Health Information Technology Oversight Council
Thursday, March 5, 2015
1:00 – 4:30 pm

Council and Ex-officio Members Present: Bob Brown, Dave Widen, Ken Carlson, Erick Doolen
Council and Ex-officio Members by Phone: Greg Fraser
Council and Ex-officio Members Absent: Ellen Larsen, Kristen Duus, Priscilla Lewis
Staff Present: Susan Otter, Lisa A. Parker, Rachel Ostroy, Marta Makarushka, Kristin Bork, Justin Keller, Karen Hale (phone), Sharon Wentz (phone)
Invited Guests: Erica Galvez (ONC), Hunt Blair (ONC), Patricia MacTaggart (ONC), Gina Bianco (phone, Jefferson HIE), Pat Bracknell (Central Oregon HIE), Chris Diaz (FamilyCare), Klint Peterson (Samaritan Health Services), Sonney Sapra (Tuality)

Welcome, Opening Comments – Greg Fraser

- Greg started the meeting with no announcements.

Goals and Meeting Overview – Susan Otter

Refer to slide 3-6

- Susan reviewed the 3 goals of HIT-optimized health care.
- Susan then introduced and welcomed guests, including representatives from ONC and an invited panel of experts from various health entities in Oregon.

Featured Topic: ONC Strategic Vision for Interoperability – Susan Otter & Erica Galvez

Refer to "Shared Nationwide Interoperability Roadmap Quick Reference;" slides 7-25
Presentation:

- Susan introduced Erica Galvez, Interoperability and Exchange Portfolio Director, ONC, to provide an overview of ONC's Shared Nationwide Interoperability Roadmap. Erica presented ONC's vision of a learning health system and how the roadmap is meant to work backward from this ultimate goal. She then reviewed the five building blocks for ONC's interoperability vision, which include:
    - Core technical standards and functions
    - Certification to support adoption and optimization of health IT products and services
    - Privacy and security protections for health information
    - Supportive business, clinical, cultural, and regulatory environments
    - Rules of engagement and governance
- Erica reviewed basic principles for interoperability, emphasizing that the roadmap is focused on nationwide interoperability—not on pockets of interoperability. She also emphasized building upon existing health IT infrastructure—that while health IT is not perfect, there has been significant investment in existing systems that can be leveraged. She also emphasized standardization, particularly on the back end of systems. This is to be distinguished from the need to standardize the user experience/interface—which should be tailored to user's needs. Erica also emphasized the measurement framework of the interoperability roadmap.
- Susan then highlighted the alignment between ONC's interoperability roadmap and health IT efforts in Oregon. The roadmap includes 10 different calls to action for states and Susan reviewed Oregon's progress on many of these activities:
    - Per the roadmap, Oregon has an established health IT business plan framework in place;
    - Oregon has leveraged Medicaid funds to support interoperability and exchange
    - The coordinated care model in Oregon aligns nicely with the roadmap's call for multi-payer payment system reforms
- Susan also highlighted areas for consideration from the roadmap, including state-level policies for interoperability standards as well as coordination between state and federal efforts around governance to support interoperability nationwide. Susan mentioned plans for a Compatibility

Program, which would provide standards for Oregon providers to connect to state health IT systems (as opposed to broader standards for operations in general across the state).

Interoperability Panel – Invited Guests

Refer to slides 26-27

Presentation:

See attached "Interoperability Panel Notes"

Discussion:

- Question: EDIE provides a clear early value proposition for health information exchange—are there any other early value propositions?
    - Answer: Pat Bracknell replied that their patients love the patient portal, but the primary use is lab results. Sonney Sapra added that Tuality has looked closely at the OpenNotes project, which adds full clinician notes to patient portals for patients to review. Other providers that have implemented this have seen considerable value.
- Question: what issues related to privacy and security have your organizations faced?
    - Answer: Gina Bianco replied that there are multiple levels of privacy and security to work through. For example, user access in Jefferson HIE is role-based and tracked on the back end to identify potential breach. User authentication is done based on provider, who is ultimately responsible for use by staff. Patients also have the ability to opt-out of the HIE. Klint Peterson added that laws like HIPAA and 42 CFR part 2, which are designed to clarify the sharing of health information, can actually be a barrier and confusing. Samaritan Health has engaged in community advisory panels to communicate about these laws.

Interoperability Roadmap In-depth Discussion – Hunt Blair

Refer to slides 28-48

Presentation:

- Susan then introduced Hunt Blair, health IT subject matter expert and consultant to ONC, to provide a more detailed discussion of the building blocks introduced by Erica Galvez.
- Hunt discussed sections of the Interoperability Roadmap on a more detailed level including: Core Technical Standards and Functions; Privacy and Security Protections for Health Information; and Rules of Engagement and Governance. He also highlighted the Standards Advisory as the first work product that was derived from the roadmap effort.

Discussion:

- Comment: Gina Bianco commented that there is a need to look at models that have come before this (e.g., Healtheway, DirectTrust) and the sometimes cost prohibitive limitations they put on health information exchange.
    - Answer (Hunt): There is a role for state government in governance, particularly as they are closer to the ground and are closer to the various needs of communities.
- Comment: Chris Diaz recommended looking at other models outside of the healthcare sector.
- Susan mentioned that OHA is doing a more in-depth analysis of the roadmap and will provide public comments. Stakeholders who would like to bring comments to OHA may do so by March 31, 2015. Susan reviewed other deadlines. Final comments from OHA on the roadmap will be brought back to HITOC in the June meeting.

HITOC Business, Approve Minutes – Greg Fraser

Refer to "Dec. 17, 2014 minutes;" slide 50

- Greg confirmed that there was still a quorum after the break, which there was.
- Dave moved to approve the December minutes, Ken seconded the motion. No opposition.

Legislation Update – Susan Otter

Refer to "HB2294-A Engrossed;" slides 51-57

Presentation:

- Susan presented a brief update on the Health IT Legislation—House Bill 2294. She reminded the

HITOC members of the three primary components of the bill:
    - Creates the Oregon Health Information Technology Program within OHA and allows OHA to charge fees to users of the Program's services;
    - Allows OHA to partner or collaborate with other entities to achieve statewide health IT services—including the ability to vote on a governing board, pay fees or dues, etc.
    - Moves HITOC under the Oregon Health Policy Board and require HITOC to monitor state health IT efforts and report to the Board.
- Susan mentioned that the bill passed the House, and for the public hearing in the House Health Care Committee, there were 14 letters of support. The bill will move forward to the Senate Health Care Committee sometime in April or May.
- There has been an adopted amendment, which adds that OHA shall report to the legislative assembly at least annually on progress of the Oregon Health IT Program. The amendment also reflects suggestions by HITOC members to make the language of certain sections broader to account for functions outside of facilitating health information exchange.
- Susan highlighted Zeke Smith's testimony, Chair of the Oregon Health Policy Board, which emphasized the Board's intention to ensure broad representation on HITOC should it move under the Board.
- If the bill passes, next steps will include the development of fees for services and the transition of HITOC under the Health Policy Board, which will include a new charter and setting membership.

Discussion:

- Question: what does the legislation say about HITOC membership—in terms of numbers?
    - Answer: the legislation leaves the number of members up to the Health Policy Board.
- Question: Fees will need to be approved by legislation at the next session?
    - There are a couple of paths—the fees can be established by rule, which the legislature would then validate later. The second path is to develop fees during the next short session, which would be February 2016.
- Question: what is the time frame for transitioning under the Health Policy Board?
    - Answer: we plan to engage the Health Policy Board over the summer and, if the bill passes closer to June, we would expect to have new members ready to attend the September 2015 meeting.

ONC Interoperability Cooperative Agreement – Susan Otter

Refer to slides 58-63

Presentation:

- Susan announced that ONC has released a Funding Opportunity Announcement (FOA) for state interoperability projects. ONC has $28 million to award to approximately 10-12 states as cooperative agreements and the projects will last at most 24 months. The grant requires a 1:3 match which can include in-kind contributions. The three focus areas of the FOA are:
    - Adoption of interoperable technology;
    - Interoperability and use (after adopted);
    - Integration of data by different types of care providers (including eligible and non-eligible providers for the EHR Incentive Programs).
- Given OHA's strategic plan, OHA decided to seek sub-grantees. There were two priorities identified for the Oregon project: 1) expanding the use of Direct secure messaging; 2) integration of behavioral health and physical health information sharing.
- Susan briefly reviewed the criteria for reviewing sub-grantees and the process. Dave Widen and Ken Carlson volunteered to assist with the review of letters of interest for this grant opportunity. If there are no sub-grantees interested, OHA will not submit the grant.

Discussion:

- Question: if the grant requires states to apply, how do organizations fit in?
    - Answer: the FOA allows for sub-grantees. The state will submit the application and

oversee the sub-grantee(s). The sub-grantee(s) will be responsible for driving the work of the project.

- Question: how will the in-kind match for this work?
  - Answer: OHA is asking sub-grantees to submit plans for how they could contribute to the 1:3 match—OHA is not planning to contribute any state funds.
- Question: how many sub-grantees are you planning to have?
  - Answer: we are considering 1-3 sub-grantees at this time. We have not seen the letters of intent at this time.
- Question: what are the types of the organizations that attended OHA's informational webinar on this grant?
  - Answer: regional HIEs are interested in the grant opportunity; some of the CCOs; a number of vendors (who are not eligible to apply directly); hospitals and provider groups.
- Question: is there a contingency in place if you do not receive sub-grantees covering both of OHA's priorities?
  - Answer: there is no requirement to cover both priorities with these projects. If three good projects are focused on priority 1, that is what we will submit. The grant does have requirements and those will need to be met across the sub-grantees.
- Question: will the sub-grantees be responsible for writing the grant with you?
  - Answer: yes—the time frame is very tight. Discussion continued around the time frame for this project.

June HITOC Meeting & Other Updates – Susan Otter

Refer to slides 64-68

Presentation:

- Susan presented OHA's thoughts for the June HITOC meeting. One option is to broaden the stakeholder involvement in HITOC's work and plan to set priorities for HITOC moving forward.
- As an alternative, there are many other topics that could be discussed during the June meeting:
  - Telehealth; OHA has pilot grants going out soon;
  - Work around 42 CFR part 2;
  - CCO profiles summary – the majority of CCOs have returned their profiles with edits and have been finalized. The goal is to have all of these profiles finalized by May.
- Invitations have been sent out for the HIT/HIE Community & Organizational Panel (HCOP), Susan reviewed the timeline and the first meeting is planned for May. The June meeting would also be a good time to report out to HITOC on this meeting.
- Susan mentioned that OHA is expecting notice of proposed rule-making on the EHR Incentive Programs for Stage 2 and Stage 3. The plan would be to have an ad hoc meeting in preparation for developing public comments to these proposed rules.
  - Question: The comment would be on the federal rule itself, not the state implementation of this rule?
    - Answer: Yes, the comments would be to the federal rule.

Discussion:

- Question: how will the HITOC charter be managed if, in the transition to the Health Policy Board, the role of HITOC changes significantly?
  - Answer: Ken replied that the discussion around priorities could drive the charter process. Susan replied that the charter will validate the role that HITOC plays and its responsibilities to the Health Policy Board. Dave mentioned that the draft charter serves as a recommendation to the Health Policy Board.
- Comment: it would be important to get the Health Policy Board's feedback on this approach prior to the June meeting.

Public Comment – Greg Fraser

- Hearing no comment, the Chair closed the public comment period at 4:11 p.m.

Closing Comments – Greg Fraser
• The meeting was adjourned at 4:16 p.m.

Next meeting is Thursday, June 4, 2015 in Salem

Health Information Technology Oversight Council (HITOC)

March 2015 Meeting: Special Panel on Interoperability

Summary of panel discussion, reaction to draft ONC National Interoperability Roadmap

Panelists:
Gina Bianco, *Jefferson HIE*
Pat Bracknell, *Central Oregon HIE*
Chris Diaz, *FamilyCare CCO*
Klint Peterson, *Samaritan Health Services*
Sonney Sapra, *Tuality*

Key Themes:

1. **Cost** – health information technologies are emerging and they are expensive to adopt and operate. When vendors change or update their products they push these costs onto providers and organizations. Particularly as organizations experiment and learn what works within their community, these costs can be considerable.
2. **Value** – demonstrating the value of HIE tools is difficult and directly tied to the scope of each solution. Large encompassing solutions are too costly and complicated to get off the ground; small solutions may not demonstrate enough value across the various sectors of the health care system.
    a. In Oregon, the Emergency Department Information Exchange (EDIE) is a good example of how clear value drives adoption of these technologies
3. **Clinical Need** – standards need to be more closely aligned with the needs of clinicians. Existing standards (e.g. HL7, CCDA, etc.) do not give clinicians everything they need to do their jobs.

Detailed Discussion:

Klint Peterson, *Samaritan Health Services*

One of the key successes for interoperability to date is that providers are willing to make it happen and are demanding it. Dedicated providers in the Corvallis area understand the need for health information exchange—they want a community perspective on their patients. A second key success is that the technology to make health information exchange work is available and works effectively.

A key challenge for health information exchange is that it is difficult to gauge what level of information to include. Too much information, from too many sources, is seemingly impossible to get off the ground. Building an HIE incrementally, using small steps, does not demonstrate value quickly enough to sustain the effort. A second challenge is cost. The technology is expensive, and organizations that are implementing it are learning as they go—which can lead to considerable financial risk.

