strategic Plan, and patient-centered care is addressed in HITOC's cover letter. | HITOC will continue to explore the role of PHRs in the statewide HIE as the market develops. |
| | I would recommend proposing legislation that provides for the privacy and security of health information stored in a personal health record (PHR) such as Google Medical. Currently the only requirement under federal and state law relates to breach notification. Only PHR vendors who are providing a PHR to an individual on behalf of a covered entity with an EHR is further covered because, pursuant to the HITECH Act, those vendors are now considered business associates. This leaves all other PHR health data at risk with no statutory requirement that the privacy and security of the patient/consumer's data be protected. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change | The Plan states that all applicable legislation will be examined, and any necessary. |
| | In order to get people really excited about HIE, PHRs are key. | June 28, 2010, Medford Community Meeting attendee | No change : PHRs are addressed on page 91 of the Strategic Plan, and patient-centered care is addressed in the Preamble. | HITOC will continue to explore the role of PHRs in the statewide HIE as the market develops. |
| | She'd like to ask that the goal that patients have safe secure access to their personal health information is made more explicit and embedded in the plan. There are instances where hospitals and providers are citing proprietary reasons for not releasing or sharing information with their patients. | June 30, 2010, The Dalles Community Meeting attendee | Patient access to their PHI is explicitly addressed and guaranteed in principle 1 of the | Refer to Legal and Policy Workgroup. |

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| | | | HHS Privacy and Security Framework, in the Strategic and Operational Plans. | |
| | There are many Oregon wide requirements/ functions that can only handled by the statewide HIE. E.g., Personal Health Record - Oregonians move between providers and HIE's - without a central PHR the health records will be fragmented and localized to certain subset of information, with no sharing of PHR's across HIE's... | July 8, 2010, Public Webinar Participant Input | No change : PHRs are addressed on page 91 of the Strategic Plan, and patient-centered care is addressed in the Preamble. | HITOC will continue to explore the role of PHRs in the statewide HIE as the market develops. |
| Role of the State, SDE, REC/OHITEC; Service Offerings | | | | |
| | Looking ahead as we transition this going to a non-profit, she hopes the same kind of accountability measures that are applied to the state (public meetings, etc.) will be applied to the non-profit. | June 30, 2010, The Dalles Community Meeting attendee | No change. | The legal structure of the non-profit SDE will be determined during Phase 1. |
| | I am somewhat concerned in regards to the "leanest possible staffing" terminology (page 66) and how it may be interpreted and result in staffing that cannot meet the obligations of the SDE. | Public input submitted to hitoc.info@state.or.us: Rod Meyer | Revisions have been made to reflect staffing increases for HITOC and SDE. | No action required |
| | While the operational and technical duties required to achieve robust health information exchange are mainly the responsibility of community hospitals and clinics under HITOC's draft plan, we support HITOC's stated role to support Oregon communities in planning and executing health information exchange. As part of its central service offerings, we encourage HITOC or its state-designated agency to offer a gateway to Nationwide Health Information Network (NHIN). | Public input submitted to hitoc.info@state.or.us: Robin Moody, Oregon Association of Hospitals and Health Systems | No change : Has been addressed by revised draft of Strategic and Operational Plans. | Refer to Technology Workgroup. |
| | Why the HIE Strategic plan focuses only on "Light Central Services"? From my prespective, the "Central Services" are key. Otherwise we will contine on the path we maybe on - everyone creating whatever for the narrow purposes... | July 8, 2010, Public Webinar Participant Input | No change : Was determined by the Workgroup that Oregon would adopt "light touch". | The Plans specify the ongoing evaluation of additional desired central services as part of the business strategies within Phase 2. Refer to Technology Workgroup. |
| | Is there going to be any effort, for the new public corporation or O-HITEC, to use the new data to | July 13, 2010, | Revised quality | Will be explored as a potential |

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| | drive outcomes, contain costs; align with Triple Aim efforts? | Roseburg Community Meeting Attendee | section addresses some of these issues. | role/ service offering of the SDE as these are formulated during Phase 1. Budget includes funding for clinical quality pilots in Phase 1 and an ongoing quality program in Phase 2. |
| | What is the REC's role in establishing an HIE/HIO in the state? | July 14, 2010, Bend Community Meeting Attendee | No change. | HITOC will continue to coordinate and communicate with the REC regarding its role in statewide HIE. |
| | So, I don't see the REC supporting 20-25 EHRs? Is this correct? | July 14, 2010, Bend Community Meeting Attendee | No change. | The strategies of O-HITEC to determine a reasonable and sustainable approach to technical assistance services are monitored by HITOC and ongoing coordination with O-HITEC on communications to stakeholders about those strategies will continue. |
| | I look forward to the "facilitation by the state" to make sure that we are on track in Oregon and within our communities. | July 14, 2010, Bend Community Meeting Attendee | No change. | HITOC will continue to communicate and coordinate with all Stakeholders into further planning and implementation phases. |
| Public Health | | | | |
| | Concern about there not being public health representation on the HITOC- only 1 member. She doesn't hear a lot of talk about how public health is going to get information to make population health decisions- how are they going to get that data? Why is this not more adequately addressed? | June 30, 2010, The Dalles Community Meeting attendee | The content pertaining to Public Health has been revised to more clearly address the strategy. | HITOC will continue to communicate and coordinate with Public Health to achieve common goals. |
| | Within their county they don't have their own public health department, so they've contracted to have people come in and do immunizations, etc. and so she thinks it's very important to incorporate public health into the state HIE system. | June 30, 2010, The Dalles Community Meeting attendee | The content pertaining to Public Health has been revised to more clearly address the strategy. | HITOC will continue to communicate and coordinate with Public Health to achieve common goals. |
| | We are currently about to engage in a Social Security Association grant where we will be working | Public input submitted to | The content pertaining to | HITOC will continue to communicate and coordinate |

