Health Information Technology Oversight Council

March 5, 2015, 1:00 – 4:30 pm
Transformation Center Training Room
Lincoln Building – Suite 775
421 SW Oak Street
Portland, OR 97204
Call in: (888) 808-6929, Participant Code: 453773

Name	Organization	Title
Greg Fraser, MD (Chair)	WVP Health Authority	CMIO
Robert Brown	Allies for a Healthier Oregon	Advocate
Ken Carlson, MD	Childhood Health Assoc. of Salem	Physician, Pediatrics
Erick Doolen	PacificSource	Senior VP/CIO
Ellen Larsen	Hood River County Health Dept.	Director
Dave Widen	Pacific University	Professor (Retired)
Kristen Duus (Ex-Officio)	Oregon Health Authority	CIO
Priscilla Lewis (Ex-Officio)	Oregon Health Authority	Deputy Director, Public Health

Time	Topic and Lead	Action	Materials
1:00 pm	**Welcome, Opening Comments**– Greg Fraser	Discussion	1. Agenda
1:05 pm	**Goals and Meeting Overview** – Susan Otter Announcements	Information Discussion	
1:10 pm	**Featured Topic: ONC Strategic Vision for Interoperability** ❖ Shared Nationwide Interoperability Roadmap ❖ Interoperability Standards Advisory • Roadmap Overview – Erica Galvez, ONC • Interoperability Panel Discussion ○ Gina Bianco, Jefferson HIE ○ Pat Bracknell, Central Oregon HIE ○ Chris Diaz, FamilyCare CCO ○ Klint Peterson, Samaritan Health Services ○ Sonney Sapra, Tuality • Discussion – Hunt Blair, ONC; Patricia MacTaggart, ONC	Information Discussion	2. Shared Nationwide Interoperability Roadmap Quick Reference A link to the full Roadmap is here: http://www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf
3:00 pm	**Break**		
3:15 pm	**HITOC Business, Approve Minutes** – Greg Fraser	Decision	3. Dec. 17, 2014 minutes
3:20 pm	**Legislation Update** – Susan Otter • Status of HB 2294 • Next steps for HITOC	Information Discussion	4. HB2294-A Engrossed

3:40 pm	**ONC Interoperability Cooperative Agreement** – Susan Otter	Information Discussion Action	A link to the Funding Opportunity Announcement is here: http://healthit.gov/newsroom/advance-interoperable-health-information-technology-services-support-health-information
4:00 pm	**June HITOC Meeting & Other Updates** - Susan Otter	Information Discussion Action	
4:15 pm	**Public Comment**		
4:25 pm	**Closing Remarks** – Greg Fraser		

Other Materials

1. Phase 1.5 Update	

Next Meeting: **June 4, 2015**
1:00-4:30 pm
Oregon State Library
Room 103
250 Winter Street NE, 1st Floor
Salem, OR 97301

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

Three Goals of HIT-Optimized Health Care:

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

The Office of the National Coordinator for Health Information Technology

CONNECTING HEALTH AND CARE FOR THE NATION: A SHARED NATIONWIDE INTEROPERABILITY ROADMAP – DRAFT VERSION 1.0

Quick Reference Factsheet

WHERE ARE WE GOING

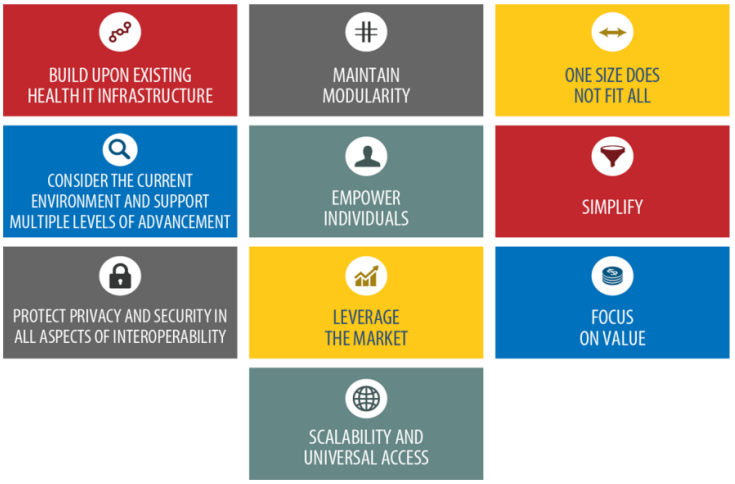
The Department of Health & Human Services has identified that sharing information more broadly to providers, consumers, and others to support better decisions while maintaining privacy, is one way of achieving better care, smarter spending and a healthier nation. To guide the nation toward these goals, the Office of the National Coordinator (ONC) released A Shared Nationwide Interoperability Roadmap – Draft Version 1.0 (Roadmap) which defines the implementation of how the government in collaboration with the private sector should approach sharing electronic health information and addresses the collaborative impact of all stakeholders in advancing interoperability. This also speaks directly to the second goal of the Federal Health IT Strategic Plan 2015-2020, to advance secure and interoperable health information, and further drives the entire nation toward realizing the development of a nationwide learning health system. ONC is accepting public comments on the draft Roadmap now through 5 p.m. ET on April 3, 2015.