There are a number of diverse interests: payer vs. clinician; profit vs. non-profit; public vs. private. In designing HIE capabilities it is very challenging trying to manage all of

these interests when the incentives are not aligned. Technology is not a solution, it is a tool used to get to a solution: information consolidation.

Pat Bracknell, *Central Oregon HIE*
One advantage to Central Oregon is its geographic isolation from other areas of the state. There are simply fewer stakeholders and interests to wrangle. The medical group and the hospital system in the area came together to build a central data repository. However, there is still a need for collaboration—not all patients in the area use the participating medical group for their care.

Meaningful use and the development of coordinated care organizations (CCOs) have helped the creation of this repository. The Direct secure messaging and patient portal requirements that are built into Meaningful Use Stage 2 have really pushed these initiatives ahead and have driven the adoption of these functionalities. The development of CCOs and the state CCO transformation funds, which were used in part to support Central Oregon HIE financially, were also critical to its success.

The biggest challenge faced by Central Oregon HIE is a sustainable funding model. Grant funding is temporary and the work that goes into this process is considerable. The Board of Central Oregon HIE has worked hard on developing a sustainability model but as Klint mentioned, you have to bring everyone to the table and they have to see the value. Organizations have competing priorities—ACOs come into the region and have a solution in hand, introducing new systems that are not utilizing the HIE. Central Oregon would like to see some of these complexities modeled out—for example, use cases for the HIE would be beneficial.

The clinical data we have standards for today do not align with what clinicians need/use day-to-day. The CCD does not require what clinicians actually need. It also does not require data needed to report on quality measures. Further development of this will move this work forward. Pat was pleased to see the inclusion of a list of use cases in the Interoperability Roadmap—this is something they really need assistance with.

Sonney Sapra, *Tuality*
There is a lot of competition in the community Tuality operates in. Tuality has been very successful in implementing Direct secure messaging, as well as the Emergency Department Information Exchange (EDIE). EDIE alerts hospitals when a registered patient is a high utilizer of emergency department services (e.g. at least 5 visits in the past 12 months). These tools have helped us to exchange data with other providers in our community. Tuality also participates in CommonWell Health Alliance which is dedicated to making EHR systems interoperable. That has been a very cost effective tool and connects users across the nation. However, some large EHR vendors are not participating in CommonWell, and these vendors have a significant presence in the Portland metro area.

The cost is a huge challenge. Whenever interoperability is discussed, it always comes down to cost.

In terms of the information being shared, it is very difficult to find the happy medium between too much information and too little. Providers do not agree on information that is included in standardized data formats such as the CCD—some find it helpful as is, some think it only covers about 5% of what they need to know. EDIE has helped by bringing in more information from a hospital perspective.

There has been a lot of pressure put on hospitals to make health information exchange work—there should be more pressure put on health IT vendors to adopt consistent standards in their products and not push these costs on to their clients. Standards both from the federal level as well as the state level through groups like HITOC, would help.

Gina Bianco, *Jefferson HIE*
Gina applauds the Interoperability Roadmap and believes it identifies the appropriate challenges and issues. Jefferson HIE has taken a phased approach to implementation, first focusing on point-to-point exchange and then shifting to more robust, query-based interoperability. Jefferson HIE has built the EHR interfaces to establish data feeds with hospitals.

A large focus has been on supporting CCOs and getting them the connectivity they need to be successful. Part of the goal of the CCO model is to integrate behavioral health and a significant challenge has been the fact that laws and policies such as 42 CFR part 2, which limit the sharing of certain kinds of addiction treatment information, have not evolved along with health system transformation. There is strong desire for clear guidance on this to ensure that information can be shared in a way that complies with existing laws.

While there are standards, vendors implement things differently and this cost usually comes back to the HIE or provider. Work is needed on CCDs to make them configurable to specific use cases. Providers do not want to leave their EHR to access information—single sign-on is needed to make this seamless from a user's perspective. Every vendor approaches this differently.

Chris Diaz, *FamilyCare CCO*
When we think of value for HIE (or any investment for that matter), value can be defined as what the customer is willing to pay for. Looking at a tool like EDIE, this definition really comes to life. For both Oregon and Washington, there is very clear value in this kind of information exchange. In Washington this started because Medicaid was no longer going to pay for the same thing twice—particularly for drugs. The uptake of EDIE in response to this was very prompt. In Oregon the approach has been more of a statewide investment—meaning that taxing and spending is done in a judicious way. This is an example to build on.

There is a distinction to make between information exchange and interoperability. Most of the information exchange occurring requires human intervention—it is not truly interoperable. Others have mentioned costs being pushed onto large hospitals and health systems but there is also a considerable market of small provider practices. They are being left behind by a lot this innovation.

As standards evolve, it is important to align with reporting metrics, which are increasingly burdensome for providers. This is reducing the incentive to participate in publicly funded health care.

The payers need to be included in this innovation also—there are improvements that could be made using IT systems that can achieve clinical and payment/operational tasks simultaneously.

Enrolled
House Bill 2294

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

CHAPTER .....

AN ACT

Relating to health information technology; creating new provisions; amending ORS 279A.050, 413.011, 413.300, 413.301, 413.303 and 413.308 and section 1, chapter 77, Oregon Laws 2014; 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) Subject to ORS 279A.050 (7), 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 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, subject to ORS 279A.050 (7), 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) 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 completing 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 279A.050 is amended to read:

279A.050. (1)(a) Except as otherwise provided in the Public Contracting Code, a contracting agency shall exercise all procurement authority in accordance with the provisions of the Public Contracting Code.

(b) When a contracting agency has authority under this section to carry out functions described in this section, or has authority to make procurements under a provision of law other than the Public Contracting Code, the contracting agency is not required to exercise that authority in accordance with the provisions of the code if, under ORS 279A.025, the code does not apply to the contract or contracting authority.

(2) Except as otherwise provided in the Public Contracting Code, for state agencies the Director of the Oregon Department of Administrative Services has all the authority to carry out the provisions of the Public Contracting Code.

(3) Except as otherwise provided in the Public Contracting Code, the Director of Transportation has all the authority to:

(a) Procure or supervise the procurement of all services and personal services to construct, acquire, plan, design, maintain and operate passenger terminal facilities and motor vehicle parking facilities in connection with any public transportation system in accordance with ORS 184.689 (5);

(b) Procure or supervise the procurement of all goods, services, public improvements and personal services relating to the operation, maintenance or construction of highways, bridges and other transportation facilities that are subject to the authority of the Department of Transportation; and

(c) Establish standards for, prescribe forms for and conduct the prequalification of prospective bidders on public improvement contracts related to the operation, maintenance or construction of highways, bridges and other transportation facilities that are subject to the authority of the Department of Transportation.

(4) Except as otherwise provided in the Public Contracting Code, the Secretary of State has all the authority to procure or supervise the procurement of goods, services and personal services related to programs under the authority of the Secretary of State.

(5) Except as otherwise provided in the Public Contracting Code, the State Treasurer has all the authority to procure or supervise the procurement of goods, services and personal services related to programs under the authority of the State Treasurer.

(6) The state agencies listed in this subsection have all the authority to do the following in accordance with the Public Contracting Code:

(a) The Department of Human Services to procure or supervise the procurement of goods, services and personal services under ORS 179.040 for the department's institutions and the procurement of goods, services and personal services for the construction, demolition, exchange, maintenance, operation and equipping of housing for the purpose of providing care to individuals with intellectual disabilities or other developmental disabilities, subject to applicable provisions of ORS 427.335;

(b) The Oregon Health Authority to procure or supervise the procurement of goods, services and personal services under ORS 179.040 and construction materials, equipment and supplies for the authority's institutions and the procurement of goods, services, personal services, construction materials, equipment and supplies for the construction, demolition, exchange, maintenance, operation and equipping of housing for persons with chronic mental illness, subject to applicable provisions of ORS 426.504;

(c) The State Department of Fish and Wildlife to procure or supervise the procurement of construction materials, equipment, supplies, services and personal services for public improvements, public works or ordinary construction described in ORS 279C.320 that is subject to the authority of the State Department of Fish and Wildlife;

(d) The State Parks and Recreation Department to procure or supervise the procurement of all goods, services, public improvements and personal services relating to state parks;

(e) The Oregon Department of Aviation to procure or supervise the procurement of construction materials, equipment, supplies, services and personal services for public improvements, public works or ordinary construction described in ORS 279C.320 that is subject to the authority of the Oregon Department of Aviation;

(f) The Oregon Business Development Department to procure or supervise the procurement of all goods, services, personal services and public improvements related to its foreign trade offices operating outside the state;

(g) The Housing and Community Services Department to procure or supervise the procurement of goods, services and personal services as provided in ORS 279A.025 (2)(n);

(h) The Department of Corrections to procure or supervise the procurement of construction materials, equipment, supplies, services and personal services for public improvements, public works or ordinary construction described in ORS 279C.320 that is subject to the authority of the Department of Corrections;

(i) The Department of Corrections, subject to any applicable provisions of ORS 279A.120, 279A.125, 279A.145 and 283.110 to 283.395, to procure or supervise the procurement of goods, services and personal services under ORS 179.040 for its institutions;

(j) The Department of Veterans' Affairs to procure or supervise the procurement of real estate broker and principal real estate broker services related to programs under the department's authority;

(k) The Oregon Military Department to procure or supervise the procurement of construction materials, equipment, supplies, services and personal services for public improvements, public works or ordinary construction described in ORS 279C.320 that is subject to the authority of the Oregon Military Department;

(L) The Department of Education, subject to any applicable provisions of ORS 329.075, 329.085 and 329.485 and the federal No Child Left Behind Act of 2001 (P.L. 107-110, 115 Stat. 1425), to procure or supervise the procurement of goods, services, personal services and information technology relating to student assessment; and

(m) Any state agency to conduct a procurement when the agency is specifically authorized by any provision of law other than the Public Contracting Code to enter into a contract.

(7) Notwithstanding this section and ORS 279A.140 (1), the Director of the Oregon Department of Administrative Services has exclusive authority, unless the director delegates this authority, to procure or supervise the procurement of all price agreements on behalf of the state agencies identified in subsection (6)(a) to (k) of this section under which more than one state agency may order goods, services or personal services and[*, except for contracts procured by the Oregon Health Authority,*] all state agency information technology contracts. This subsection does not apply to contracts under which the contractor delivers to the state agency information technology products or services incidental to the performance of personal services contracts described in ORS chapter 279C or construction contracts described in ORS chapter 279C. A state agency identified in subsection (3) or (6)(a) to (k) of this section may not establish a price agreement or enter into a contract for goods, services, personal services, construction materials, equipment or supplies without the approval of the director if the director has established a price agreement for the goods, services or personal services.

SECTION 8. Section 1, chapter 77, Oregon Laws 2014, is amended to read:

Sec. 1. (1) As used in this section:

(a)(A) "Information technology initiative" means a project to develop or provide, with the state contracting agency's or public corporation's own personnel and resources, or to obtain by means of a procurement or set of related procurements:

(i) New hardware, software or services for data processing, office automation or telecommunications;

(ii) An overhaul, upgrade or replacement of a substantial portion of the hardware or software in an existing data processing, office automation or telecommunications system; or

(iii) A substantial expansion of existing data processing, office automation or telecommunications services.

(B) "Information technology initiative" does not include:

(i) A procurement for preliminary quality assurance services or quality management services;

(ii) A routine update to or purchase of hardware or software within an existing data processing, office automation or telecommunications system;

(iii) A renewal of an existing contract for data processing, office automation or telecommunications services under terms and conditions that are substantially the same as in the existing contract; or

(iv) A replacement of a component of an existing data processing, office automation or telecommunications system that is not essential for the system to function as designed or that occurs at the end of the component's anticipated life cycle.

(b) "Preliminary quality assurance services" means a set of services in which a contractor provides an independent and objective review of a state contracting agency's or a public corporation's plans, specifications, estimates, documentation, available resources and overall purpose for an information technology initiative, including services in which the contractor evaluates a proposed information technology initiative against applicable quality standards and best practices from private industry and other sources.

(c) "Procurement" has the meaning given that term in ORS 279A.010.

(d)(A) "Public corporation" means a corporation:

(i) The operations of which are subject to control by this state or by an agency or instrumentality of this state, or by officers of this state or of an agency or instrumentality of this state;

(ii) That is organized, at least in part, to serve a public purpose; and

(iii) That receives public funds or other support from an entity described in sub-subparagraph (i) of this subparagraph.

(B) "Public corporation" does not include:

(i) A person or entity described in ORS 174.108 (3);

(ii) A city, county, local service district, school district, education service district, community college district or community college service district or a university with a governing board listed in ORS 352.054; or

(iii) An administrative subdivision of an entity described in sub-subparagraph (ii) of this subparagraph.