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| | with our software vendor to transmit CCD documents to the SSA. If we can accomplish this transmition of information, we would also be able to transmit immunizations and public health reports if the public health department was able to receive it. | hitoc.info@state.or.us: Mary Moore, BACIA Liaison | Public Health has been revised to more clearly address the strategy. | with Public Health to achieve common goals. |
| Quality Reporting & Improvement | | | | |
| | Oregon could more aggressively and explicitly plan to synchronize the HIE with Oregon's quality improvement initiatives discussed on pages 54-56 of the draft plan.<br><br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Michael Cochran | No change. | HITOC will continue to coordinate with quality improvement initiatives and OHA quality improvement goals. Budget includes funding for clinical quality pilots in Phase 1 and an ongoing quality program in Phase 2. |
| | Quality data collection<br>The OMA supports efforts to measure and improve health care quality and thus supports HITOC's statements regarding use of an EHR to collect important quality data. With the usual but important cautions that we need to make sure we collect meaningful data that physicians are reasonably able to provide, the OMA is here to help.<br>Request: The OMA would like to discuss with HITOC the potential role of the OMA in facilitating quality data collection. | Public input submitted to hitoc.info@state.or.us: Gwen Dayton, JD, General Counsel, Oregon Medical Association | No change. | HITOC will continue to coordinate with quality improvement initiatives, and will conduct clinical quality pilots in Phase 1 to ensure strategies are manageable to providers. |
| | A concern that I've had, for awhile, is that everyone is looking at achieving MU, but we aren't looking at metrics on how we are going to really improve health care. Metrics that will show us that we are really making a difference. What is your response to that? | July14, 2010, Bend Community Meeting Attendee | No change. | OHA both through HIE and other avenues will continue to develop metrics to reach the goals of health, increased quality and lower cost. |
| | We are not going to have relationships with a number of partners. I've got to get my doctors electronic, period. I need to know what data is really going to be useful to improve patient care, to improve what we are doing now. It doesn't have to be at the state level but at least at the regional level. | July14, 2010, Bend Community Meeting Attendee | No change. | OHA, HITOC and O-HITEC will be sharing best practices. |
| Performance Evaluation & Feedback; Accountability; Triple Aim | | | | |
| | Feedback system to measure success. | June 30, 2010, The Dalles Community | No change : Addressed in the Evaluation | Will explore how to implement this mechanism during Phase 1. |

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| | | Meeting attendee | section of the Operational Plan. | |
| | The plan is clear in stating Oregon's goals. However, it isn't at all clear how the proliferation of health information technology will actually improve patient care or reduce health care expenses. I find this to be an issue with most of the documents I've reviewed at all levels and not just Oregon's plans. Because the Congress made certain decisions to not truly reform our health care delivery systems, I understand that overlaying technology on our fragmented systems will make it really hard to achieve our overarching goals. However, I encourage all of us who are interested in quality improvement and cost containment to continue to push ourselves to match our goals to our actions. | Public input submitted to hitoc.info@state.or.us: David Greenberg, Ph.D. President and CEO, Planned Parenthood Columbia Willamette | No change. | HITOC agreement that the goals of improved quality, improved health and lower costs needs to be the focus. Will be addressed in the Communications Plan. |
| | We encourage the inclusion of a HIT Ombudsman, or addition of a Complaint/Audit capacity. Data is overwhelming, especially if it potentially includes information on what is covered, what is paid for, etc. The system should be easy for patients to navigate and understand, and when there are errors or abuses identified an independent, non-biased office should be available for reporting. | Public input submitted to hitoc.info@state.or.us: Community Leadership Council of the Archimedes Movement | No change. | The Plan states that an auditing system will be established, and that the potential role of an Ombudsman will be explored during Phase 1. |
| Requirements, Standards, and Accreditation | | | | |
| | The document identified using NHIN standards for the technical implementation of the data exchange. This works when we are talking about health organizations, but public safety uses NIEM standards for data exchange. How different are NIEM and NHIN? If the standards do not align, it may be difficult to get information from the public safety systems. For example, we are currently intending to share eligibility and claims information between a vendor and MCSO using NIEM standards.<br><br>I have a concern about the statement on page 45 that HITOC does not want to wait for federal guidelines for standardizing HIPAA transactions, but wants to take the lead. We face the risk of incurring large costs to rework the technology we develop if we do not have the federal guidelines, or at least the feds involved in the development of our guidelines. | Public input submitted to hitoc.info@state.or.us: Liv Jenssen, Multnomah County, Dept. of Community Justice | No change. | Refer to Technology Workgroup. Section on page 45 refers to the Administrative Simplification Committee's recommendations for DCBS.The planning for HIE assumes the use of federal standards. |
| | Do providers/clinics/groups have an option? Maybe they don't have a big Medicare population, and they don't want to spend that money- is this going to be mandated? If it's not mandated, that seems like a big hole in the plan- if there are providers who are not part of the HIE, you'll have an incomplete picture. | June 30, 2010, The Dalles Community Meeting attendee | No change. | HITOC will continue to look for opportunities to engage and support currently ineligible providers, with the long-term goal of bringing all providers in the state into the statewide HIE. |