WHO NEEDS TO COME ALONG ON THE JOURNEY

People who receive care or support the care of others		**People and organizations that deliver care and services**	
Organizations that pay for care		**People and organizations that support the public good**	
People and organizations that generate new knowledge, whether research or quality improvement		**People and organizations that provide health IT capabilities**	
People and organizations that govern, certify, and/or have oversight		**People and organizations that develop and maintain standards**	

WHAT ARE THE GUIDING PRINCIPLES

An interoperable health IT ecosystem that is person-centered makes the right electronic health information available to the right people at the right time across products and organizations, in a way that can be relied upon and meaningfully used by recipients. This ecosystem should adhere to the interoperability guiding principles. Based on feedback from a wide range of stakeholders, ONC updated this set of guiding principles in version 1.0 of the Roadmap.



WHEN AND HOW WE GET THERE

The Roadmap identifies critical actions that are necessary to achieve interoperability goals over the next three, six, and ten-year timeframes.

For more information: www.healthit.gov/interoperability

January 28, 2015

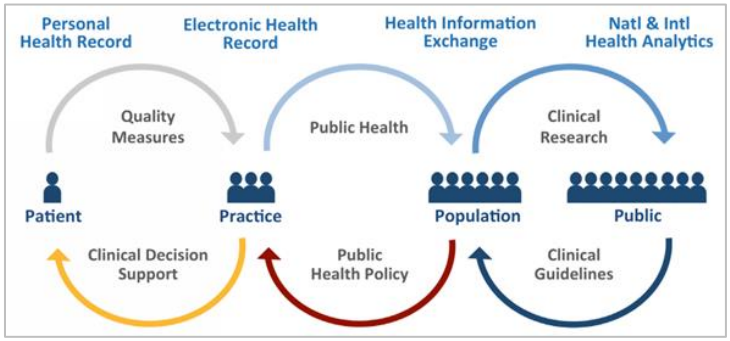
The Roadmap is based on a core set of business and functional requirements to achieve a learning health system, organized by five critical building blocks that support the business, policy and technical needs of a nationwide interoperable electronic health information infrastructure.

Interoperability Roadmap Building Blocks	Learning Health System Requirements
Rules of engagement and governance	A. Shared governance of policy and standards that enable interoperability
Supportive business, clinical, cultural and regulatory environments	B. A supportive business and regulatory environment that encourages interoperability C. Individuals are empowered to be active managers of their health D. Care providers partner with individuals to deliver high value care
Privacy and security protections for health information	E. Ubiquitous, secure network infrastructure F. Verifiable identity and authentication of all participants G. Consistent representation of permission to collect, share, and use identifiable health information H. Consistent representation of authorization to access health information
Certification and testing to support adoption and optimization of health IT products and services	I. Stakeholder assurance that health IT is interoperable
Core technical standards and functions	J. Consistent Data Formats and semantics K. Standard, secure services L. Consistent, secure transport technique(s) M. Accurate identity matching N. Reliable resource location

Although these actions will have to be taken by stakeholders to achieve near-term and long-term interoperability goals, the following four critical pathways are of highest priority:

1. Establish a coordinated governance framework and process for nationwide health information interoperability
2. Improve technical standards and implementation guidance for sharing and using a common clinical data set**
3. Advance incentives for sharing health information according to common technical standards, starting with a common clinical data set
4. Clarify privacy and security requirements that enable interoperability

WHY IT MATTERS



Most determinants of health status are social and are influenced by actions and encounters that occur outside traditional institutional health care delivery settings, such as in employment, retail, education, and other settings. This shift requires a high degree of information sharing between individuals, providers, and organizations, and therefore a high degree of interoperability between many different types of health IT, such that systems can exchange and use electronic health information without special effort on the part of the user. The goal of this shift is to a nationwide learning health system—an environment that links the care delivery system with communities and societal supports in "closed loops" of electronic health information flow, at many different levels, to enable continuous learning and improved health. This kind of system allows individuals to select platforms and apps to share and use their own electronic health information to meet their needs without undue constraints.

**The draft 2015 Interim Interoperability Standards Advisory was released on January 30, 2015. ONC is also accepting public comment on this document now through May 1, 2015 5 p.m. ET.