(e) "Quality management services" means a set of services in which a contractor provides an independent and objective review and evaluation of a state contracting agency's, a public corporation's or another contractor's performance with respect to an information technology initiative, such as services in which the contractor:

(A) Identifies quality standards that apply or should apply to the information technology initiative;

(B) Suggests methods and means by which the state contracting agency, the public corporation or the other contractor may meet quality standards identified in subparagraph (A) of this paragraph;

(C) Reviews and evaluates the state contracting agency's, the public corporation's or the other contractor's performance regularly as the information technology initiative progresses from start to finish;

(D) Identifies omissions or gaps in the state contracting agency's, the public corporation's or the other contractor's planning, execution, control, methodology, communication or reporting as the information technology initiative progresses from start to finish;

(E) Identifies risks in the state contracting agency's, the public corporation's or the other contractor's plans or approach to designing, developing or implementing the information technology initiative and suggests methods to reduce, mitigate or eliminate the risks;

(F) Assists the state contracting agency or the public corporation in testing or otherwise evaluating the hardware, software or services that are developed, provided or obtained as part of an information technology initiative to determine whether the hardware, software or services conform with the quality standards identified in subparagraph (A) of this paragraph;

(G) Advises the state contracting agency or the public corporation as to whether the hardware, software or services that are developed, provided or obtained as part of an information technology initiative meet the contracting agency's or the public corporation's needs, specifications or expectations and otherwise enable the state contracting agency or the public corporation to achieve the objectives for the information technology initiative; or

(H) Identifies unsatisfactory performance and suggests methods the state contracting agency, the public corporation or the other contractor might use to eliminate the causes of unsatisfactory performance.

(f) "State contracting agency" has the meaning given that term in ORS 279A.010.

(2)(a) A state contracting agency or a public corporation that implements an information technology initiative shall obtain quality management services from a qualified contractor if the value of the information technology initiative exceeds $5 million or if the information technology initiative meets criteria or standards that the State Chief Information Officer or the Director of the Oregon Department of Administrative Services specifies by rule or policy.

(b) A state contracting agency or public corporation may, subject to ORS 279B.040, procure preliminary quality assurance services from a contractor if the information technology initiative meets the standards set forth in paragraph (a) of this subsection or if the state contracting agency or public corporation otherwise believes that the preliminary quality assurance services will enable the contracting agency or public corporation to implement an information technology initiative successfully.

(3) A state contracting agency or public corporation may not artificially divide or fragment an information technology initiative so as to avoid the application of this section.

(4)(a) Notwithstanding any procurement authority that a state contracting agency or a public corporation has that is not subject to the authority of the Director of the Oregon Department of Administrative Services under ORS 279A.050 (2) or (7), the state contracting agency or public corporation is subject to the provisions of subsection (2) of this section and shall consult with and follow the rules, policies and procedures of the State Chief Information Officer and the Oregon Department of Administrative Services in determining the extent of preliminary quality assurance services or quality management services that the state contracting agency or public corporation will require for an information technology initiative.

(b) [*Notwithstanding the Oregon Health Authority's exemption in ORS 279A.050 (7) from the authority that the Oregon Department of Administrative Services has over all state agency information technology procurements,*] The Oregon Health Authority shall consult with and follow the rules, policies and procedures of the State Chief Information Officer and the Oregon Department of Administrative Services in determining the extent of preliminary quality assurance services or quality management services that the state contracting agency or public corporation will require for an information technology initiative.

(5)(a) If a state contracting agency or a public corporation awards a contract for preliminary quality assurance services or quality management services, the contract must provide that at the same time a contractor provides a preliminary or final report to the contract administrator, the contractor shall also provide a copy of the report to:

(A) The State Chief Information Officer;

(B) The Director of the Oregon Department of Administrative Services; and

(C) As appropriate for the specific information technology initiative, to:

(i) The director of the state contracting agency or, if a board or commission sets policy for the state contracting agency, to the board or commission; or

(ii) The governing body of the public corporation.

(b) The state contracting agency or public corporation shall provide the contractor with names, addresses and other contact information the contractor needs to comply with paragraph (a) of this subsection.

(6) This section does not apply to the Secretary of State or the State Treasurer.

SECTION 9. ORS 413.302 and 413.306 are repealed.

SECTION 10. (1) Section 1 of this 2015 Act, the amendments to ORS 279A.050, 413.011, 413.300, 413.301, 413.303 and 413.308 and section 1, chapter 77, Oregon Laws 2014, by sections 2 to 8 of this 2015 Act and the repeal of ORS 413.302 and 413.306 by section 9 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 279A.050, 413.011, 413.300, 413.301, 413.303 and 413.308 and section 1, chapter 77, Oregon Laws 2014, by sections 2 to 8 of this 2015 Act and the repeal of ORS 413.302 and 413.306 by section 9 of this 2015 Act.

SECTION 11. 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.

Passed by House February 23, 2015

Repassed by House May 26, 2015

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate May 21, 2015

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2015

Approved:

.....M.,....., 2015

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2015

.....
Jeanne P. Atkins, Secretary of State

The Virtual Dental Home comes to Polk County

Capitol Dental Care (CDC) is launching an innovative pilot project that utilizes teledentistry technology to connect a dentist in the dental office with licensed allied dental professionals working with underserved populations. The specific aims of this project are to:

- Demonstrate the ability to create and deploy telehealth-connected oral health teams capable of reaching children who have not been receiving dental care on a regular basis and providing community-based dental diagnostic, prevention and early intervention services;
- Undertake on-site data collection for diagnostic records and perform preventive procedures designed to keep children from developing advanced dental disease;
- Demonstrate a reduced need for most children to be seen by dentists in stationary dental practices or clinics (the Virtual Dental Home);
- Achieve the Triple Aim in oral health care in Oregon with people having better experiences of care, better oral health and doing so at a lower the cost per-capita; and
- Develop lessons that can be used to disseminate the Virtual Dental Home concept throughout Oregon

The pilot project will comprise around 1,500 children in a school district in Polk County, Oregon, where CDC provides children dental care in a school based setting. Oregon has yet to study the efficacy of the tele-dentistry model. However, the use of a "virtual" dentist to direct care has proven highly effective in other states. Studies in California and Arizona have shown that a remotely located dentist, working with an Expanded Practice Dentist Hygienist (EPDH), who is seeing a patient at a different location, can collaboratively deliver quality dental care. Secure technology delivers health information between EPDH and dentist, allowing the dentist to diagnose and develop a specific treatment plan comparable to a face-to-face evaluation done in a bricks and mortar dental office, but at far lower cost. It is the hypothesis of this project that a tele-dentistry model is a solution that will be appropriate for Oregon's many dental professionals' shortage areas as a component of the ongoing health care transformation. Start-up costs are low, the technology is readily available and the model is infinitely scalable to any demographic or population. Embraced by 50 medical sub-specialties, telemedicine is a keystone of America's next-generation medical model. CDC and its partners intend to bring this innovative model into mainstream dentistry, and to the state of Oregon, whose leadership has a long history of embracing technologies that improve the health of its citizens.

Contact:
Linda Mann, EPDH
Director, Community Outreach, Capitol Dental Care
3000 Market St NE, Suite 228
Salem, OR 97301
mannl@interdent.com
503-917-2604

HCOP Panel Projects Overview

Project Name	HCOP Panelist Name	Organization	Project Type	Region	Vendor	Financing/ Governance	Incorporated Data Types	Users	Identified Use Cases	Implementation Status
Jefferson HIE	Gina Bianco	Jefferson Health Information Exchange	HIE	Southern Oregon, Columbia Gorge	Medicity	501c3, broad stakeholder representation on Board, hospitals vetted the vendor	Labs & Pathology, Radiology reports, transcribed reports, cardiology studies, care team list, automated HL7 Admit Discharge Transfer (ADT) feeds, care summaries	Live: Providers, Hospitals, Clinics/FQHCS, CCOs; Future: Other Labs/Diagnostics, First Responders, Pharmacies, Registries, Other Health Plans	Closed Loop Clinical Referrals, Direct Secure Messaging, Community Health Record, Hospital notifications, Transitions of Care	Phased Implementation: Phase 1: Referrals and Direct SM (completed) Phase 2: Community health record (completed), planned integration with EDIE Phase 3: Population Health Mgmt; Analytics
Community Connected (C2) Network	Stephanie Mendenhall	Jackson County Health and Human Services	HIE	Jackson County	VistaLogic	CCOs put in costs, matched by HHS	Behavioral health, Social service data, Court data, School district data, employment	HHS – Mental Health, DHS, Medical Providers, CBOs, other HIEs	Central contact registry/referral service, auto-populated forms, access & utilization notifications, data aggregation & reporting	Vendor contract signed—in development

Project Name	HCOP Panelist Name	Organization	Project Type	Region	Vendor	Financing/ Governance	Incorporated Data Types	Users	Identified Use Cases	Implementation Status
Care Team Link (Regional Health Information Collaborative; RHIC)	Klint Peterson	InterCommunity Health Network CCO (IHNCCO)	HIE	Lincoln, Benton, Linn Counties	Intersystems Product - HealthShare	CCO funded (IHNCCO)	EMR encounter data, claims data, pharmacy	IHNCCO affiliates	Care history for coordination, Hospital notifications, order tracking (closed loop prescriptions), Emergency Preparedness	Vendor contract signed. IT work on claims data has been implemented (currently updating nightly) Real-time Encounter feeds are being received from area hospitals. Data feeds from other partners are in-process.
CareAccord	Britteny Matero	Oregon Health Authority	Direct Secure Messaging Provider (HISP)	Statewide	Harris, Mirth Mail	Medicaid and state funded, currently offered for free	N/A – Direct is a transport mechanism, allows for sharing of a broad range of data	Oregon health care entities, providers and care team members, state agencies (OHA/DHS)	Direct secure messaging use for care coordination across organizational and geographical boundaries; EMR-integration pilots will support Meaningful Use requirements for sending Transitions of Care summaries	Web portal currently operational, about to engage in EMR-integration pilots

Project Name	HCOP Panelist Name	Organization	Project Type	Region	Vendor	Financing/ Governance	Incorporated Data Types	Users	Identified Use Cases	Implementation Status
Care Management, Analytics & Reporting Tool (CMART)	Deborah Rumsey	Children's Health Alliance (CHA)	Population Management Tool	Portland Metro Area	Wellcentive	Provider-Purchased, providers vetted the vendor	EMR data (varies by vendor), EDIE, payer claims data	CHA member Pediatricians (100+)	Robust data aggregation, analytics, and reporting, pay for performance analytics, care management supports, shared care plans.	Vendor contract signed; development work for pediatric content ongoing; 2 EMR Interfaces complete; 1 health plan interface complete; EDIE interface complete, asthma registry complete.
Central Oregon Health Connect	Pat Bracknell	St. Charles Health System	HIE	Central Oregon	N/A	Governance and financing structure created – currently considering next steps for technology efforts	TBD	CCO, St. Charles Health System, community providers, etc.	TBD	Data foundation for HIE created—will determine further efforts in the future
Emergency Department Information Exchange (EDIE)	Susan Kirchoff	Oregon Health Leadership Council	Hospital Event Notification System	Statewide (for Hospitals)	Collective Medical Technologies	Costs shared: half by hospitals and half by commercial plans/OHA on behalf of CCOs. Representative Governance Committee	Automated HL7 Admit Discharge Transfer (ADT) Information, supplemented by manual entry of care guidelines/ history	EDIE: Oregon and WA Hospitals PreManage: Medical groups, health plans, CCOs, other care coordinators	Hospital notifications, shared care guideline/history	EDIE Utility almost at full participation (95%) for ED and inpatient ADT Information, PreManage expanding across user types

HITOC's HIT/HIE Community and Organizational Panel (HCOP)
Themes from First Meeting
May 21, 2015

The first meeting of the Health IT/Health Information Exchange Community and Organizational Panel (HCOP) was held on May 21, 2015. The focus of the first meeting was to provide a forum for the panelists to share information on their HIT/HIE project to inform their colleagues and to identify challenges and opportunities that have been identified thus far. Panelists include:

- Gina Bianco, *Acting Executive Director*, **Jefferson HIE**
- Pat Bracknell, *Executive Director*, **Central Oregon Health Connect**
- Stephanie Mendenhall, *Service Integration Manager*, **Community Connected Network**
- Klint Peterson, *Project Manager*, **RHIC**
- Deborah Rumsey, *Executive Director*, **Children's Health Alliance**
- Susan Kirchoff, *Consultant*, **Oregon Health Leadership Council**
- Britteny Matero, *CareAccord Director*, **Oregon Health Authority**

The 'Themes' below are a high-level compilation of the ideas that were expressed during these discussions. The 'Comments' noted for each theme are thoughts that were shared by the various panelists in the process of the discussions. As such, this is not a comprehensive list representing all the panelists' input on each theme. This list of themes offers the HCOP a starting point for identifying relevant topics for future meetings. The list is not in any particular order (e.g., of importance, priority). The topics identified for discussion at the second meeting include policies that impact security, privacy, and information sharing, as well as a look at the broader state and federal policies that impact HIT/HIE work.