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| | I would recommend including incentives for HIOs to become certified. Often the stick approach is not effective and, at this point, I did not note any incentives for HIOs to expend the funds to become interoperable. EHR interoperability will not necessarily lead to HIO interoperability. | Public input submitted to hitoc.info@state.or.us:Chris Apgar, Apgar & Associates, LLC | No change : The Plan states that accreditation will be piloted, then implemented, to ensure interoperability, and security. | Will be addressed as the Accreditation Program is developed during Phase 1. |
| | Do you foresee the recommendations/guidelines coming out of HITOC's accountability/oversight workgroup becoming part of Oregon statute? | July 13, 2010, Coos Bay Community Meeting attendee: Bob Adams | No change. | Refer to Legal and Policy Workgroup. |
| | Oregon specific?<br>On a different note, we support the references in the plan to make implementation of EHRs and health information exchange specific to Oregon, because we are unique in some ways, but don't really understand what that might mean. Aside from building on the existing nascent HIEs in place, how will Oregon's implementation of EHRs and health information exchange be different than other states? | Public input submitted to hitoc.info@state.or.us: Gwen Dayton, JD, General Counsel, Oregon Medical Association | No change. | Potential Oregon- specific standards may be explored if and when they are deemed necessary throughout the phases of planning and implementation. |
| | HIE participant certification program<br>The OMA supports HITOC's efforts to develop HIE interoperability standards. We hope that these standards will accommodate use of an interoperable EHR by all physicians, including rural physicians, and are glad to offer our assistance to accomplish this goal. | Public input submitted to hitoc.info@state.or.us: Gwen Dayton, JD, General Counsel, Oregon Medical Association | No change. | Refer to Technology Workgroup. |
| | We need to ensure that as systems develop and vendors put forward products, we want to ensure that there is interoperability and that we can have bi-directional exchange of personal health information. | July 13, 2010, Roseburg Community Meeting Attendee | No change. This is to be addressed by the use of federal standards for HIE, federal and HIO accreditation. | Refer to Technology Workgroup. |
| | Question about certification process. What does accreditation mean and how is an organization | July 13, 2010, | No change. | The Plan states that an |

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| | certified? Also curious about the entity that will be doing the certification? | Roseburg Community Meeting Attendee | | accreditation program and all related details will be developed during Phase 1. |
| | There is a naivety at the federal level in what we can actually achieve and accomplish within the proposed timeline and with resources available. | July14, 2010, Bend Community Meeting Attendee | No change : The Plan communicates realistic timelines and resource needs to the ONC. | A sustainable finance plan will be developed during Phase 1. |
| | It would be nice to have standards that we can focus early on. Such as local data centers where we are going to store this information. | July14, 2010, Bend Community Meeting Attendee | Revised language around technical implementation now included in the plan. | Refer to Technology Workgroup. |
| | It is going to be a local solution. We are going to have to make sure that the state standards are adopted and integrated into local solutions. The approach so far is right on in terms of Oregon. I think there is a lot that we can do locally to find solutions. Acknowledges the great work and product reflected in the strategic plan. | July14, 2010, Bend Community Meeting Attendee | No change. | Implementation parameters and operationalization of standards will be developed with workgroups and feedback from local stakeholders. |
| | I recommend taking into account existing regulatory mandates that will impact the healthcare industry in Oregon and nationally, reducing dollars available for HIT expansion (such as implementation of the 5010 transaction set by 2012, the implementation of ICD 10 diagnostic codes by 2013 and healthcare reform requirements). | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change. | The Plan states that all applicable federal and state laws will be examined during Phase 1. |
| Administrative Simplification | | | | |
| | Standard electronic transactions<br>Regarding the standardization of electronic transactions, it appears HITOC's goals are aligned with the work of the Health Leadership Council Administrative Simplification Committee. The OMA is actively engaged in this effort and, thus far, is supportive of the general direction. We are glad HITOC is aligning with others on this issue rather than going a different path. | Public input submitted to hitoc.info@state.or.us: Gwen Dayton, JD, General Counsel, Oregon Medical Association | No change. | The Plan reflects the recommendations made by the Administrative SimplificationCommittee. , and HITOC will continue to coordinate with all interested parties regarding administrative simplification. |
| | I would appreciate a closer review of the administrative simplification section of the draft strategic plan –<br>7. Some of the recommendations are already mandated by federal rule and have been since | Public input submitted to hitoc.info@state.or.us: Chris Apgar, | No change. | The Plan reflects the recommendations made by the Administrative Simplification Committee and |

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| | October 2003<br>8. Some are not necessarily in compliance with federal law<br>9. Some impose a potential significant burden on small to medium sized health care organizations<br>10. Why is the HITOC recommending adoption and further amendment of Minnesota's companion documents for the 5010 code set given the Oregon healthcare industry developed companion documents for all HIPAA transactions in 2002 to 2003 and are freely available on the Web (http://www.oregonhipaaforum.org/Page.asp?NavID=70) – it would seem appropriate to look to what Oregon has created for Oregon first before looking to another state where there will be an added requirement to adopt the documents to Oregon's environment and redact requirements specific to the healthcare environment in Minnesota | Apgar & Associates, LLC | | HITOC will continue to coordinate with all interested parties regarding administrative simplification. |
| Implementation, Timing/ Phasing, and Workgroups | | | | |
| | I would like to suggest that there be a high level ballpark estimate of timing (dates) for Phase 1 and Phase 2 - including caveats that would prevent or affect those estimated targets. | Public input submitted to hitoc.info@state.or.us: Rod Meyer | Language clarifying dates are included in the Strategic and Operational Plans. | The Risks and Mitigations Table included in the Operational Plan reflects the HITOC strategies. |
| | Under this draft plan for HIE, many of the most critical decisions are to be made over the course of the next two years. These decisions include selecting an HIE governance and operational entity to implement light centralized exchange services, and choosing a sustainable financing model. We look forward to the opportunity to offer future comments and input on these topics as they arise. | Public input submitted to hitoc.info@state.or.us: Robin Moody, Oregon Association of Hospitals and Health Systems | No change. | HITOC will continue to communicate and coordinate with all Stakeholders, including the OAHHS, into further planning and implementation phases. Applications to the Phase 1 workgroups are encouraged. |
| | Can you share how HITOC plans to form WGs to help formulate the next steps in planning: Technology - Standards, Common Services WG? | July 8, 2010, Public Webinar Participant Input | No change | Workgroups will be chartered and the application process will be confirmed by HITOC at their August meeting. |
| | What is the selection process and how do we nominate members to the workgroups? | July 8, 2010, Public Webinar Participant Input: Wayne Manuel | No change : part of the Operational Plan and/or announced via the HITOC meeting in August. | Workgroups will be chartered and the application process will be confirmed by HITOC at their August meeting. |
| General HIE, | | | | |