Health Information Technology Oversight Council
Wednesday, December 17, 2014
1:00 – 4:30 pm

Council and Ex-officio Members Present: Erick Doolen, Greg Fraser, Dave Widen, Bob Brown
Council and Ex-officio Members by Phone: Priscilla Lewis
Council and Ex-officio Members Absent: Ken Carlson, Kristen Duus, Ellen Larsen
Staff Present: Susan Otter, Karen Hale (phone), Justin Keller, Marta Makarushka, Rachel Ostroy, Samina Panwhar (phone), Lisa A. Parker, Sharon Wentz (phone), Terry Bequette (Consultant)
Guests: Sharon Fox (Oregon Health Leadership Council (OHLC) – Presenter), Laureen O'Brien (Consultant to OHA and OHLC – Presenter)

Welcome, Opening Comments, Approve Minutes – Greg Fraser

Refer to September and October HITOC Meeting minutes; slide 2

- Greg started with introductions and welcomed Rachel Ostroy, recently hired Implementation Director for the Office of Health IT.
- Agenda/Minutes review. Bob moved to approve September and October minutes. Dave seconded. There were no objections.

Goals and Meeting Overview – Susan Otter

Refer to slide 3

- Susan started by announcing that CareAccord will act as the Health Information Service Provider (HISP) for OCHIN.
- Susan then reviewed the three goals of a Health IT-Optimized Health Care System.

Legislation Update – Susan Otter

Refer to slides 4-8

Presentation:

- Susan reviewed the primary components of the 2015 Health IT Legislation—LC 482.
- Susan then announced that the bill has been sponsored by the House Committee on Health Care. From the transition from an OHA-sponsored bill to a House Committee bill, OHA had an opportunity to make some small revisions, including the name Oregon HIT Program, and the inclusion of a new clause on broad representation across HITOC membership.
- Susan then continued by discussing her presentation of the LC to the Health Policy Board during their December meeting. Susan mentioned that the Board was very engaged, due in part to the fact that this presentation followed a broader review of health IT in Oregon during the Board's November meeting.
- Susan reviewed other stakeholders that OHA has presented the LC to, which include: Oregon Association of Hospitals and Health Systems, Oregon Medical Association, Allies for Healthier Oregon, Oregon Primary Care Association, HIMSS, and the Oregon Health Leadership Council.
    - The Organization of Community Health Clinics was suggested as a potential stakeholder for this presentation.

Discussion:

- Question: have there been any other legislators besides Rep. Mitch Greenlick who OHIT has talked to.
    - Answer: we met with Senator Bates during December legislative days.
- Question: Has there been any pushback?
    - Answer: there have been some questions about the fees. That has been the primary question. There has been very positive feedback from provider audiences about EDIE. Susan also mentioned that there may also be a misconception about whether the legislation requires OHA to undertake new IT projects (it does not).
    - Susan mentioned that Zeke (chair of OHPB) asked for clarification about the charge to

the Oregon Health Policy Board relating to HITOC if the legislation passed, which would include re-chartering HITOC and resetting membership.

- Question: there have been some deletions in the legislation, particularly the removal of a definition of personal health record.
    - Conversation around the evolution of HITOC's role, starting with an early HIT committee (HIIAC).
- Erick Doolen mentioned his observation regarding the specificity of some of the clauses—could they exclude analytics and other uses beyond health information exchange as written? These may need to be broadened in an amendment.
- Question: who is the primary lead on the legislation for OHA?
    - Answer: Susan is the lead with the full support of OHA leadership.

Featured Topic: EDIE Utility/PreManage – Sharon Fox, Laureen O'Brien, OHLC

Refer to slides 9-26

Presentation:

- Laureen reviewed EDIE and the EDIE Utility; described how EDIE works from a technical standpoint; reviewed the EDIE Utility goals and components, etc.
    - Question: is there communication from the ED who has received a notification back to primary care providers?
        - Answer: Yes – hospitals can push the notification back to the primary care provider. The Hospital Transformation Performance Program ties incentive metrics to hospitals for this. PreManage also allows for communication of notifications to subscribing primary care providers and other care team members, health plans, etc.
    - Question: Does EDIE Utility expand the users in addition to the type of data.
        - Answer: It expands to the entire hospital care team—outside of the hospital setting, PreManage allows for this access.
- Laureen described how EDIE implementation in Oregon has differed from Washington, where EDIE was mandated by legislation. She provided the status of EDIE implementation, which currently has over 95% of hospitals live and sending/receiving information.
- Sharon Fox described the governance of EDIE Utility including its governance and financing and Susan added that the ongoing funding to support the CCO/Medicaid share of the Utility is federal/state match funds from CMS.
- Sharon described PreManage, the companion product to EDIE that allows non-hospital entities access to real-time notifications—including providers, health plans/CCOs, and other entities like Health Information Exchanges (HIEs). Sharon continued by describing plans for community-level purchasing of PreManage, among commercial health plans. Susan added that OHA is exploring a state-level Medicaid subscription to PreManage as well, and that planning will begin in 2015.