Themes	Comments
Opportunities	
Broad Stakeholder Support	• JHIE has broad stakeholder involvement in their Board and committees. [Gina Bianco] • We started by asking potential users what they wanted—centralized directory for social services for referral purposes and a registry of clients being served in common were prioritized. [Stephanie Mendenhall] • We started this process by asking providers what they wanted—the providers wanted more information about where their patients have been and what treatments are being provided. This need is particularly relevant for new Medicaid patients that are assumed to have a medical history. [Klint Peterson] • [CHA's tool] arose organically from the provider side—the provider wanted to see a more holistic view of the patient as they incorporated care management and population management in their practices; additionally. [Deborah Rumsey]
The multitude of use cases that are possible	• There are a multitude of high-value use cases right now including: EMS/paramedics for information at the point of care in emergency response; care coordination across the care team; reporting. [Klint Peterson]
Challenges	
Value Proposition and Buy-in/Adoption	• Value has to be demonstrated to users on the ground—particularly if it leads to an extra step in their work flow. [Gina Bianco]

	• Marketing is needed to get folks to buy into the system. People have been burned by big data systems before and this just feels like one more database. [Stephanie Mendenhall] • We want health care providers to anticipate using this new tool – so we put time into branding, marketing and creating awareness. All of our partner organizations have a prioritized list of projects to complete. We want this project to be very visible and high on their list of priorities. The focus must remain on patient care. [Klint Peterson]
Variability in EMR vendor capabilities & costs	• The costs that vendors charge for turning some of these capabilities on vary significantly. [Gina Bianco] • For Direct secure messaging: some vendors require a CCDA attachment to send (tied to meaningful use requirement); others require users of Direct to have an NPI number. [Britteny Matero] • The ICD 10 delay pushed the vendors' readiness back. There are a lot of different EMR vendors and their capabilities are very different. [Deborah Rumsey]
Lack of clarity around policies for security/ privacy/information sharing	• Without clear guidance on federal laws like 42 CFR part 2, we are subject to different interpretations by each individual organization's attorneys. [Gina Bianco] • The inability to share certain categories of mental health information limits a physician's ability to serve a patient holistically. As a Mental Health provider, we want to be able to share that information in order to move towards unified treatment plans. [Stephanie Mendenhall] • Every individual organization has its own interpretation. We have a working approach and are vetting that with partners. Each partner decides whether to withhold certain types of data based on their own interpretation. [Klint Peterson] • Connecting to behavioral health providers and information is desperately needed. [Susan Kirchoff]
Training and Work Flow Issues	• The transition of care process is often outside of the user's workflow and the magnitude of data required by the meaningful use standard does not always add value to providers. HIE adoption is a change management process which takes time. We spend a significant amount of time training users on appropriate (HIPAA compliant) use of the system, and monitor use to quickly identify issues. [Gina Bianco] • Even with electronic tools and transport mechanisms (e.g. Direct secure messaging), people do not know where to send things – because they lack an address book or directory for providers outside their organization. [Britteny Matero] • It takes time to do this right—it requires the building of trust. Taking this time is costly. [Klint Peterson] • Metrics that incentivize providers to use certain tools need to make sense for existing work flows so that value/buy-in are not threatened. [Susan Kirchoff] • Training happens in stages, and practices are at varying states of readiness to incorporate in their workflow. It can be a very long process. [Deborah Rumsey]

Strategy and Scope of Efforts	• Keeping up with the many use cases and staffing new technologies is a challenge. [Gina Bianco] • The scalability and cost structure of this long-term is a challenge. [Stephanie Mendenhall] • There is a concern that existing notifications efforts may lead to providers receiving three identical notifications for the same patient event. There needs to be some level of coordination across these projects. [Klint Peterson] • People want [EDIE] to be more than it is—it is challenging to communicate to stakeholders what the tool does and does not do. [Susan Kirchoff]
Data and Technical IT Challenges	• A big challenge is the integrity of the data and managing errors—how to identify them and how to handle this once they are identified. [Klint Peterson] • The integrity of the data can be a challenge, as well as the normalization of data. Standards can be interpreted multiple ways. We are building our own [data specs] because we work with pediatricians and most of the existing standards are based around adult chronic conditions. [Deborah Rumsey]

Oregon Coordinated Care Organizations' Health Information Technology Efforts

Oregon Health Authority, Office of Health Information Technology

DRAFT REPORT TO HITOC, June 2015

This summary describes the health information technology (HIT) initiatives underway in Oregon's 16 Medicaid coordinated care organizations (CCOs), based on information collected in summer/fall 2014 and revised in spring 2015. This summary is intended to inform Oregon Health Authority's (OHA) HIT planning efforts and the policy and strategic planning work of Oregon's HIT Oversight Committee (HITOC) through HITOC's monitoring of the status of major HIT efforts across the state, and the barriers and challenges faced in Oregon's communities around HIT. In addition, this summary may provide useful information to CCOs, providers, accountable care organizations, health plans, and other stakeholders as they pursue HIT efforts to support new expectations for care coordination and accountability.

INTRODUCTION

Health Information Technology (HIT) and the Coordinated Care Model

Oregon's coordinated care model is designed to improve health, improve care, and lower costs (the "Triple Aim"). HIT plays a critical role in realizing these goals of transforming Oregon's health care delivery system.

The collection, sharing, and use of health information can facilitate improved:

- Care coordination and population management throughout the system
- Integration of physical, behavioral, and oral health
- Accountability, quality improvement, and metrics
- Alternative payment methodologies
- Patient engagement

The coordinated care model relies on access to patient information and the Health IT infrastructure to share and analyze data. Each of Oregon's 16 Medicaid CCOs has committed to a variety of HIT initiatives to assist them in pursuing the Triple Aim.

The Three Goals of HIT-Optimized Health Care

The vision for Oregon is a transformed health system where HIT and health information exchange (HIE) efforts ensure that the care all Oregonians receive is optimized by HIT. In an HIT-optimized health care system:

1. Providers have access to meaningful, timely, relevant, and actionable patient information at the point of care including information about the whole person, including information pertaining to relevant physical, behavioral, social and other needs.
2. Systems (health plans, CCOs, health systems, and providers) have the ability to effectively and efficiently use aggregated clinical data for quality improvement, population management and incentivizing value and outcomes. 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.
3. Individuals, and their families, can access and engage with their clinical information and are able to use it as a tool to improve their health and engage with their providers.

Role of Health System Transformation Funds in Investments in HIT

In 2013, the Oregon Legislature approved $30 million in Health System Transformation Funds. The OHA Transformation Center awarded $27 million in Transformation Fund Grant Awards to help CCOs launch innovative projects aimed at improving integration and coordination of care for Medicaid patients. Specifically, the Legislature directed the funds to be used for projects that would create services targeting specific populations or

disease conditions, enhance the CCO's primary care home capacity, and invest in information technology and electronic medical records. Almost all of the CCOs invested a portion of their grant funds in HIT initiatives, including health information sharing and exchange, telemedicine, data aggregation tools for population health, electronic health records, and metrics collection.

All 16 CCOs agreed to support OHA's plan to use the remaining $3 million to leverage and secure significant federal matching funds for investing in statewide HIT infrastructure. These funds are being used to support OHA's vision of a statewide approach for achieving HIT-optimized health care. OHA-supported HIT infrastructure will connect and support community and organizational HIT and HIE efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have a means to participate in basic sharing of information needed to coordinate care. The CCO HIT Advisory Group (HITAG) guides OHA's use of the $3 million. OHA's commitment to the CCOs in state-level HIT infrastructure includes:

- A statewide Provider Directory, critical to supporting health information exchange, analytics and population management and accountability efforts, and operational efficiencies.
- Statewide Direct secure messaging and CareAccord, offer a standards-based, HIPAA-compliant, common method of health information exchange, leveraging new requirements for certified EHRs and for hospital and providers seeking to meet meaningful use.
- Notifications of hospital events, via a subscription-based product called PreManage that would allow CCOs to access this data as real-time notifications when their member has a hospital event (emergency department or inpatient admission, transfer, discharge).
- A Clinical Quality Metrics Registry to capture clinical quality metrics from electronic health records (see below for CCO reporting requirements).
- Technical assistance to support Medicaid practices with the adoption and meaningful use of certified EHR technology as well as support providers in submitting their clinical quality metrics electronically from providers' EHRs to meet meaningful use and OHA's CCOs clinical quality metrics reporting requirements.

Role of CCO Clinical Quality Metrics (CQM) Reporting Requirements

In 2012, as part of Oregon's 1115 waiver agreement with CMS, Oregon committed to an extensive plan of measurement and monitoring, including quarterly and annual reporting on a number of performance metrics at the CCO and state levels. This was to allow CMS to ensure that cost savings were not being realized by withholding needed care or degrading quality. CCOs have been encouraged to meet a number of quality metrics by being offered a financial incentive for achieving performance benchmarks.

Under OHA's waiver with CMS, CCOs are eligible to receive incentive payments (currently 3 percent of their budgets) associated with their performance on 17 outcome and quality measures. Four of the 17 measures are directly related to HIT. One of the incentive metrics is EHR adoption and three others are clinical quality metrics (hypertension, diabetes poor control, and depression screening) that require the CCOs to extract data directly out of EHRs.

To meet benchmarks and receive quality pool funding in 2014 and 2015 (for their 2013 and 2014 reporting years), CCOs had to submit technology plans to OHA, describing the EHR and HIT environment in their service areas, their HIT efforts, and their proposal for collecting sample data for the three clinical quality metrics. The sample size for these three metrics increases over time – emphasizing an expectation that CCOs would work with an increasing number of their key practices to collect these data. The plans for future years involves moving from technology plans and sample data to obtaining more robust data from EHRs, using it for measurement, and paying incentives for performance based on this data. CCOs have therefore been indirectly incentivized to pursue HIT initiatives that would support and facilitate their collection of clinical quality metrics data from providers' EHRs. As discussed further below, CCOs chose to pursue a variety of approaches to this end.

CCO Deeper Dive Sessions

In the summer and fall of 2014, OHA's Office of HIT conducted in-person "Deeper Dive" meetings with each of the CCOs. The overall objective of these meetings was to gain a deeper understanding of each CCO's HIT initiatives and coordinate around OHA's HIT infrastructure in development at the state level. The aim was to ensure that (1) the state's HIT services support CCO investments; (2) CCO and state efforts remain aligned; and (3) CCOs have a clear understanding and expectations for what state-level services will include.

Following these in-depth meetings, in the winter of 2014-15, Office of HIT produced CCO profile documents (see Appendix B) summarizing each CCO's HIT initiatives including information sharing and care coordination; quality improvement, population management, and data and analytics tools; clinical quality metrics collection and reporting; technical assistance to practices for EHRs and Meaningful Use; patient engagement; and telehealth. CCOs were given two opportunities to review and update their draft profiles; all CCOs responded to the review request and profiles were edited accordingly. In some cases, the CCO HIT efforts changed since our Deeper Dive meetings. The profiles represent the CCOs' HIT status at a point-in-time. Though we have made every effort to ensure that they are accurate and up-to-date, HIT efforts may have continued to evolve and some information may therefore be out-of-date.

OVERVIEW OF CCO HIT EFFORTS

All 16 CCOs have made an investment in HIT in order to facilitate healthcare transformation in their community. These efforts have been supported, in part, by the transformation funds described above. CCOs have invested in helping their provider communities implement and make effective use of various HIT tools intended to improve their patients' health and their patients' care, as well as manage their costs. Various factors have influenced the unique paths each chose to take (see below).

Each CCO had to assess their circumstances and determine their best path forward, given their unique characteristics. Although no two paths were exactly the same, nearly all CCOs are pursuing and/or implementing both a health information exchange/case management/care coordination tool as well as a population management/metrics tracking/data analytics tool. Even with those similarities, each of the 16 CCOs chose to invest in a different set of HIT tools.

Through their implementation and use of HIT, CCOs reported early successes in achieving goals such as:

- Increased information exchange across providers to support care coordination
- Supporting providers by making new data available to assist with identifying patients most in need of support/services and to help providers target their care appropriately
- Improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data

CCO Context for HIT Development

CCOs report a number of factors that have influenced their approach to HIT development in support of healthcare transformation in their community, such as:

- The types of organizations from which they evolved, and thus their organizational structure (physician-owned/Independent Practice Association-based, health system-based, commercial health plan-based, community/county led, etc.)
- Community and governance factors
    - The already existing (community) efforts, including existing governance structures, they evolved from and therefore whose support they had from the beginning
    - The degree of already existing (community) support for initiatives like HIT at the time of establishment, and the degree of HIT infrastructure that was already in place
- Provider environments
    - The extent of variation in EHRs implemented across their provider community
    - Partnerships with hospital systems
    - The size and type of community members they support
        - The number, type, and size of key practices
        - Concentration of Medicaid patients among primary care clinics
        - Regions with multiple hospitals vs. relatively closed systems where one hospital system dominates care in the area
- The geography of their community
    - Southern Oregon has the most concentrated presence of CCOs: 4 serving 4 counties
    - Eastern Oregon CCO service area covers 12 counties (over 50% of Oregon's land mass)

Role of Community Support

It seems a particularly relevant factor in both a CCO's approach to HIT development and the pace at which they have made progress is the degree to which they began with an already established collaboration in the community. As one engaged stakeholder said during one of the Deeper Dive meetings "*Building the trust and shared commitment is foundational*" – and several CCOs had pre-established community governance and shared commitment to work together on common goals. Some communities had already come together specifically

around HIT efforts, such as Southern Oregon's Jefferson HIE and Central Oregon's Central Oregon Health Connect. Having the support of a collaborative community can facilitate the many challenging discussions that are required to make decisions around shared HIT tools and move such a significant process forward. In community-based HIT efforts, CCOs participated or led work to assess and pursue HIT tools which would likely most benefit their community, and would require buy-in and, in some cases, financial commitment, from providers and hospitals and other stakeholders.