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| General Approach, General Comments | | | | |
| | Throughout the document we kept asking what does health services include. Does it mean specifically physical health or does it include behavioral health; developmentally disabled. There are many things related to health that are covered by Medicaid/Medicare as stated at the end of the document; we thought it would be helpful to define at the beginning what Health Services the HIE will include.<br><br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Liv Jenssen, Multnomah County, Dept. of Community Justice | Clarifying language in Strategic and Operational Plans about initial services to be included as required by ONC. | Refer to Technology Workgroup. |
| | I would appreciate clarification regarding HIE. HIE encompasses transmission of data between two organizations (point-to-point) as well as through a RHIO or HIO. HIE is already widespread in this state but much of it is point-to-point. Just concentrating on HIE at the RHIO or HIO level misses what needs to be not only organizational requirements but increases in organizations' comfort level in exchanging data through a RHIO or HIO. Mistrust related to patient data exchange between providers in non-emergent situations was found as a HISPC project outcome to be a significant barrier nationally and in Oregon and really has not been addressed to date. | Public input submitted to hitoc.info@state.or.us: Chris Apgar, Apgar & Associates, LLC | No change. | Refer to Legal and Policy Workgroup. |
| | To us the plan seemed to be more of a research outcomes document than a plan. It outlines HIT efforts throughout the state and briefly how they may interact with an HIE. It repeatedly describes the mission statement level goals of the initiative and a handful of guiding principals. It talks about potential future funding sources and throws out the names of some standard secure transmission and interface protocols. It also makes a point of repeatedly pointing out why you really can't develop any firm plans at this point.<br><br>In short, we feel that this plan doesn't say much beyond "here's what we have been doing something with the money you've already given us". We do think there's value in what you've done so far, we just don't think the document constitutes a "plan" as we understand the definition of "plan".<br>Some suggestions for improvement could include:<br><br>• A glossary of terms for the whole document.<br>• Some form of a time line, even without any actual dates, would be helpful. It would be nice to have a planned chronology of tasks. In BHIP we like to use Seasons instead of actual dates. :-)<br>• A few slight updates to the BHIP description may be in order as well, please see below.<br><br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Ben Kahn, Behavioral Health Integration Project | Glossary has been added, time line is included in the Operational Plan. Revisions have been made to the Behavioral Health Integration Project language in the Strategic Plan according to the third bulleted suggested in the submission. | No action required. |
| | They're grateful to the HITOC staff & SWG for their work. Oregon hospitals and OAHHS are excited about the prospect of expanding HIE throughout the state. Our hospital CIO technical | June 17, 2010, HITOC Public | No change. | No action required. |

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| | advisory committee will be meeting next week to review the plan. | Meeting Attendee: Sunny Sapra | | |
| | The appendices as listed on page 93 were not included, I am assuming that they can be found on the HITOC website, but haven't checked yet. | Public input submitted to hitoc.info@state.or.us: Rod Meyer | No change : the appendices have been made available to the public via the website. | No action required. |
| | We support HITOC's phased approach to health information exchange planning, recognizing that federal rules have yet to adequately define many of the details of this work. We also support the plan to empower community leadership in the formation of local and regional health information organizations, as trust and strong working relationships among local providers are requisites for successful health information exchange. We are supportive of HITOC's envisioned role as a standards-setting body for clinical messaging and other elements of HIE operations, and of its envisioned communication and coordination roles. A lack of clear and comprehensive exchange standards will stymie progress toward statewide and interstate health information exchange, and drive up costs for all parties involved.<br><br>Oregon hospitals are excited about the prospect of improved clinical information sharing, which we recognize leads to enhanced clinical quality, reduced health care costs, and better population health. Our overarching vision for health information exchange is one in which useful, accurate medical information efficiently follows patients among all sites of care, where it can be easily retrieved and navigated for informed clinical decision making. Our hospitals acknowledge HITOC's draft plan places much of the responsibility for initiating health information exchange onto local communities, and they have expressed a strong willingness to do the work necessary to realize this noble goal. | Public input submitted to hitoc.info@state.or.us: Robin Moody, Oregon Association of Hospitals and Health Systems | No change. | Standards and a Legal Toolkit are high priorities for development early in Phase 1, and HITOC will continue to communicate and coordinate with all Stakeholders throughout the continued planning and implementation phases. |
| | This is from my perspective, which is a hospital perspective. We are already in implementation mode already. So, with some caution, how is the strategic plan from an IT perspective going to provide value and gain benefit? How does the strategic plan integrate into what is already going around HIE in various communities? Getting technology to mature to achieve our strategies is a challenge. We are in change management for the next 5 years. | July 13, 2010, Roseburg Community Meeting Attendee | No change. | Refer to Technology and Finance Workgroups. |
| | Are we including the Practice Management Systems (PMS) in the 65%? | July14, 2010, Bend Community Meeting Attendee | No change. | The 65% refers to EHRs. |
| | I get the same message, that this strategy is a top-down approach. There is a gap in that how and when are we going to get the bottom and the top to meet? | July14, 2010, Bend Community Meeting Attendee | No change required. | Refer to Communications Plan to address the central role of local providers, communities, and HIOs in the overall Strategic Plan and the market-driven approach being taken. |
| Other HIT/ | | | | |