Discussion:

- Question: are PreManage alerts using the same criteria for notifications as EDIE?
    - Answer: PreManage alerts are fully customizable by the subscriber, both in terms of what criteria are needed to push a notification and the destination of that notification (in terms of what form of notification and to what member of the care team).
    - Susan added that the vendor is flexible in terms of the functionality—the vendor offers the data feeds to those entities that are already pushing notifications to their communities without requiring use of the full PreManage tool.
- Question: What kinds of challenges are you facing in going forward with this and sustaining it?
    - Answer: Operational challenges appear to be the most important—as information increases in the system, standardization becomes more important. OHSU has taken the lead in trying to drive standardization for care guidelines across the hospital users.

- Sharon and Laureen concluded that it will be important to protect the scope of the alert so that it doesn't begin to duplicate the EMR—the purpose is to provide concise, actionable information.

Policy and Planning/HITOC Role– Susan Otter

Refer to slides 27-34

Presentation:

- Susan described some important highlights of the work of OHA and HITOC in 2014 and potential priorities for 2015, including membership for HITOC (with or without new legislation) and a more sophisticated understanding of the health IT environment in Oregon. In addition, Susan mentioned policy and planning areas that are of interest to the Health Policy Board—integration of behavioral health using IT tools, and patient engagement and patient portal management.
  - HITOC members discussed the Health Policy Board priorities. They agree that the areas are important but had concern that there were current challenges that may need focus for basic health information exchange in the state and some concepts seem like "down the road" concepts
- Susan continued by describing a high-level work plan for HITOC in 2015, which includes categories of work that have seemed to flow organically over the course of 2014 meetings.
  - HITOC members appreciated these categories.

Discussion:

- There was a question around how the HITOC agenda for 2015 corresponds to the OHA Health IT plan for 2015.
  - These are bridged through the Health IT Policy and Portfolio "bucket" of HITOC's work. Susan added that the role of HITOC is not necessarily to focus on implementation efforts, but on larger policy/strategy concerns that might tie to these specific health IT projects.
- A comment was made about the concern that HITOC may be in limbo due to the limited membership that is currently active. Question: could HITOC work on membership issues that would work for both the Governor's office and the Health Policy Board?
  - The Chair is concerned by the underrepresentation of certain perspectives on HITOC currently. Discussion continued around this topic and it was noted as an important priority for HITOC moving forward to diversify the perspectives on the Council.
  - OHA will look into moving forward with membership and report back to HITOC

Health IT Environmental Scan – Marta Makarushka

Refer to "HIT Optimized Health Care System;" slides 35-51

Presentation:

- Marta discussed the evolution of the CCO profile, which started as a tool for the Deeper Dive discussions, and later became a meaningful document for the CCOs. Susan and Marta passed around a template for the profile and discussed the content that is planned to be included in the profile [slides 40-43].

Discussion:

- Question: What is the final use of these profiles? What is the implication for this profile for the next CCO technology plan which is due in February?
  - Answer: A summary will be made public; the detailed profiles will be used internally. Susan added that in talking with the CCOs, they were curious about how they compared to each other in the context of health IT. The purpose of the profile is descriptive and not evaluative—OHA is not "grading" the CCOs in terms of their health IT capabilities.
  - The goal is that CCOs can rely on these profiles to complete the technology plan without have to reinvent the wheel.
  - Discussion about the format, suggestions for presenting information more descriptively to avoid inference of a judgment.

- Question: what was the original intent of the profile and who is it meant to benefit?
    - Answer: It is meant to benefit both OHA and HITOC who are looking at these efforts across the state, and individual CCOs who are interested in having their efforts reflected back to them, and possibly compared to other CCOs in some cases.
    - The Chair added that in the future HITOC can communicate this type of information up to the Oregon Health Policy Board. He cautioned against interpreting a snapshot of the CCOs' HIT efforts as reflective of what is happening across the state as a whole.
    - Marta described the components of an HIT-optimized health care system as laid out in the Business Plan Framework—the information in the CCO Profile is meant to crosswalk to this framework.
- Marta continued by discussing the HIT Dashboard and the metrics involved in it. This is meant to be a tool for HITOC and the Health Policy Board in looking at health IT across the state—beyond the Medicaid program.
    - Discussion continued around metrics and the importance of denominators in making these metrics meaningful. A recommendation was made to start with areas that are well defined and develop the metrics from there.