Impact of Geography and Size

A high concentration of CCO members across a small number of clinics/health systems means there are fewer groups to bring into the conversation compared to areas where members are distributed across a large number of clinics. Having fewer entities involved in getting buy-in on a new HIT tool can make it easier to communicate more effectively and therefore coordinate across groups more closely. According to one CCO, this has allowed them to "*make an impact quickly.*"

CCO communities with more concentration of the Medicaid members in fewer providers/clinics may have less EHR variation to contend with and therefore fewer workflow modifications to support. In such communities, maintaining closer contact with each provider may be less burdensome, and CCOs report having greater influence on practices where their members make up a greater proportion of the patients.

Organizational Affiliations

Many CCOs are affiliated with a health plan that also serves the commercial or Medicare markets. In these cases, the HIT investments made to support CCO operations are often used for their commercial population as well. Three CCOs are affiliated with an IPA that provides a hosted EHR to practices. This resource can make a significant difference in implementing changes to reporting data to the CCO, supporting functionality within the hosted EHR that enables sharing patient information and care coordination across providers, and an already established relationship with providing technical assistance to providers around using their EHR and improving workflows.

CCO Approaches to Developing and Implementing HIT Efforts

Many CCOs reported challenges in setting their HIT strategy. Some CCOs found it confusing to piece together the puzzle of EHRs and HIT resources and gaps in their region, and/or found the offerings from technology vendors challenging to navigate as well. CCOs in general sought to understand what HIT and EHR resources were in place in their community and provider environments, identify what HIT capabilities were needed to support the CCO's efforts, and identify strategies to meet those needs including leveraging existing resources or bringing in new HIT tools to fill priority needs. In some cases, CCOs invested in consultants to support their HIT strategic planning and project development efforts. Several CCOs expressed an interest in learning from other CCOs and regional efforts – unsure of whether they selected the best approach, or were making as much progress as their CCO peers, and were interested to learn from other's successes.

Ultimately, the combination of different CCO community, organizational, geographic and provider contexts as well as the variation in EHR and existing HIT resources led to a number of differing approaches to HIT. Some examples of HIT approaches CCOs have taken include:

- A focus on improving CCO case management of their members leveraging a module in their existing administrative software.
- Implementing a coordinated care management system for CCO staff including utilization, disease, and case management which integrates data from disparate sources and combines it into a single, member-centric workflow which enables use of one system in managing the health needs of each member.
- Launching a care management tool that includes actionable clinical information and psychosocial risk factors in support of behavioral health integration and perinatal programs to be used both by CCO staff and provider partners
- Providing a community-wide EHR operating as a community health record, which includes data on more than 85% of the CCO's members and is available to both physical and behavioral health providers.

- Leading the collaborative development of a regional health information exchange tool, which will collect patient data from various sources, organize it, and make it available and easily accessible to providers at the point of care.
- Supporting local entities that have developed their own HIT tools, while also developing and implementing centralized tools to support care management, population management, utilization and analytics, with a long-term vision for an integrated solution for sharing clinical information with the provider network to support patient care and population health.
- Implementing a comprehensive tool that includes predictive analytics/risk assessment, care coordinator and PCP/Provider management reports, quality metrics and care gaps information, and business intelligence tools.
- Coordinating across local entities that have developed their own HIT tools while also developing and implementing centralized HIT including a data aggregation, analysis, and reporting solution.
- Pursuing a Community Data Warehouse pilot project to develop and implement a population health management, data aggregation, and analytics tool that integrates hospital, ambulatory EHR, pharmacy, and claims data.
- Investing in a tool that allows for gathering/aggregating/sharing of clinic-level EHR data to identify gaps in care and specific health data points in the population (e.g., members in need of screening), as well as produce the three CCO clinical quality metrics.

Changing Approaches and Next Phases for CCO's HIT Efforts

In some cases, CCOs faced unexpected challenges, which caused them to alter their HIT efforts. Some CCOs reported changing course after facing: vendor limitations and mergers, unanticipated prohibitive costs, challenges with community support and buy-in, longer than anticipated development periods, and/or other issues. Some degree of flexibility has been critical given the realities of an ever-changing landscape.

Many CCOs are in the process of building upon their progress to date and are pursuing additional and/or improved HIT tools to add to (or replace) what they have currently implemented:

- Connecting providers to HIT/HIE through integration within their EHR workflows
- Moving from administrative/claims based case management and analytics to incorporating and extracting clinical data from provider's EHRs.
- Working with providers and providing technical assistance to establish clinical data reporting
- Supporting providers in new ways with providing data and dashboards back to them
- Investing in new tools for patient engagement and telehealth

New Relationship to Data

A consistent theme across all CCOs in their efforts to use HIT to improve healthcare delivery, is that they have developed and fostered a new relationship with data and their provider network. CCOs report that they have become more sophisticated with data, and, in some cases, have supported a culture change with their provider networks who are also learning to become more sophisticated with data. The CCOs support providers using data in a variety of ways including:

- collecting data (e.g., providing assistance to shift burden for collecting data from providers to other staff)
- compiling, interpreting, understanding data (e.g., prioritizing care coordination, identifying high utilizers and missing screenings, incentive metric progress monitoring, identifying populations to target for complex case management and disease management, tracking clinical quality metrics performance). One CCO described that their HIT tool *"takes a haystack and pull[s] a few needles out.*"
- ensuring credibility of data (e.g., working with clinics to understand and mitigate quality issues)
- educating and evolving the delivery system to use the data
- refining how to meaningfully present and effectively communicate the data

Though this is an evolving process in which both CCOs and providers will continue to learn new ways to maximize the value of data, CCOs report that significant progress has already been made in using data to improve care.

Many CCOs are distributing regular reports to their providers which might include a variety of information on the provider's patient panel, such as: risk scores, quality metrics measures, top utilizing members, patients in need of screenings, basic ED and inpatient utilization, top 10% members at risk for poor outcomes, diagnoses, and prescription drug use. One CCO describe themselves as an 'information company' as they "*have information coming in and better information going out*".

Also of note, providers and healthcare systems have demonstrated an increased interest in metrics and are becoming accustomed to reflecting on the data and its implications. Some have changed their approach to patient care management and have newly begun accessing, examining, and utilizing their data for the purpose of population management, decreasing their reliance on the CCO to fulfill this role. Some providers have become increasingly involved with and invested in their data and outcomes, which has fostered a healthy competition and incentive to improve their metrics.

Workflow Changes
Some CCOs are actively engaged in helping providers make workflow changes to accommodate the implementation of HIT tools and/or data needed by the CCO. For example, providers need assistance modifying their workflows to ensure they are accurately capturing the depression screening data required for CQM reporting. Some CCOs are adding staff to conduct training, selecting best practices for workflow, and/or finding provider champions.

Access to Clinical Data
CCOs are all either currently able to access clinical data or are actively pursuing access, in a variety of ways. Some CCOs are working to extract clinical data from their providers' EHRs. Some CCOs are building a process to store and analyze clinical information. One CCO described their interest in moving toward clinical data for population management, metrics, etc., as being related to the lag time with claims data which can make those data not actionable: "*We want to get [data] further upstream to be able to impact care*." Another CCO has piloted a tool that pulls clinical data out of EHRs and integrates it into their case management tool. In the case of regional HIEs with a community health record model, interfaces are established with hospitals, laboratories, and provider EHRs to collect clinical data using standards-based formats like HL7, etc.

Moving beyond Primary Care and Physical Health Information
Though CCOs have focused their efforts largely on primary care providers and physical health information, they are interested in incorporating behavioral health information in order to increase care coordination across different provider types. Most CCOs, however have significant concerns regarding the security and privacy issues surrounding behavioral health information sharing. Some CCOs have invested funds and significant effort into overcoming barriers and taking steps toward increasing behavioral health information sharing. Some have plans to integrate mental health claims with physical health; one CCO has been provided with integrated mental health claims since 2013.

CCOs expressed that exchanging information across the full care team of entities involved in their members' care is an area of priority. For example, some CCOs are taking steps to electronically share information and coordinate care with long-term care and social services. One CCO has expressed interest integrating social services, non-emergency medical transportation, residential care settings, schools and school-based health centers, in addition to behavioral health and long-term care.

SUMMARY OF CCO-SPECIFIC HIT INVESTMENTS

See Appendix A and Appendix B for further details. Note that the categories used below are not necessarily mutually exclusive, as tools can be used to serve more than one function (and often do). The HIT tools are grouped based on their primary function.

	# of CCOs	Overview	Details
Health Information Exchange	13	2 active HIEs (6 CCOs)	Medicity: Jefferson HIE (5 CCOs)
			RelayHealth: Central Oregon Health Connect
		2 HIEs in development	InterSystems: Care Team Link (Regional Health Information Collaborative; RHIC)
			BACIA
		1 Community-wide EHR	GE Centricity: Umpqua One Chart
		Hospital Notifications (4 CCOs are live, 3 CCOs are in discussion)	Collective Medical Technologies: PreManage
Case Management and Care Coordination	10	1 Social Services focused tool (2 CCOs)	VistaLogic: Community Connected Network
		Case Management Tools (9 CCOs)	Essette: Case Management
			PopIntel Care Coordination Registry
			InterSystems: Care Team Link
			McKesson: VITAL
			The Advisory Board: Crimson CM (2 CCOs)
			Milliman: Patient Relationship Manager
			IMA Technologies: CaseTrakker (2 CCOs)
Population Management, Metrics Tracking, Data Analytics	15	Population Management tools (9 CCOs)	Milliman: MedInsight (2 CCOs)
			Optum: Impact Intelligence
			The Big Kahuna
			Arcadia: Community Data Warehouse
			Crimson Population Risk Management
			Milliman: Patient Relationship Manager
		Business Intelligence (BI) tools (6 CCOs)	SAS BI (3 CCOs)
			IBM Cognos BI
			Microsoft BI (2 CCOs)
		Health Analytics tools (11 CCOs)	Inteligenz: CCO Metrics Manager
			Truven Health Analytics (2 CCOs)
			Inovalon Indices
			SAS Data Store
			IBM: SPSS
			SAS
			Tableau (2 CCOs)
			IBM Cognos Query Studio
			PopIntel
EHR Hosting via	3		DCIPA: Umpqua One Chart

	# of CCOs	Overview	Details
Affiliated IPA			MVIPA: NextGen
			MRIPA: Greenway PrimeSuite

Health Information Exchange
CCO health information exchange investments include a variety of tools and services each intended to securely share health information electronically between providers and across organizations. There are two health information exchanges currently in use in Oregon including Jefferson HIE in use by five CCOs and Central Oregon Health Connect in use by one CCO, and two that are in development including IHNCCO's Care Team Link (Regional Health Information Collaborative; RHIC) and an effort in Coos Bay lead by BACIA (Bay Area Community Informatics Agency). Umpqua One Chart is a community wide EHR which has been adopted by over 85% of providers in the area. Finally, four CCOs have gone live with a PreManage subscription, which provides them with hospital event (emergency department admission, inpatient, and discharge) notification, some are opting for the 'complete' PreManage package, which includes making the notifications available to their key practices in their provider network.

Case Management and Care Coordination
CCOs have implemented a range of case management and care coordination tools. One of the tools, Community Connected Network supported by two CCOs, is a social service-based tool which is expected to include data across the patient population across a variety of social service agencies. There are seven case management tools in use by nine CCOs. They differ in the data that is incorporated into the tool and made available as well as the tool functionality. Some are intended to be used only by CCO staff (e.g., case managers) and others are intended to be used across providers. CCO staff use case management tools for various tasks including: to record assessments; develop care plans; record tasks, notes, correspondence; and get daily email alerts/reports for important events such as surgery. Case management tools may allow case managers to set goals, identify interventions and assign members to care teams, support coordination around transitions of care, and identify barriers for managed patients that need to be addressed.

Population Management, Metrics Tracking, Data Analytics
CCOs reported implementing and/or using seven population management tools, three Business Intelligence (BI) tools, and nine health analytics tools. Some CCOs have developed and/or implemented claims-based analytic reporting via BI software. This type of reporting might include aggregate reporting for CCO-, provider-, and member-level data for demographics, utilization, and gaps in care.

EHR Hosting via Affiliated IPA
Three Independent Practice Associations (IPAs) host EHRs for some of their member clinics: Douglas County IPA hosts Umpqua One Chart, Mid Valley IPA hosts NextGen, and Mid Rogue IPA hosts Greenway PrimeSuite.

Other HIT efforts: Technical Assistance, Patient Engagement and Telehealth
Many CCOs offer technical assistance to their provider network including assistance in support of workflow modifications (including effective handoff protocols), HIE connectivity, and Direct secure messaging. Other types of assistance has included training about meaningful use, IT and analytic resources to help providers set up reporting tools needed to pull relevant information out of their own EHRs and systems.

Several CCOs expressed support for increasing patient engagement and for access to specialty care through HIT and telehealth. CCOs mentioned supporting the use of patient portals that include access to medical records, scheduling, and secure correspondence with primary care providers; and/or supporting the OpenNotes movement, which makes full clinician notes available to patients via their provider's EHR patient portal.