| Telemedicine | | | | |
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| | While the plan recognizes the work of Oregon's large health care systems in pursuing health information exchange, and mentions the growing number of local and regional HIO's, there is no mention of the work that is currently underway by some of these same health systems to implement telemedicine services. Telemedicine partnerships with rural hospitals are being developed that expand beyond a local or regional HIE, but rather touch all corners of the state, and beyond. Common access to patient health information is essential to these health care partners to insure quality care for the patient.<br><br>Creation of a telemedicine network requires multiple independent entities to work together toward a common goal of providing healthcare, much like the creation of an HIO requires collaboration around the common goal of sharing electronic health information. Since many of these telemedicine relationships may fall outside the boundaries of a local or even regional HIO, consideration should be given to using these developing telemedicine networks as test beds for HIE development.<br><br>[Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Kim Hoffman , Chair, Telehealth Alliance of Oregon | No change. | HITOC will continue to work on other key HIT issues, including telemedicine. |
| | HIT Adoption Strategies<br>Health Information Technology (HIT) is global in nature, practice and usage. This needs to be recognized, accepted and integrated into the HIT Adoption Strategies. In doing so, co-operation with all competent Healthcare Practitioners, Providers, Organizations and Supporters should be included as a policy, strategy, mechanism and practice. Co-operation should be bi-directional and mutually beneficial. Co-operation beyond Oregon's borders exists today.<br><br>Telemedicine, Telehealth, eHealth, ePractice and Others<br>These technologies are supported by Global organization and Participants. For Policy and Research Oregon needs to join and participate in the Global Communities.<br><br>Example:<br>The Universities in Oregon have appropriate resources for such activities Some international programs exist. In support of Oregon's HIT initiatives the Universities need the support to expand such international HIT initiatives. | Public input submitted to hitoc.info@state.or.us: Dr Thomas Clark<br>Patient Measurement and Monitoring Corporation | No change. | HITOC will continue to work on other key HIT issues, including telemedicine. Intrastate and interstate exchange and coordination will be the first priorities, before coordinating nationally or internationally. |
| | As part of the Public Response to the Oregon HITOC reviews currently underway, the following information is provided as a workable example at the State level of a Telemedicine Program serving Patients and Providers.<br>The Arizona Telemedicine Program ( http://www.telemedicine.arizona.edu/index.cfm) was developed in response to Healthcare-related programs that exist in many States with substantial population diversity and distributions. As the Press Releases indicate, work and solutions continue.<br>The following description from the website is appropriate:<br>"...The Arizona Telemedicine Program is a statewide program intended to increase access to healthcare to all residents in Arizona using telemedicine technologies. The Program's telecommunications network spans the entire state and is linked to other telecommunications | Public input submitted to hitoc.info@state.or.us: Thomas Clark | No change required. | HITOC will continue to work on other key HIT issues, including telemedicine. |

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| | networks in Arizona. The Arizona Telemedicine Program also delivers continuing educational programming to healthcare providers on a regular basis, and provides the telecommunications link for administrative meetings...."<br>This Program should be used as a model only and, as such, used only as a guidance.<br>It does independently establish the following:<br>-Assistance in designing and developing such a Program is available<br>-Operational environments are available for observation and review<br>-Cost-effectiveness can be evaluation with accuracy and precision<br>-Benefits, performance, scalability, quality and compliance are measurable in advance of implementation<br>-Universities can be effective Participants.<br>Related URLs:<br>http://www.oregon.gov/OHPPR/HITOC/<br>http://www.telemedicine.arizona.edu/index.cfm<br>Other models are available. This model was chosen based upon relative similarity to Oregon. | | | |
| | Future HIT Systems and Networks should:<br>-Serve Patients, their Families and their Support Groups<br>-Maintain appropriate 'local' infrastructure that will supported distributed Systems and Networks<br>-Maintain Secondary-level Systems and Networks for 'Data Center' appropriate applications<br>-architect all systems and networks for reliability, availability and survivability (e.g., so the storm in Hillsboro, or computer crash, does not impact the operations in the remainder of this area.<br>-Usage is configurable so that classes of Patients (e.g., Women, Men, children, seniors, by choice) can communicate effectively and privately.<br>An example would be a Self-organizing infrastructure in which individual and small practice practitioners can establish and maintain dedicated communities that are connected to larger infrastructures when needed and appropriate. The 'single-practitioner' system has been developer elsewhere.<br>It is important that a Medical Sociologist(s) be involved in the HITOC review. Health Psychology as well is quite important. | Public input submitted to hitoc.info@state.or.us: Thomas Clark | No change : | HITOC will continue to work on and investigate other areas of HIT. |
| | Two included documents pertain to communications from the Vice-Rector of Adam Mickiewicz University in Poznan, Poland and to the President of the University of Oregon.<br>The letter was forwarded to the International Affairs Department at the University of Oregon. A discussion with the Department established that the International Affairs Department provided services to the several Departments and that co-operative work between the Departments and the Universities, and other organizations in Poznan, Poland, could proceed directly. Similar letters from the Vice-Rector were sent to Oregon Health and Science University, Oregon State University and Portland State University. Feedback from these Universities is not available at this time.<br>Current activities have expanded to include a proposal for a one-to-three year project for the design and development of "ICT-based Solutions for Advancement of Older Persons Independence and Participation in the 'Self-Serve Society' ". The Project will be 1/3 Research and 2/3 Technology Transfer and Business<br>Development. Project budgets will range: 1 - 7 million Euros; Project time will range: 12 – 36 months. The Ambient Assisted Living Organization is a Consortium of several EU Nations that | Public input submitted to hitoc.info@state.or.us: Thomas Clarke | No change. | HITOC will continue to work closely with universities, including PSU, to perform the necessary research to facilitate and inform our HIE and HIT efforts. |