OHA HIT Updates – Marta Makarushka, Sharon Wentz, Terry Bequette, Karen Hale

Refer to "Revised HCOP Materials;" slides 52-69

- Marta reviewed changes that were made to the HCOP materials, reflecting suggestions made by HITOC members.
- Sharon described the details around the rollout of CareAccord acting as OCHIN's HISP and described updates to the flat file directory.
- Terry updated HITOC on Provider Directory and the Clinical Quality Metrics Registry.
    - Question: Is OHA sharing the timeline for this process? Are the urgency of these projects being communicated?
        - Answer: The timeline needs to be reset based on existing knowledge of areas OHA can control and attempting to anticipate areas outside of OHA control such as external reviews required by state and CMS processes.
    - Conversation continued around stakeholder engagement for these components and the importance of validating the data gathered by reflecting this back to those stakeholders who were engaged.
- Karen discussed the current disbursement numbers on the EHR incentive programs both nationally and within Oregon.

Public Comment – Greg Fraser

- With no public comment, Greg closed the public comment period at 4:27 p.m.

Closing Comments – Greg Fraser

- Greg acknowledged OHIT staff in the 2014 accomplishments and asked if there were any final comments.
- The meeting was adjourned at 4:29 p.m.

Next meeting is Thursday, March 5, 2015 in Portland

A-Engrossed
House Bill 2294

Ordered by the House February 17
Including House Amendments dated February 17

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Health Care)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires Oregon Health Authority to establish Oregon Health Information Technology program. Allows authority to participate in or fund health information technology partnerships or collaboratives. Revises membership and duties of Health Information Technology Oversight Council. Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health information technology; creating new provisions; amending ORS 413.011, 413.300, 413.301, 413.303 and 413.308; repealing ORS 413.302 and 413.306; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) The Oregon Health Authority shall establish and maintain the Oregon Health Information Technology program to:

(a) Support the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.620;

(b) Facilitate the exchange and sharing of electronic health-related information;

(c) Support improved health outcomes in this state;

(d) Promote accountability and transparency; and

(e) Support new payment models for coordinated care organizations and health systems.

(2) The authority may engage in activities necessary to become accredited or certified as a provider of health information technology and take actions associated with providing health information technology.

(3) The authority may enter into agreements with other entities that provide health information technology to carry out the objectives of the Oregon Health Information Technology program.

(4) The authority may establish and enforce standards for connecting to and using the Oregon Health Information Technology program, including standards for interoperability, privacy and security.

(5) The authority may conduct or participate in activities to enable and promote the secure transmission of electronic health information between users of different health information technology systems, including activities in other states. The activities may include, but are not limited to, participating in organizations or associations that manage and enforce agreements to abide by a common set of standards, policies and practices applicable to health

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

information technology systems.

(6) The authority may, by rule, impose fees on entities or individuals that use the program's services in order to pay the cost of administering the Oregon Health Information Technology program.

(7) The authority may initiate one or more partnerships or participate in new or existing collaboratives to establish and carry out the Oregon Health Information Technology program's objectives. The authority's participation may include, but is not limited to:

(a) Participating as a voting member in the governing body of a partnership or collaborative that provides health information technology services;

(b) Paying dues or providing funding to partnerships or collaboratives;

(c) Entering into agreements with partnerships or collaboratives with respect to participation and funding in order to establish the role of the authority and protect the interests of this state when the partnerships or collaboratives provide health information technology services; or

(d) Transferring the implementation or management of one or more services offered by the Oregon Health Information Technology program to a partnership or collaborative.

(8) For the purpose of participating in a partnership or collaborative under subsection (7) of this section, the authority is exempt from the Public Contracting Code. The authority shall establish standards and procedures and specify the considerations to be applied to contracting and procurement activities described in this subsection.

(9) At least once each calendar year the authority shall report to the Legislative Assembly, in the manner provided in ORS 192.245, on the status of the Oregon Health Information Technology program.

SECTION 2. ORS 413.011 is amended to read:

413.011. (1) The duties of the Oregon Health Policy Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and fund access to affordable, quality health care for all Oregonians by 2015.

(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

(d) Establish and continuously refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks.

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the Oregon health insurance exchange.

(k) Investigate and report annually to the Legislative Assembly on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

[*(C) The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.*]

(L) Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

(m) Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(o) Work with the Health Information Technology Oversight Council to foster health information technology systems and practices that promote the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.620 and align health information technology systems and practices across this state.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042 and 741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in com-

pleting the tasks set forth in subsection (1)(j) and (k)(A) of this section.