Several CCOs have made an investment in various telehealth efforts including:

- Tele-dermatology
- Genetic counseling via telehealth
- Behavioral health telemedicine/tele-mental health
- Telementoring
- Virtual Provider Triage (supports delivery of care in the most appropriate setting)
- Text 4 Baby
- Tablet-based CAHPS survey
- Gladstone by Kannact (providing high-risk individuals with tablets to facilitate remote patient monitoring)
- Tablet/laptop-based needs and health risk assessments
- Provision of post-hospital discharge tablet/laptop by which member can contact care support

BARRIERS AND CHALLENGES

Barriers to HIT Implementation

During the Deeper Dive conversations, CCOs discussed various barriers they themselves or their member clinics have encountered in the process of the CCOs' implementation of their HIT initiatives. The top 6 barriers are listed in the table below. Another 6 barriers mentioned by only a few CCOs are listed toward the end of this section. As the CCOs were not specifically asked about the various barriers, the frequency of the barriers reported is not a representative count of all the CCOs who are experiencing each barrier. Rather, the percentage of CCOs reporting each barrier is the total for whom the barrier was reported during the Deeper Dive meetings or included in the CCO HIT Profiles. See below for further details regarding each barrier.

Barriers to HIT Implementation	CCOs Who Included Description of Barrier (n=16)
Technology, Interoperability and EHRs	88%
Workflows/ Staffing/Training	81%
Clinical Data Collection/ Reporting	75%
Data Analysis, Processing, Reporting	44%
HIPAA, Privacy, Security	31%
Metrics	31%
Other	81%

Technology, Interoperability and EHR barriers

- Lack of EHR adoption or the use of disparate EHRs across the network clinics
- Use of disparate EHRs complicates HIE efforts and clinical data collection
- Lack of EHR/HIE capabilities
- Lack of or challenges with EHR interoperability
- Lack of a standardized and central data repository for patient health information
- Cumbersome to retool each EHR interface when new CQMs are released
- Challenges with Direct secure messaging as implemented within certain EHRs
- Concerns about making significant investment in HIE given interoperability challenges (integration of care summaries in CCDA format, limits on some EHRs regarding message delivery via Direct secure messaging)

Workflows/Staffing/Training barriers

- Push back from clinics on workflow requirements
- Some clinics don't see value of changing workflows to accommodate CQM reporting requirements.
- Challenges getting providers to adjust their workflows to be able to properly collect/report on data for the depression screening measure
- Clinics lack knowledge and understand regarding Direct secure messaging
- Clinics and providers need implementation training and technical assistance about all aspects of data (getting, using, coordinating)
- Limitations of time, resources, bandwidth
- Change fatigue (constant change, competing demands)

Clinical Data Collection/ Reporting barriers

- Lack of access to clinical data

- Obtaining CQMs data is often tedious
- Challenges with getting some organizations to share clinical data for purposes of CQM reporting
- CQM data quality is limited by workflow
- Unsure about reliance on new CQM reporting formats in EHRs such as QRDA
- Providers at the mercy of vendors for CQM reporting
- Challenges with data collection consistency across providers
- Challenges with CQM reporting due to workflow and data extraction issues
- Financial burden on smaller practices to configure their system to produce CQMs
- Requiring CQM data transmission to multiple CCOs could increase costs for providers, which may deter treatment of Medicaid patients
- EHR usability is a barrier to data entry (thus accurate reporting)

Data Analysis, Processing, Reporting barriers

- Small offices struggling with reporting requirements
- Push back from clinics on reporting requirements
- Some providers are unable to share data in standardized formats (e.g., HL7)
- Pressure to meet diverging regulatory and reporting requirements
- Challenges with obtaining clean and complete data
- Challenges with performing data verification
- Demand on providers to collect and enter data is a major barrier due to growing and conflicting requirements
- Practices lack resources to develop improved analytic capabilities (dependent on what's inherent in EHR)

HIPAA, Privacy, Security barriers

- Issues with FIRPA (federal privacy requirements related to education) and HIPAA
- Concerns about data sharing policies and adequate consent procedures to allow for the sharing of data
- Concerns among providers about correct business agreements that identify who has access to data and lack of clarity about what information is acceptable to share

Metrics barriers

- Providers want credible metrics - some are not relevant or credible to specific providers
- Metrics data are collected in non-primary care environments (e.g., schools, behavioral health, dental), but there are no means by which to capture these data

Other Barriers

- Lack of provider understanding or interest of available HIT tools (e.g., Epic CareEverywhere for providers with Epic EHRs)
- Challenges with logistical and geographical technology capabilities
- Ongoing changes with provider networks
- Broadband connectivity issues in some rural areas
- Lack of CCO technology/analytics staff

Additional barriers, each identified by one to three CCOs, include:

- Interoperability
    - Interoperability challenges
    - Providers at the mercy of vendors for interoperability
    - Bringing systems together across a common platform takes time, work, and a lot of testing
- Vendors
    - Waiting on 2014 updates (to support meaningful use Stage 2) from EHR vendors

    - Difficulty in engaging EHR vendors about getting certain information into the standardized care summary format (CCDA)
    - Providers at the mercy of vendors for interface expansion
- Patient Attribution
    - Challenges with managing patient attribution
    - Some challenges with ensuring information only goes to right health plan
    - Patient attribution challenges: PCP reconciliation between the plan, provider records, and provider providing services
- Dental
    - Lack of EHR adoption among dental providers
    - Uncertain of when dental providers must meet meaningful use and other HIT goals/metrics
- Care Coordination
    - Questions about the management of access to patient information and how case managers would coordinate data

Barriers to Behavioral Health Information Sharing:
The draft CCO HIT Profiles included a section asking that each CCO identify which of the listed barrier to behavioral health information sharing they have experiences. Thirteen of the CCOs completed this section. The table below summarizes the responses, in order from most to least frequently experienced.

Barriers	CCOs Reporting Experiencing Barrier (n=13)
Confusion over compliance with state or federal laws	77%
Concerns over privacy and confidentiality protection for the patient	77%
Technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data).	62%
Concerns over liability if information you share is later improperly shared	62%
Lack of proper consent forms from the patient	38%
State or federal laws prohibit the type of sharing I want/need to do	23%
Other	15%

INTEREST IN OHA'S HIT INITIATIVES

As mentioned above, OHA's Office of HIT is pursuing five statewide HIT initiatives: (1) a Statewide Provider Directory; (2) PreManage hospital event notifications; (3) a Clinical Quality Metrics Registry; (4) Technical Assistance to Medicaid practices; and (5) CareAccord providing Direct secure messaging. All of these initiatives were discussed with each CCO at the Deeper Dive meetings. Below is a tally of the level of interest reported by all 16 CCOs in each of the five initiatives.

OHA's HIT Initiatives	CCO Interest Level		
	Using or expect to use	Considering	Not currently interested
Statewide Provider Directory	69%	31%	0%
PreManage – hospital event notifications	50%	44%	6%
Clinical Quality Metrics Registry*	38%	38%	25%
Technical Assistance on EHRs and Meaningful Use for Medicaid Practices	25%	75%	0%
CareAccord Direct secure messaging	16%	69%	19%

*All CCOs will need to report to the Registry – the interest level reflected here is whether the CCO is considering having any of their providers submit clinical quality metrics directly to the Registry.

Overall, the CCOs expressed the most interest in the Statewide Provider Directory and the PreManage hospital notifications. The CCOs had the most questions about whether or how they would use Technical Assistance for Medicaid practices and CareAccord. In terms of technical assistance, some CCOs reported prior challenges with providing technical assistance to providers and having some unknowns about what the assistance would include when it becomes available. In terms of CareAccord, CCOs varied in their understanding and approach to Direct secure messaging, including the relatively new availability of Direct secure messaging capability via providers' EHRs. Conversely, several CCOs are invested in a regional HIE that includes Direct secure messaging capability. Some CCOs are interested in communicating securely with non-health entities such as law enforcement and education (e.g., early learning hubs), and are exploring the use of Direct secure messaging as a service for those entities to use for that purpose.

As noted above, four CCOs have gone live with a PreManage subscription, which provides them with hospital event (emergency department admission, inpatient, and discharge) notification. Some have opted for the 'complete' PreManage package, which includes PreManage subscriptions for their key practices in their provider network. In addition, three CCOs are in discussions with CMT about purchasing PreManage.

Appendix A: Summary of CCO HIT Investments

	Health Information Exchange	Case Management & Care Coordination	Population Management, Metrics Tracking, Data/Analytics	EHR Hosting Via Affiliated IPA
AllCare	Medicity: JHIE	Essette: case management; Vistalogic: Community Connected Network (C2)	Milliman: MedInsight	MRIPA: Greenway PrimeSuite EHR
Cascade Health Alliance	Medicity: JHIE	*Pursuing new CM tool;* EZCap has CM module		
Columbia Pacific			SAS BI	
EOCCO		*Provider Portal (in development)*	SAS Data Store	
FamilyCare	Collective Medical Technologies (CMT): PreManage	McKesson: VITAL	Milliman: MedInsight; Inovalon: Indices	
Health Share	Alignment across EPIC CareEverywhere installations; *Pursuing CMT: PreManage*	PopIntel: Care Coordination Registry	The Big Kahuna/PopIntel	
IHN	*InterSystems: Care Team Link (Regional Health Information Collaborative; RHIC)*	*InterSystems: Care Team Link (Regional Health Information Collaborative; RHIC)*	IBM: Cognos Data Marts, BI, Query Studio	
Jackson Care Connect	Medicity: JHIE	Vistalogic: Community Connected Network (C2)	SAS BI	
PacificSource Central OR CCO	RelayHealth: Central Oregon Health Connect; CMT: PreManage	IMA Technologies: CaseTrakker Dynamo	Truven Health Analytics; Internally developed tools, SAS, Tableau, Microsoft BI	
PacificSource Gorge CCO	Medicity: JHIE; CMT: PreManage	IMA Technologies: CaseTrakker Dynamo	Truven Health Analytics; Internally developed tools, SAS, Tableau, Microsoft BI	
PrimaryHealth	Medicity: JHIE	*Exploring CareManager solution*	Inteligenz: CCO Metrics Manager	
Trillium	*Pursuing CMT: PreManage*	The Advisory Board: Crimson Care Management; Internally developed: Care Timeline	Optum: Impact Intelligence and ImpactPro; SAS, SPSS	
Umpqua	GE Centricity: Umpqua One Chart (Community-wide EHR)	Plexis Case Management	Inteligenz: CCO Metrics Manager; Inteligenz Reporting	DCIPA: Umpqua One Chart EHR

	Health Information Exchange	Case Management & Care Coordination	Population Management, Metrics Tracking, Data/Analytics	EHR Hosting Via Affiliated IPA
Western Oregon Advanced Health	*BACIA; In development: tool to exchange clinical data with PRM*	Milliman: Patient Relationship Manager (PRM)	Milliman: Patient Relationship Manager (PRM)	
WVCH	*Pursuing CMT: PreManage*		Arcadia: Community Data Warehouse	MVIPA: NextGen EHR
Yamhill County	CMT: PreManage	*The Advisory Board: Crimson Care Management*	Crimson Care Registry; Crimson Population Risk Management (Milliman analytic support); SAS BI	

Appendix B: CCO HIT/HIE Profiles

(In alphabetical order)

1. AllCare
2. Cascade Health Alliance
3. Columbia Pacific
4. EOCCO
5. FamilyCare
6. Health Share
7. IHN-CCO
8. Jackson Care Connect
9. Pacific Source Central OR
10. Pacific Source Gorge CCO
11. PrimaryHealth
12. Trillium
13. Umpqua
14. Western Oregon Advanced Health
15. WVCH
16. Yamhill County

AllCare CCO HIT/HIE Profile

Southern Oregon, 47,805 members[1]

CCO Description:

- Mid Rogue AllCare Health Assurance, Inc. owns AllCare CCO, Inc.
- Medicaid members who reside in Jackson, Josephine, Curry and Southern Douglas Counties.
    - Includes more than 8,500 new enrollees for 2014 through the ACA Medicaid expansion. Majority of new enrollees reside in Jackson County.
    - Medicare Advantage plan, CareSource, serves 2,100 Members who reside in Jackson and Josephine Counties, of which about 800 are dually eligible.
- Network of providers exceeds 1400 primary care and specialty care providers with an extensive network of behavioral health and dental health providers. AllCare has a varied provider network and doesn't rely as heavily on FQHCs as other CCOs. AllCare's network has grown considerably with the ACA expansion population.
- Mid Rogue AllCare Health Assurance, Inc, AllCare's owner, owns AllCare eHealth Services, an EMR company that provides Greenway's PrimeSuite EHR solution to a number of clinics in AllCare's network. They also own Mid Rogue Independent Physicians Association, a contracting entity for the Josephine County Providers.
- AllCare is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).
- AllCare is also supporting Community Connected (C2) Network – led by the county agency, in partnership with 2 CCOs, education and social services stakeholders, to develop a database and system for coordinating and integrating information related to social services assessment and delivery in Jackson County

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			**Quality Improvement, Population Management, Data and Analytics Tools**
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing
Vendor Name	Medicity	Essette	Vistalogic	Milliman
Product Name				MedInsight
Version		2013		
Comment	Provided by Jeffferson HIE	Case management software	Provided by Community Connected Network for social service delivery	Predictive Modeling, assist in population management through our case management team

[1]As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	AllCare is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area. **Health Information Exchange:** • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing "phase 2" to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. AllCare is also supporting Community Connected (C2) Network – a committed group of organizations working together to change the way individuals access and receive social service support in Jackson County; startup funding supported by county and 2 CCOs; other partner organizations from social services, education sectors. Launch expected in 2015. Intersections with JHIE are under discussion. • Goals include: to support sharing of information and coordination of services amongst community partners, to provide tools to help integrate and coordinate the existing social service delivery infrastructure including identifying service providers for common clients, and to provide a mechanism to connect existing systems within social service, health care, and education sectors. • C2 database will include centralized contact registry, resource/referral module, onboarding tool, release of information module, record capabilities, survey/assessment module, auto-populating forms/summary sheets, integrated calendar and discussion forum, aggregate data reporting. **Direct Secure Messaging[2]:** AllCare sees value in getting their case managers signed up with and using JHIE, specifically the Direct secure messaging feature. • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. • The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange • AllCare is interested in communicating securely with non-health entities such as law enforcement and education (e.g., early learning hubs), and is therefore exploring the use