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| | receive roughly 50% of the funding from the EU Commission.<br>This arrangement could be duplicated by several State Governments, including Oregon, and the Federal Government. The total allocation for all approved Projects is 54.60 million Euros with 23 million Euros provided by the European Commission.The results should benefit both Research and Commercial Organizations.The AAL Organization has been in operation for several years and has supported top quality Projects (all reviewed by Research and Business Professionals).<br>SUGGESTION:<br>Adapt this model to include other States and the Federal Government to develop a similar Organization here. | | | |
| [Multiple- see attachment] | [Please see attached document for full submission of comments and suggestions.] | Public input submitted to hitoc.info@state.or.us: Chris Apgar, President, Apgar & Associates, LLC | No change | All concerns and suggestions will be referred to appropriate HITOC Workgroups and Advisory Panels for their review and consideration in further planning to take place during Phase 1. |

## Brief: Revisions to Draft Strategic Plan

## For review by HITOC, August 5, 2010

Several substantive changes to the draft strategic plan have been made since the original release of the draft on June 17. These changes have been prompted by public input received during the June-July 2010 public comment period, feedback from the ad-hoc HITOC Advisory Panel on how to incorporate that public input, team suggestions, and the July 6 ONC Program Information Notice guidance (the "PIN"). This brief will provide a synopsis of those changes, the public input, the Advisory Panel feedback, as well as changes to our operational planning based on the PIN.

### Revisions to draft Strategic Plan

1. Referenced and described the newly designated Office of Health IT
2. More comprehensively addressed collaboration with Medicaid and the P-APD
3. Addressed consumer concerns and the balance of the triple aim goals with patient control of medical information, through a new cover letter from HITOC
4. Referenced the second round of the Beacon Community grant process
5. More comprehensively addressed public health laboratory systems and functions
6. Included an updated graphic on governance relationships among various agencies and commissions
7. Included a new map on interstate hospital referral regions
8. Provided greater detail on privacy and security according to the HHS framework
9. Adjusted the description of the Oregon Health Network
10. Changed name of HIO and Consumer "Councils" to "Panels"
11. Adjusted list of objectives and deliverables to match operational plan
12. Updated list of Oregon HIOs in appendix
13. Added an imperative addressing health equity
14. Included information about legislative process for creation of SDE
15. Clarified that phase 1 starts with submission of application to ONC, not approval by ONC
16. Adjusted and expanded long term care language
17. Clarified that ongoing review of the budget will take place
18. Added list of acronyms and completed glossary
19. Added appendix describing approach to meaningful use objectives
20. Changed terminology to describe the "master provider index" as a potential subset of the "HIE registry", which could include other HIE participants, such as pharmacies, labs and state and local health departments.
21. Expanded section on educational programs and communications, which now includes HIOs along with providers and consumers, and a legal resource guide or "toolkit" for providers and HIOs.
22. Added new language about the specific options for providers for secure connectivity to address Meaningful Use in the three priority areas: structured laboratory reports, electronic prescribing and shared clinical summaries between unaffiliated organizations.
23. Addressed how the plan will further clinical quality reporting to Medicaid and Medicare

24. Added a new table describing Meaningful Use requirements and how the strategic plan addresses providers' ability to meet them in an appendix with discussion within the plan itself about the MU exchange capabilities in the state and how those are monitored and tracked over time
25. Described a pilot program for the accreditation of HIOs
26. Added the need for adequate consumer information/education about consent policies to the table of potential risks
27. Clarifying language around the roles of Oregon Health Authority and HITOC, particularly in the area of contracting and technology acquisition
28. Clarifying language on the proposed opt out consent model, review of specially protected health information and possible legislation.
29. Other updates to implementation dates for OR-Kids and submission dates for various portions of the State Medicaid Health IT Plan.

## Public Input

From June 17 through July 14, 2010, the HITOC HIE Planning Team received, collected, reviewed, and analyzed over 150 comments from more than 100 individuals and organizations as part of the public comment period for the Draft HIE Strategic Plan. Feedback was requested and received via a diversity of forums, including the HITOC Public Meeting in Portland on June 17; five community meetings held across the state in Medford (June 28), The Dalles (June 30), Coos Bay (July 13), Roseburg (July 13), and Bend (July 14); a public webinar on July 8; attendance at the Northwest Portland Area Indian Health Board meeting on July 12 in North Bend; and finally, via e-mail submitted to hitoc.info@state.or.us. A full list of individual comments and feedback has been compiled, is included with the materials for the August 5 HITOC meeting.