SECTION 3. ORS 413.300 is amended to read:

413.300. As used in ORS 413.300 to 413.308**, section 1 of this 2015 Act and ORS chapter 414**:

[*(1) "Electronic health exchange" means the electronic movement of health-related information among health care providers according to nationally recognized interoperability standards.*]

[*(2)*] **(1)** "Electronic health record" means an electronic record of an individual's health-related information that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized [*clinicians*] **health care providers** and staff [*across more than one health care provider*].

[*(3)*] **(2)** "Health care provider" or "provider" means a person who is licensed, certified or otherwise authorized by law in this state to administer health care in the ordinary course of business or in the practice of a health care profession.

(3) "Health informatics" means the interdisciplinary study of the design, development, adoption and application of information technology based innovations in health care services delivery, management and planning.

(4) "Health information technology" means an information processing application using computer hardware and software for the storage, retrieval, sharing and use of health care information, data and knowledge for communication, decision-making, quality, safety and efficiency of a clinical practice. "Health information technology" includes, but is not limited to:

[*(a) An electronic health exchange.*]

[*(b)*] **(a)** An electronic health record.

[*(c) A personal health record.*]

[*(d)*] **(b)** An electronic order from a **health care** provider for diagnosis, treatment or prescription drugs.

[*(e)*] **(c)** An electronic **clinical** decision support system **that links health observations with health knowledge to assist health care providers in making choices for improved health care, for example by providing electronic alerts or reminders.** [*used to:*]

[*(A) Assist providers in making clinical decisions by providing electronic alerts or reminders;*]

[*(B) Improve compliance with best health care practices;*]

[*(C) Promote regular screenings and other preventive health practices; or*]

[*(D) Facilitate diagnoses and treatments.*]

[*(f)*] **(d)** Tools for the collection, analysis and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction and other health care related performance measures.

(5) "Interoperability" means the capacity of **different health information technology systems and software applications to communicate and exchange data and to make use of the data that has been exchanged.** [*two or more information systems to exchange information or data in an accurate, effective, secure and consistent manner.*]

[*(6) "Personal health record" means an individual's electronic health record that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared and controlled by the individual.*]

SECTION 4. ORS 413.301 is amended to read:

413.301. (1) There is established a Health Information Technology Oversight Council within the Oregon Health Authority[*, consisting of 11 members appointed by the Governor*]. **The Oregon Health Policy Board shall:**

(a) Determine the terms of members on the council and the organization of the council.

(b) Appoint members to the council who, collectively, have expertise, knowledge or direct experience in health care delivery, health information technology, health informatics and health care quality improvement.

(c) Ensure that there is broad representation on the council of individuals and organizations that will be impacted by the Oregon Health Information Technology program.

(2) To aid and advise the council in the performance of its functions, the council may establish such advisory and technical committees as the council considers necessary. The committees may be continuing or temporary. The council shall determine the representation, membership, terms and organization of the committees and shall appoint persons to serve on the committees.

(3) Members of the council are not entitled to compensation, but in the discretion of the board may be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by the members of the council in the performance of their official duties in the manner and amount provided in ORS 292.495.

[*(2) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.*]

[*(3) The appointment of the Health Information Technology Oversight Council is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.*]

[*(4) A member of the Health Information Technology Oversight Council is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2). Claims for expenses incurred in performing the functions of the council shall be paid out of funds appropriated to the Oregon Health Authority for that purpose.*]

SECTION 5. ORS 413.303 is amended to read:

413.303. (1) The [*Governor shall appoint*] **Health Information Technology Oversight Council shall select** one of the **council's** members [*of the Health Information Technology Oversight Council as chairperson and another as vice chairperson, for such terms*] **as chairperson, for such term** and with such duties and powers necessary for the performance of the functions of [*those offices*] **the chairperson** as the [*Governor*] **Oregon Health Policy Board** determines.

(2) A majority of the members of the council constitutes a quorum for the transaction of business.

(3) The council shall meet at least quarterly at a place, day and hour determined by the council. The council may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the council.

SECTION 6. ORS 413.308 is amended to read:

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

[*(1) Set specific health information technology goals and develop a strategic health information technology plan for this state.*]

[*(2) Monitor progress in achieving the goals established in subsection (1) of this section and provide oversight for the implementation of the strategic health information technology plan.*]

[*(3) Maximize the distribution of resources expended on health information technology across this state.*]

[*(4) Create and provide oversight for a public-private purchasing collaborative or alternative mechanism to help small health care practices, primary care providers, rural providers and providers whose practices include a large percentage of medical assistance recipients to obtain affordable rates for high-quality electronic health records hardware, software and technical support for planning, installation, use and maintenance of health information technology.*]