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	of CareAccord as a service for those entities to use for that purpose, if these organizations do not become part of JHIE. • AllCare clinics using AllCare eHealth Services' Greenway EHR will have access to Direct secure messaging. Greenway's preferred HISP is Updocs. • AllCare notes that clarification and information about Direct secure messaging and JHIE would be helpful for communicating with provider network and affiliates including about the value and need for health information exchange. **Hospital Notifications[3]:** • JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of "phase 2" and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. • AllCare case managers will use JHIE as well for referrals, hospital event notifications, etc. They used to receive hospital event (ADT) information which made a big difference in behavior health/physical health integration. Looking forward to having that info again. **Care Management and CCO-Provided Information to Providers/Care Teams:** • AllCare uses Essette case management system for members who need case management and/or do not have care managed by a PCPCH. AllCare case management staff use Essette to record assessments; develop care plans; record tasks, notes, correspondence; and get daily email alerts/reports for important events such as surgery. The care plan allows case managers to set goals, identify interventions and assign them to care teams, supports coordination around transitions of care, and identifies barriers for managed patients that need to be addressed. AllCare case management teams are organized to support groups of patients such as those needing disease management, exceptional needs care coordination, community health worker assistance, etc. • AllCare case managers will use JHIE as well for referrals, hospital event notifications, etc. AllCare would like to add lab, hospital data for case managed members integrated into the Essette dashboard. • Many AllCare members have their care coordinated within a PCPCH. AllCare provides member information to their PCPCHs to support care management and care coordination, including including provider specific lists of their, CMHPs a list of their members diagnosed with Severe and Persistent Mental Illness (SPMI) and Diabetes who have not had the appropriate lab monitoring (LDL and HgbA1C testing).
Quality Improvement, Population Management, Data and Analytics Tools	AllCare is anxious to better leverage the data they have, and add new data to the mix. They have staffed a data team. ▪ Roll-out of new compensation formulas and incentives will require better use of data and provide the opportunity to strengthen the health plan's ability to collect and report on specific quality measures in a standardized, replicable, and comparable format. o As part of their OHA Transformation Grant, AllCare created new provider incentive compensation plan for its primary care providers that commenced on January 1, 2014. o Quarterly, the team distributes quality dashboard reports for each provider, focusing on access, number of member in practices, compensation capitation tied to acuity, then adding basic ED and inpatient utilization and primary care data, and third are 17 measures for PCPs.

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	○ The team has developed a Specialty incentive compensation plan this is in a pilot phase as of the end of 2014. ○ The team has developed a Dental and a Behavioral Health incentive compensation plan which are in the final phases of development. <u>Incorporating clinical data</u>**:** • AllCare will also need to access utilization and clinical quality data within a provider's EHR system in order to manage the new provider compensation formulas real time. • Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE. • In addition, AllCare anticipates it might need to implement or develop its own data warehouse & database management system in the future for clinical data for analytics and metrics (e.g., JHIE data, HL7 messages, CCDs, etc.). Particularly interested in getting lab data – potentially through JHIE, which is needed for multiple reporting requirements including HEDIS.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** • AllCare providers largely use 3 different 2014 CCHIT certified electronic medical record systems (Epic, Greenway, and NextGen). The three software systems have the capacity to report electronic clinical quality measures per Meaningful Use Stage 1 requirements and are working towards those criteria for Meaningful Use Stage 2. (See update under "Other" below for the Greenway solution.) • AllCare reports it will need some of the smaller (1 to 2 doc practices) with EHRs to participate in order to achieve the Year 2 population % CQM requirements. The clinics on Greenway will not be enough to meet these requirements. **Longer term CQM Strategy:** Utilizing JHIE is part of the CCO's long-term strategy for CQM reporting. JHIE member CCOs will be able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.
Technical Assistance to Practices for EHRs and Meaningful Use	AllCare eHealth Services, an EMR company that provides Greenway's PrimeSuite EHR solution to a number of clinics in AllCare's network, provides technical assistance and support to those clinics related to using the EHR and meeting Meaningful Use. AllCare found many providers faced challenges in 2013 for recording depression assessments in EHRs – didn't know where to put the assessments in the EHR. AllCare provides training to providers to ensure they are putting the data in the right place.
Telehealth and Patient Engagement through HIT	▪ In the fall 2014, AllCare worked with Providence for eHealth Express, which offers "virtual provider triage" to support delivery of care in the most appropriate setting, including identifying non-emergent issues. ▪ AllCare is interested in texting initiatives for telehealth. Have been doing Text 4 Baby for about 4-5 years. Interested in moving into disease management.
Other	**EHR Hosting** • AllCare eHealth Services (hosting Greenway's PrimeSuite EHR) – upgraded to 2014 version in fall 2014; fully integrated practice management and EMR; includes a meaningful use dashboard for providers monitoring their metrics and CQMs. The dashboard is great for meaningful use, but not the best for other metrics like the PCPCH metrics, since meaningful use dashboard is set for a calendar year. Can export meaningful use CQMs. **Local Provider Directories:** • AllCare maintains a provider directory within their administrative systems including within Essette case management; and AllCare eHealth Services (hosting Greenway's

	PrimeSuite EHR). JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards.
Barriers to Implementation of HIT Tools/ Services	• Lack of EHR adoption with some private solo and small practice sites. Certain providers and clinics that serve as key access points for patients to the care system have not yet adopted EHRs and it's unclear if they will be doing so in the future. • Many smaller offices are struggling with reporting burden and meeting PCPCH, PQRS, meaningful use, and other requirements. Concerned that burden will become a barrier to achieving or maintaining PCPCH status. Our AllCare eHealth Services spends plenty of time supporting EHR and pulling reports – some small practices just may not have sophistication to do it or the time to deal with upgrading EMR, and it is frustrating for them when we keep pushing in that direction when they don't have the resources to do those things. One-stop reporting for providers would be helpful. • Providers want credible metrics – some metrics aren't credible, such as holding a PCP accountable for mammograms, when the PCP orders but doesn't perform them. The certified EHR system doesn't account for that. • AllCare is experiencing some pushback from clinics because of all of the reporting/workflow requirements placed on them. Some clinics are averse to becoming primary care homes because of the reporting burden (e.g., NQF measures). AllCare is using its case management staff to fill some of the gaps in care coordination experienced by practices in its network. • For C2 and sharing individual-level data between non-health providers – many issues around FIRPA (laws regulating sharing of student data within the education system) and HIPAA arise. C2 and JHIE sharing HIPAA resources. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral Health Information Sharing	JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE's community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges. Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: _X__ Confusion over compliance with state or federal laws ___State or federal laws prohibit the type of sharing we want/need to do ___Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). __X_Concerns over privacy and confidentiality protection for the patient ___Concerns over liability if information you share is later improperly shared ___Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

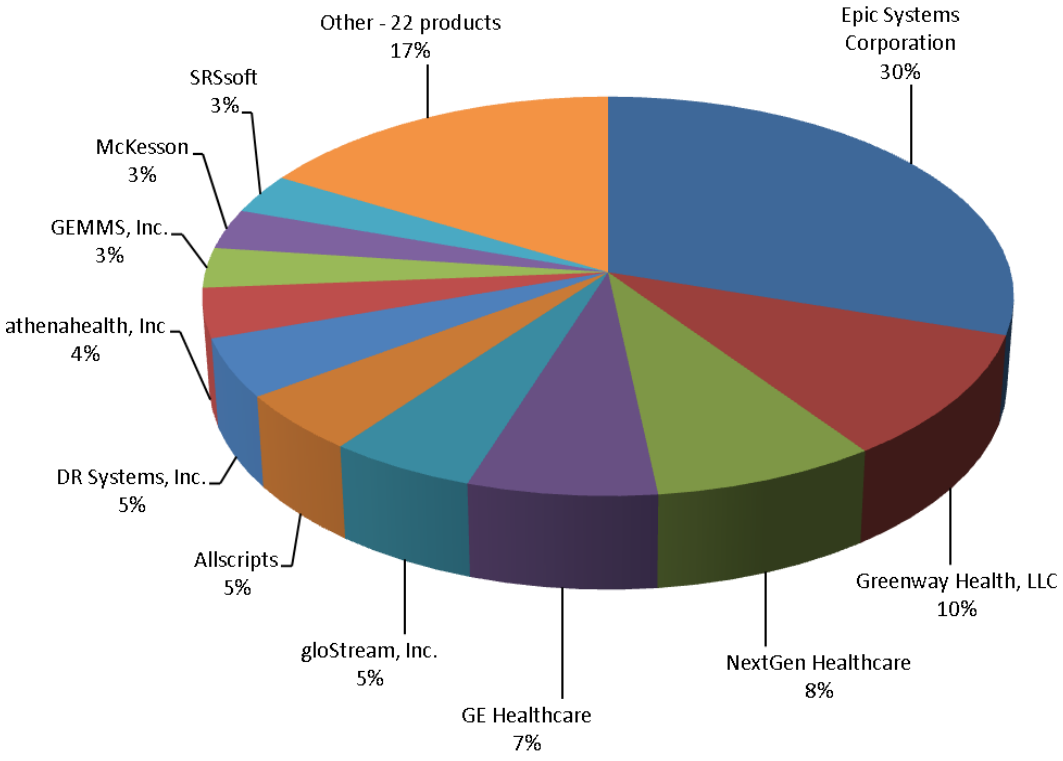
Hospital Name	EHR Vendor	Stage of Meaningful Use*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Asante Three Rivers Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Ashland Community Hospital	N/A	N/A	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Rogue Regional Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Curry General Hospital	CPSI	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Providence Medford Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for AllCare

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 400 unique providers affiliated with AllCare CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, EHR represented in data is based on the most recent information. There are a total of 32 different EHRs in use within the CCO. The top 11 products are represented in the chart, which are in use by 334 unique providers.



Cascade Health Alliance CCO HIT/HIE Profile

17,125 members[1]

CCO Description:

- 9 primary care clinics and 45 primary care providers, with 75 local IPA specialists and 1hospital.
- 3 largest clinics are assigned approximately 25% of membership each. As of December 2013, the largest 4 clinics (two of which are pediatric clinics) made up a total of 91.82% of membership.
- Cascade Health Alliance is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing
Vendor Name	Medicity	
Comment	Provided by Jefferson HIE	Pursuing new case management software

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	Cascade Health Alliance is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area. **Health Information Exchange:** • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing "phase 2" to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. **Direct Secure Messaging[2]:** • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system

[1] As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	through its technology vendor Medicity. • The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. **Hospital Notifications[3]:** • JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of "phase 2" and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. **Care Management and CCO-Provided Information to Provider/Care Teams:** CHA is heavily involved in providing case management to their members. EZCap, their practice management software, has a case management module that is in use by the CCO. MedImpact (Atrio's chosen reporting software) and MedOptimize (Pharmacy) are used for running reports from Atrio for dual eligible population. The CCO is exploring the possibility of implementing a new case management application, which would have the ability to ingest data from the state, interface with practices and/or the JHIE platform, and access claims data from EZCap.
Quality Improvement, Population Management, Data and Analytics Tools	CHA has a focus on claims analytic capabilities and report preparation. A key barrier to improved analytics is the lack of access to EHR clinical data. **Incorporating Clinical Data:** • Expecting significant growth in the capacity to report clinical metrics internally with the advent of JHIE tools for data analytics and population health management. Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE. • Additional opportunities exist for future alternate data collection. In time, these may be the best opportunities because they are less dependent on clinic personnel resources. o Utilize JHIE for the majority of clinical data reporting. Looking forward to using JHIE to get aggregate data. o The CCO expects to rely on report from their anticipated (new) care coordination software integrated with clinic EHRs. This will depend on the software's ability to integrate effectively, but will serve a dual purpose – more real time data as well as faster turnaround for clinical reports because of direct access.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** • As in year 1, CHA plans to utilize aggregate-level data provided by OCHIN for year 2 CQM reporting. • One of CHA's larger clinics, Klamath Open Door, has recently implemented Greenway EHR technology, which is currently only capable of reporting on one of the three CQMs. • Klamath Open Door is providing data generated from internal reporting for all three CQMs. Despite the new EHR not having canned reports, the data desired is in the system and can be extracted. **Longer term CQM Strategy:** Utilizing JHIE is part of the CCO's long-term strategy for CQM reporting. JHIE member CCOs will be

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.
TA to Practices for EHRs and MU	CHA provides Technical Assistance to practices for EHR adoption/workflow optimization, but uptake has been limited. JHIE is providing some assistance in HIE connectivity and Direct.
Other	**Local Provider Directory:** • JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards. • CHA maintains a provider directory within EZCap
Barriers to Implementation of HIT Tools/ Services	• Use of disparate EHRs within the CCO. • Lack of access to clinical data, needed for analytics and care management. • Ongoing changes within CHA, including training and setup of new employees (primarily case managers) on JHIE. Case managers access a variety of tools (dual eligible tools through Atrio, etc.) and need 3 monitors to do so. • Pushback from practices due to drastic workflow changes associated with implementing a new application. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral Health Information Sharing	JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE's community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges. Identify the barriers/challenges CHA experiences in sharing behavioral health data (including mental health, substance abuse, and addictions): _X__ Confusion over compliance with state or federal laws ____ State or federal laws prohibit the type of sharing I want/need to do ___ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). _X__ Concerns over privacy and confidentiality protection for the patient _X__ Concerns over liability if information you share is later improperly shared ____ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