The comments and questions spanned a broad range of HIE issue areas, including:

1. **Legal and policy issues** (privacy and security, consent and patient rights, specially protected information, liability and legal guidance, legislative changes, and interstate exchange)-34 comments
2. **Data quality, accuracy, and integrity** – 2 comments
3. **Meaningful use** – 8 comments
4. **Finance** – 8 comments
5. **EHR/HIE** (selection, adoption, implementation, and connectivity) – 21 comments
6. **Technical infrastructure** – 7 comments
7. **Stakeholder perspectives** (dentists, long term care providers, tribes, payers, patients/consumers, foster children, rural providers, the VA, HIOs, public safety, and other organizations) – 20 comments
8. **Personal Health Records** – 5 comments
9. **Role of the State, the SDE, and the REC/O-HITEC** – 8 comments
10. **Public Health** – 3 comments
11. **Quality reporting and improvement** – 4 comments
12. **Performance evaluation, feedback, triple aim, and accountability** – 3 comments
13. **Requirements, standards, and accreditation** -12 comments
14. **Administrative simplification** – 2 comments
15. **Implementation, timing/phasing, and workgroup process** – 4 comments
16. **General comments around HIE, our approach, and the Plan** – 9 comments

17. **Telemedicine and other HIT efforts** – 5 comments

## Changes made to Strategic Plan based on Public Input and Advisory Panel feedback

1. **Expanded long term care section** in response to input from long term care providers, including the Oregon Health Care Association, the Oregon Alliance of Senior and Health Services, the Division of Seniors and People with Disabilities, and other concerned individuals.
2. **Newly drafted Cover Letter from HITOC** addressing consumer concerns around privacy, security, and a consumer/patient-centric focus.
3. **Explicit commitment to health equity** in response to HITOC Advisory Panel feedback.
4. **Identifying potential consumer lack of information for consent policy as a potential risk**, in response to HITOC Advisory Panel feedback.
5. **Expanded section on education programs/communications** to explicitly include the development of a legal resource guide or "toolkit" in response to public input concerns regarding the difficulty of knowing and complying with laws, regulations, and standards.
6. **Expanded section on coordination** to explicitly state a commitment to coordinating with other local organizations, such as school-based health centers, the Tribes, and public safety partners.

While some of the public input comments resulted in changes to the draft Strategic Plan, other comments and suggestions will be given to the appropriate workgroup, panel, or other forums to inform Phase 1 activities.

## Operational changes made in response to the July 6 ONC Program Information Notice (PIN). These changes have impacted both the strategic and operational plans.

1. Primary impact is to timing.
    - Technology selection, purchasing, & some implementation activities now in Phase 1.
    - Service introductions begin earlier – Phase 1.
        - Services iteratively introduced, continuing into Phase 2.
        - Starts with those required for "push" capabilities to enable summary sharing and receipt of labs, progressing to "pull".
2. Procurement
    - Initially through existing State-approved processes & methods
    - Dependent on requirements & specifications for services
    - To meet PIN requirements, progressive introduction & rollout of central services starting Phase 1
    - Push Services
        - Base services required for "push" capabilities
        - Introduction & rollout in Phase 1

- HIE Registry (Provider Registry)
  - Directory of HIE participants, such as providers, lab testing companies, state agencies, & others
  - Introduction & rollout in Phase 1 (first for “push”, extended as needed for “pull”)
- Trust Services
  - Certificate authority & other “circle of trust” functions
  - Sufficient introduction & rollout in Phase 1 for “push”
  - Extensions introduced as needed for “pull” later in Phase 1, rollout continuing into Phase 2

**Phase 1 Workgroup and Panel Framework**

| Group Type | Responsibility | Duration/Meetings | Staffing | Selection |
|---|---|---|---|---|
| Technology Workgroup | Phase 1 deliverables and objectives<br><br>Certifications and Standards<br><br>Definition of Central Services<br><br>Projects-As needed | One year appointments 1X/month<br>Task-based subcommittees 1X/month or more frequently as needed | Coordinated by State staff<br><br>HITOC members encouraged to participate<br><br>Subject matter experts as needed<br><br>Consultants as needed | Open Application Process<br><br>HITOC Subcommittee Reviews and Recommends<br><br>HITOC selects |
| Finance Workgroup | Phase 1 deliverables and objectives<br><br>Financial Sustainability Plan<br><br>Projects-As needed | One year appointments 2X/month or more frequently as needed | | |
| Legal and Policy Workgroup | Phase 1 deliverables and objectives<br><br>Privacy and Consent<br><br>Security<br><br>Policy/Other | One year appointments 1X/month<br>Task-based subcommittees 1X/month or more frequently as needed | | |

| Panels | Responsibility | Duration/Meetings | Staffing | Selection |
|---|---|---|---|---|
| HIO Executive Panel* | Strategic input and HIO coordination and planning | One year appointments<br>Quarterly | Coordinated by State staff<br><br>HITOC members encouraged to participate<br><br>Subject matter experts as needed<br><br>Consultants as needed | In consultation with HITOC Subcommittee each HIO shall put forth a representative<br>Subcommittee selects |
| Consumer Advisory Panel | Strategic Input | Quarterly | | Open Application Process<br><br>HITOC Subcommittee Reviews and Recommends<br><br>HITOC selects |
| Notes | *Please note that the HIO Executive Panel will comprise CEO or equivalent from the HIOs.<br><br>An annual forum will be held for all groups. Each workgroup will base its work on the HITOC guiding and operating principles and have a specific charter based on the deliverables and objectives defined in the HIE Strategic Plan | | | |

**HITOC Workgroup and Panel Application Process**

**HITOC is pleased to announce the formation of workgroups and panels for Phase 1 of the implementation of statewide health information exchange (HIE) on the foundation of the strategic and operational plans. HITOC is conducting an open and transparent selection process. Planning groups include:**

- **Legal and Policy Workgroup**
- **Finance Workgroup**
- **Technology Workgroup**
- **Consumer Advisory Panel**
- **HIO Executive Panel**

**For Workgroups:**
**The application process will commence August 9. Applications for workgroups are due August 20. Applicants will be notified no later than August 30. Initial meetings will be held in September.**

**For the Consumer Advisory Panel:**
**The application process will commence August 9. Applications for the Consumer Advisory Panel are due September 20. Applicants will be notified no later than September 27.**

**Membership of the HIO Executive Panel will be made in consultation with existing HIOs.**

**Please see the attached application and sample draft charter for more information.**

**For further information about health information exchange planning and implementation efforts in Oregon, please go to the HITOC website http://www.oregon.gov/OHPPR/HITOC/**

**HITOC HIE Planning Application**

**Check One:**

- o **Legal and Policy Workgroup**
- o **Finance Workgroup**
- o **Technology Workgroup**
- o **Consumer Advisory Panel**
- o **HIO Executive Panel**

Name:
Job Title:
Organization:
Email:
Phone:

Please describe why you are interested in sitting on the Workgroup or Panel.