[*(5) Identify and select the industry standards for all health information technology promoted by the purchasing collaborative described in subsection (4) of this section, including standards for:*]

[*(a) Selecting, supporting and monitoring health information technology vendors, hardware, software and technical support services; and*]

[*(b) Ensuring that health information technology applications have appropriate privacy and security controls and that data cannot be used for purposes other than patient care or as otherwise allowed by law.*]

[*(6) Enlist and leverage community resources to advance the adoption of health information technology.*]

[*(7) Educate the public and health care providers on the benefits and risks of information technology infrastructure investment.*]

[*(8) Coordinate health care sector activities that move the adoption of health information technology forward and achieve health information technology interoperability.*]

[*(9) Support and provide oversight for efforts by the Oregon Health Authority to implement a personal health records bank for medical assistance recipients and assess its potential to serve as a fundamental building block for a statewide health information exchange that:*]

[*(a) Ensures that patients' health information is available and accessible when and where they need it;*]

[*(b) Applies only to patients who choose to participate in the exchange; and*]

[*(c) Provides meaningful remedies if security or privacy policies are violated.*]

[*(10) Determine a fair, appropriate method to reimburse providers for their use of electronic health records to improve patient care, starting with providers whose practices consist of a large percentage of medical assistance recipients.*]

[*(11) Determine whether to establish a health information technology loan program and if so, to implement the program.*]

(1) Identify and make specific recommendations related to health information technology to the Oregon Health Policy Board to achieve the goals of the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.620.

(2) Regularly review and report to the board on the Oregon Health Authority's health information technology efforts, including the Oregon Health Information Technology program, toward achieving the goals of the Oregon Integrated and Coordinated Health Care Delivery System.

(3) Regularly review and report to the board on the efforts of local, regional and statewide organizations to participate in health information technology systems.

(4) Regularly review and report to the board on this state's progress in the adoption and use of health information technology by health care providers, health systems, patients and other users.

(5) Advise the board or the Oregon Congressional Delegation on changes to federal laws affecting health information technology that will promote this state's efforts in utilizing health information technology.

SECTION 7. ORS 413.302 and 413.306 are repealed.

SECTION 8. (1) Section 1 of this 2015 Act, the amendments to ORS 413.011, 413.300, 413.301, 413.303 and 413.308 by sections 2 to 6 of this 2015 Act and the repeal of ORS 413.302 and 413.306 by section 7 of this 2015 Act become operative on July 1, 2015.

(2) The Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to carry out the provisions of section 1 of this 2015 Act, the amendments to ORS 413.011, 413.300, 413.301, 413.303 and 413.308 by sections 2 to 6 of this 2015 Act and the repeal of ORS 413.302 and 413.306 by section 7 of this 2015 Act.

SECTION 9. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.

Oregon Health Authority
OFFICE OF HEALTH INFORMATION TECHNOLOGY

HIT Legislation Update:

House Bill 2294 has passed through the Oregon House, 59 Ayes, 1 Excused

VOLUME 3, ISSUE 2 | MARCH 5, 2015

HITOC UPDATE: PHASE 1.5 IMPLEMENTATION

VISION:

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

THREE GOALS OF HIT-OPTIMIZED HEALTH CARE:

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

EHR INCENTIVE PROGRAMS PROVIDE OVER $348 MILLION TO OREGON PROVIDERS

National EHR Incentive Program Payments

As of December 2014, $27.7 billion in total payments have been paid out from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs across states

More than $18.8 billion in Medicare EHR Incentive Program payments have been made between May 2011 and December 2014.

More than $8.9 billion in Medicaid EHR Incentive Program payments have been made between January 2011 (when the first states launched programs) and December 2014.

Oregon EHR Incentive Program Payments

A total of $348.6 million has been paid to Oregon providers for the Medicare and Medicaid EHR Incentive Programs: $117.4 million for Medicaid and $231.2 million for Medicare.

In Oregon, 21 hospitals have completed their participation in the Medicaid EHR Incentive Program (three years of participation).

For more information on EHR Incentive Programs, visit the CMS website http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html.

CALL FOR NOMINATIONS: PROVIDER DIRECTORY ADVISORY GROUP

The Oregon Health Authority (OHA) is convening a Provider Directory Advisory Group (PDAG). The call for nominations went out February 5th and nominations are due March 5th. The Provider Directory will allow healthcare entities access to a state-level directory of provider and practice setting information and functions to support operations, analytics, and the exchange of health information.

More information on the PDAG is available on the OHIT website: http://healthit.oregon.gov/News/Pages/OHA-Seeks-Nominations-for-PDAG.aspx.

EHR INCENTIVE PROGRAM UPDATE CONTINUED

PAYMENTS TO HOSPITALS

	# Hospitals	# Payments	Total Paid
Medicare	~48	92	$128,868,088
Medicaid	56	121	$62,685,314
Medicaid/Medicare	**57**	**213**	**$191,371,402**

PAYMENTS TO ELIGIBLE PROFESSIONALS (EP)

	# Payments	Amount paid	# EPs	# MU
Medicare	8266	$102,055,122	4172	4172
Medicaid	3372	$54,689,040	2123	983
Total	**11638**	**$156,744,162**	**6295**	**5155**

Payment year	Year 1		Year 2	Year 3	Year 4	Totals
	AIU	MU	MU	MU	MU	
2011	912	0				912
2012	604	0	526			1130
2013	463	30	401	355		1249
2014	61	19	1			81
Totals	2040	49	928	355		3372

PreManage Update

The Emergency Department Information Exchange (EDIE) has brought real-time hospital notifications to almost every hospital in Oregon and Washington. PreManage expands upon EDIE by bringing hospital event notifications to Oregon's coordinated care organizations (CCOs), health plans, provider groups and other members of the care team for their patients. Hospital notifications improve care coordination across the care team by providing real-time alerts on relevant hospital event information. PreManage allows care team members to customize alerts to manage their patients by subpopulation for a variety of uses.

Discussions regarding a statewide Medicaid Subscription to PreManage have been continuing. A webinar is scheduled for March 13th to discuss a proposed subscription model with CCOs.

Meanwhile, a pilot for PreManage with the Assertive Community Treatment (ACT) teams that serve individuals with severe mental illness will go live in March 2015.

Technical Assistance

OHA continues its work to bring technical assistance to Oregon Medicaid providers for using electronic health records (EHRs) and meeting Meaningful Use (MU) requirements. The RFP to secure a contractor to provide these services was developed and informally approved by CMS. The next step will be to finalize and post the RFP.

COMMON CREDENTIALING UPDATE

OHA is continuing to work on the implementation of the Oregon Common Credentialing Program (OCCP) that will provide a centralized repository of practitioner credentialing information for use by credentialing organizations in Oregon. To ensure there is sufficient time to implement the solution in an effective way, Senate Bill (SB) 594 has be introduced this session and will allow OHA to establish the operational date by rule if passed. Under current legislation, the date is set at January 1, 2016. Without flexibility in the operational date, the implementation of common credentialing in Oregon will be more condensed and complex. OHA supports SB 594 and wants to ensure a successful common credentialing solution that is not hindered by a rushed implementation effort.

PROVIDER DIRECTORY AND CLINICAL QUALITY METRICS REQISTRY UPDATE

OHA recently completed a Request for Information (RFI) process on the Provider Directory and Clinical Quality Metrics Registry projects, as well as a Systems Integrator to manage implementation of these solutions and coordinate with other projects in OHA's health IT portfolio. We received 20 responses to the RFI, which have been reviewed and analyzed and will inform our procurement for these solutions.

CROSSWALK OF EFFORTS SUPPORTING HIT-OPTIMIZED HEALTH CARE GOALS IN OREGON

	GOAL 1: SHARING PATIENT INFORMATION ACROSS CARE TEAM	GOAL 2: USING AGGREGATED DATA FOR SYSTEM IMPROVEMENT	GOAL 3: PATIENT ACCESS TO THEIR OWN HEALTH INFORMATION
EHR Incentive Program	X	X	X
Hospital Notifications	X	X	
Provider Directory	X	X	
CareAccord	X	X	
Technical Assistance for Medicaid Practices	X	X	X
Clinical Quality Metrics Registry		X	

DIRECT SECURE MESSAGING AND CAREACCORD UPDATES

CareAccord is the state's Health Information Exchange (HIE), offering Direct secure messaging at no cost for all members of the care team. In January, Sharon Wentz, CareAccord Business Development Coordinator, made a webinar presentation to the Office of the National Coordinator for Health IT (ONC) and other state partners on the Flat File Provider Directory work. The presentation was well received and highlighted the successes and challenges of interoperability.

The latest Flat File Directory exchange included Jefferson HIE, Oregon Health & Science University, Legacy Health Systems (Emanuel, Good Samaritan, Meridian Park, and Mt. Hood), Lake Health District, Tuality Community Healthcare, Childhood Health Associates, and CareAccord. There are now more than 3,100 Direct secure addresses included in the directory. OCHIN and St. Charles Health System are expected to be in the next directory exchange.

CareAccord is pleased to welcome two new Engagement Specialists, Jessica Wilson and Christina Romeo.

CareAccord now has 128 active organizations with nearly 1,200 users of Direct secure messaging. During the last quarter, CareAccord's number of Direct secure messages exchanged increased to more than 1,000 per month.