Please describe your areas of related experience and content expertise that would assist in this process.

Please describe other successful collaborative efforts you have been involved in and how you contributed.

In addition to your own areas of content expertise, please describe what other content resources would you be able to quickly incorporate into this effort (relationships with peers, etc.):

For Workgroups:
Can you commit to 8-15 hours per month of participation for the next 12 months? Some, but not all of this time would be attending one or two workgroup meetings with possible additional subcommittee meetings each month. The rest would include reviewing materials, helping with additional research, development of recommendations, or other support as required.

For Panels:
Can you commit 4 – 6 hours per month of participation for the next 12 months? Some of this time would be spent attending quarterly meetings. The rest would include reviewing materials and other support as needed.

**SAMPLE CHARTER**

**Same general format to be used for all workgroup and panel charters with adaptations as appropriate. Initial charters and workgroup members will be approved at September HITOC meeting.**

**HITOC HIE PLANNING WORKGROUP Charter-DRAFT**
**Legal and Policy**



**Summary**

The Legal and Policy Workgroup's charter is to provide strategic input to HITOC regarding Legal and Policy issues. To the greatest extent practicable, members will represent the geographic, ethnic, gender, racial and economic diversity of this state. The Workgroup will have leadership, industry and content expertise in order to effectively and efficiently review the statewide strategic and operation plans, and potential opportunities and challenges for statewide HIE. The workgroup will have 8-15 members. Representation could draw from some or all of the following sectors:

- Health Care (insurers, hospitals, provider organizations and individual providers)
- Consumers
- Legal
- Industry (employers who purchase or self-insure to provide health care for their employees)
- Government
- Education
- Others as required

The charter of the Legal and Policy Workgroup is to:

- Develop a framework and input for Legal and Policy goals for statewide HIE based on the strategic and operational plans
- Establish task-based subcommittees as needed
- Develop recommendations for specific goals, actions and timelines for the execution of the strategic and operational plans
- Provide input regarding directional changes
- Assess and provide input regarding potential opportunities
- Review and provide input regarding risks and challenges

## Membership

The Council is composed of 8-15 representatives selected by the HITOC selection subcommittee appointed by the Chair and Vice-Chair. The HITOC Director will designate staff to serve the Workgroup. Members of the Workgroup will receive no compensation for their services.

The Workgroup is authorized to engage other stakeholders as appropriate in order to inform the work of the Workgroup.

## Selection Process

HITOC shall develop an open application process, announcing the opportunity on the HITOC website and shall request potential applicants to respond. The HITOC Selection Sub-committee shall select the Workgroup members. Following are recommended elements for inclusion in the application:

1. Name, Title Organization, Contact Information
2. Experience in relevant areas named above
3. Areas of specific expertise
4. Examples of previous successes, experiences and work in collaborative efforts
5. Any other relevant information applicant wishes to provide
6. Stated ability to invest the time required (up to 15 hours per month)

Applicants shall be selected based upon relevant experience, proven managerial and collaborative abilities, availability, and to provide the broadest statewide reach possible. Ad-hoc members may be added or included from time to time as needed by the Chair of the Workgroup.

## Participation Guidelines

The HITOC Chair will select the Chair and Vice-Chair. These individuals will serve for 1 year from the date of their confirmation or until the Workgroup disbands, whichever comes first. Members can continue for additional terms at the pleasure of HITOC.

The HITOC Director and Workgroup will provide regular status updates to HITOC.

Duties of the Chair are:

- Preside at all meetings of the Workgroup.

- Coordinate meeting agendas after consultation with HITOC Director and staff.
- Review all draft Workgroup meeting minutes prior to the meeting at which they are to be approved.
- The Chair may designate, in the absence of the Vice-Chair or when expedient to Workgroup business, other Workgroup Members to perform duties related to Workgroup business.

Duties of the Vice Chair are:
- Perform all of the Chair's duties in his/her absence or inability to perform.
- Perform any other duties assigned by the Chair.
- Take minutes to be approved by the Workgroup and presented to the board on a monthly basis.

Duties of Workgroup Members:
- Attend all Workgroup meetings.
- Participate in a task-based subcommittee.
- Provide input to strategic direction.
- Other input as needed.

**Member Participation**
- If a Workgroup Member is unable to attend a meeting in person, the Member may participate by conference telephone or Webinar.

- Members shall inform the HITOC Director or staff with as much notice as possible if unable to attend a scheduled meeting.

- The Workgroup will conduct its business through discussion, consensus building and informal meeting procedures. The HITOC Director may establish procedural processes as needed.

- A majority of Workgroup Members shall constitute a quorum for the transaction of business.

- Workgroup and subcommittee meetings will be held monthly or as needed.

**Amendments**

- The Workgroup and the affirmative vote of HITOC may amend this Charter and Guidelines upon recommendation and confirmation.