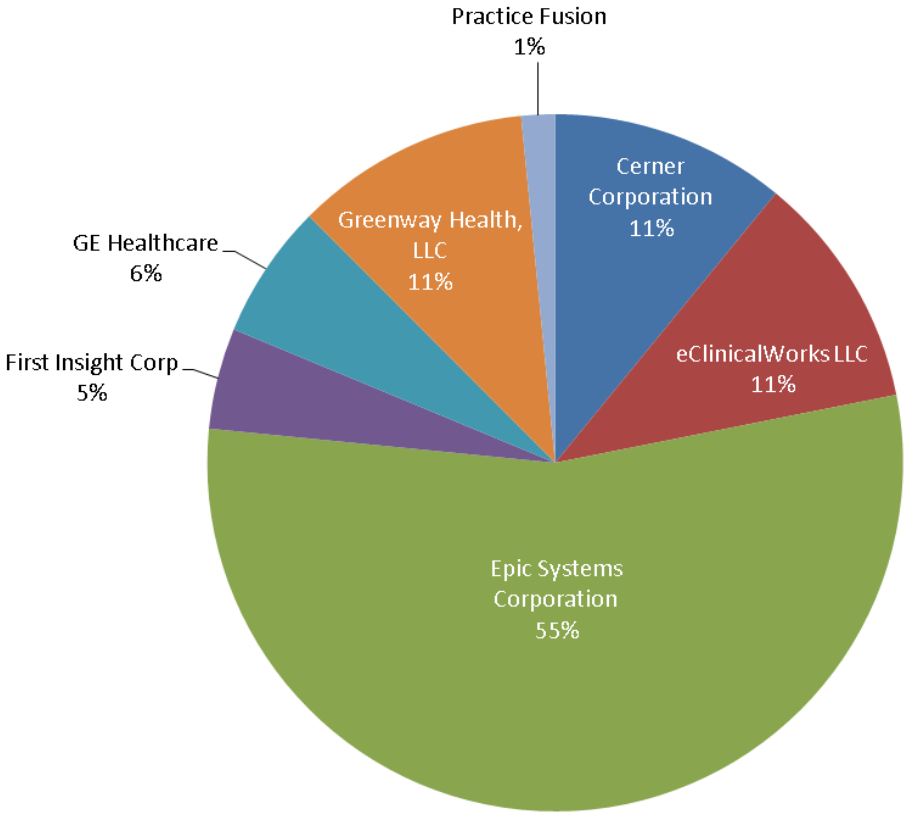
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Sky Lakes Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Certified EHR Technology Products Cascade Health Alliance

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 64 unique providers affiliated with Cascade Health Alliance CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 7 different EHRs in use within the CCO.



Columbia Pacific CCO HIT/HIE Profile

28,850 members[1]

CCO Description:

- Services members in Tillamook, Clatsop, Columbia and five zip codes in Douglas County
- 29 contract primary care clinics sites, 13 mental health/addictions sites, and 4 hospitals within its service area
- Majority of primary care clinics are licensed FQHCs or RHCs; a smaller proportion of the Medicaid population is served by small clinics and independent practitioners within the CCO
- Over 40% of members are empaneled to two clinics: OHSU Scappoose and Coastal Family Health Center
    - Both clinics are PCPCH Tier 3 clinics and have OCHIN's Epic certified electronic health record (EHR) and participate in Meaningful Use
- Due to the Affordable Care Act and Medicaid expansion, Columbia Pacific CCO (CPCCO) grew 70%.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	CareAccord	
Product Name		SAS Business Intelligence Software
Comment	Exploring pilot projects with CareAccord	Claims-based analytic reporting, ideally expanding to incorporate clinical information

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	Overall, Columbia Pacific anticipates leveraging state HIT/HIE efforts and expects to work toward a CCO-specific technology roadmap. **Health Information Exchange:** • Patient information is shared across physical health care teams that are using Epic EHR (including FQHCs using OCHIN's Epic) via Epic CareEverywhere. • Columbia Pacific is interested in exploring approaches for supporting information sharing with behavioral health providers and other members of the care team including with their behavioral health partner, the Great Oregon Behavioral Health Inc. (GOBHI) (see Direct secure messaging below). **Direct Secure Messaging[2]:** Columbia Pacific is considering how to support and facilitate the use of Direct secure messaging,

[1] As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	including considering Direct secure messaging pilots around physical and behavioral health information sharing using CareAccord. **Hospital Notifications[3]:** CPCCO has a strong interest in EDIE and PreManage, as it has patients that seek care at hospitals outside of the CCO network, including OHSU and hospitals in Washington state. The CCO has been engaged in some ad hoc notifications of providers related to ED follow up, which PreManage would replace. **Care Management and CCO-Provided Information to Provider/Care Teams:** The CCO is interested in supporting transitions of care workflow with primary care providers, when their patients are discharged from the hospital, for example. The CCO plans to utilize the hospital notifications obtained via PreManage to assist with care management, including its care coordination efforts and support for providers. CPCCO would like to be able to provide clinics with reports that would allow for follow-up with specific patients. Patient-level information would need to be extracted from the EHRs in order to be actionable, rather than current aggregate metrics reporting.

Quality Improvement, Population Management, Data and Analytics Tools	• CareOregon supports Columbia Pacific CCO with claims-based analytic reporting through SAS Business Intelligence software, using data warehouse to store claims and administrative data.
	  • In 2013, GOBHI mental health claims were incorporated into the data warehouse and made available in SAS BI.
	  • Current reporting capability includes aggregate reporting for CCO level data, provider level data, and member level data for demographics, utilization, and gaps in care
	• Partnership with OCHIN to report capability for clinical data

Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** The high penetration of Epic and use of OCHIN's Epic installation in particular, has allowed for the reliance on OCHIN as the current strategy. **Longer-term CQM Strategy:** The CCO intends to utilize the statewide CQMR service for Medicaid reporting instead of standing up its own comparable technology.
Technical Assistance to Practices for EHRs and Meaningful Use	CPCCO is currently providing EHR technical assistance to clinics through our PC3 collaborative as well as when the practice coach provides one-to-one assistance as well. When working on clinical process and workflow improvement, how to document and code the activity in the EHR is always one aspect of the process we discuss and guide clinics through. We are currently looking into Scribes however no firm decision has been made yet.
Patient Engagement through HIT	Supporting clinic-based initiatives to encourage the use of MyChart.
Telehealth	Interested in and exploring various telehealth opportunities including specialty apps (e.g., tele-dermatology), virtual specialists, telemedicine after hours care, and Project ECHO (tele-mentoring).
Other	**Local Provider Directory:** CareOregon maintains a provider directory in its internal administrative systems.

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Barriers to Implementation of HIT Tools/ Services	• Providers in rural areas are serving many more of the CCO's members due to Medicaid expansion, and layering changes or new expectations (such as new metrics) on top of this much new growth is difficult for providers. • HIT tools for providers, such as PreManage hospital notifications, are more likely to be used if a clinic's entire patient panel is supported by the HIT tool. • A lack of access to clinical data. In need of patient-level actionable information. • A number of additional small practices use other (non-Epic) EHR systems that do not have the same HIE capabilities • Current lack of understanding among clinics/providers in optimal use of Epic's CareEverywhere.
Barriers to Behavioral Health Information Sharing	Integration of Behavioral Health clinical data with physical health clinical data will be an ongoing challenge as the county Mental Health providers use differing software/ EHR platforms. Identify the barriers/challenges Columbia Pacific experiences in sharing behavioral health data (including mental health, substance abuse, and addictions): __X__ Confusion over compliance with state or federal laws __X__ State or federal laws prohibit the type of sharing I want/need to do __X__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). __X__ Concerns over privacy and confidentiality protection for the patient __X__ Concerns over liability if information you share is later improperly shared __X__ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

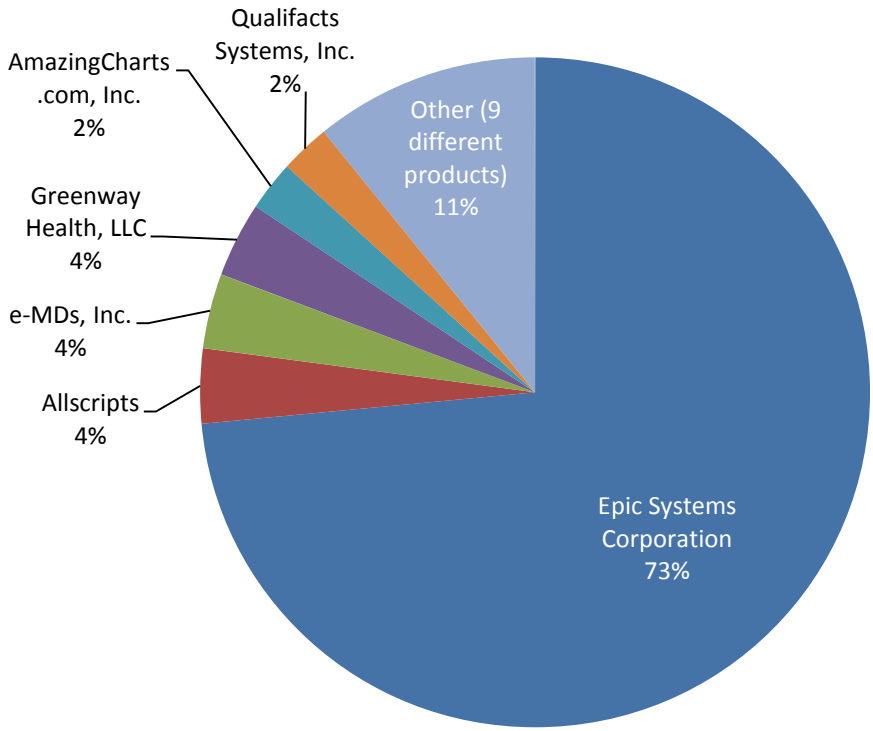
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Columbia Memorial Hospital	CPSI	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Providence Seaside Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Lower Umpqua Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.
Tillamook Regional Medical Center	Cerner	Stage 1	Feed is live for ED data—receiving notifications to fax.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Columbia Pacific CCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 83 unique providers affiliated with Columbia Pacific CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 15 different EHRs in use within the CCO. The top 6 products are in use by 74 unique providers.



Eastern Oregon CCO HIT/HIE Profile

46,701 members[1]

CCO Description:

- Service area covers 12 counties in rural eastern Oregon, the land mass of which is more than 50,000 square miles, representing over 52% of the land area in the State of Oregon.
- There are 57 widely dispersed clinics and individual providers: 24 are certified as Rural Health Clinics (RHCs), 6 as Federally Qualified Health Centers (FQHCs). Twenty-four of EOCCO's contracted clinics within the 12 counties of EOCCO are PCPCHs. An additional Twenty-two (22) clinics that boarder the EOCCO geography are certified.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools	
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name			SAS
Product Name		Provider Portal	Data Store
Comment	Exploring how to support clinics with Direct secure messaging	Being developed/offered by Moda Health (Q2 2015). Reporting: quality, utilization, rosters, etc.	Includes risk analysis tool

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	EOCCO has developed a regional HIT/HIE strategy that focuses on leveraging state HIT/HIE services and otherwise relies largely on technology resources developed and provided by Moda Health. EOCCO plans to contract with a vendor to provide technical assistance, who would work in conjunction with the Innovator Agent as needed to engage providers around HIT efforts. **Health Information Exchange:** (see Direct secure messaging, below) **Direct Secure Messaging[2]:** The CCO sees significant value in getting providers and other care team members (e.g., public health, social services, corrections, etc.) in their network enrolled in CareAccord or other Direct secure messaging so they can exchange information and communicate amongst themselves. The CCO is interested in pilot testing use cases across a diverse care team. The CCO itself uses Moda Health's own secure email service and does not currently intend on utilizing Direct secure messaging separately.

[1] As of 10/01/2014
http://www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	Hospital Notifications[3]: Hospitals in the EOCCO service area are providing hospital notifications directly to many key CCO practices. EOCCO is considering whether PreManage would provide added value for their CCO or practices. **Care Management and CCO-Provided Information to Provider/Care Teams:** EOCCO plans to utilize a provider portal (expected in 2015) which is currently being developed and offered by Moda Health. It will provide reporting, including quality and utilization metrics, and patient rosters to providers. Currently this information is being provided via secure email.
Quality Improvement, Population Management, Data and Analytics Tools	• EOCCO/Moda's analytical capacity includes the ability to extract, transform and load data into a data store for analytic and reporting functions. This data store provides the foundation for the analytic team to assess information quickly and run various analytics against information about members and providers and to make recommendations surrounding members' care. • EOCCO Leverages the analytics capabilities of Moda Health who supplies: o a dedicated analyst o ad-hoc support from the larger Moda analytical team as needed o support by the full portfolio of Moda analytical tools and organizational knowledge • With Moda resources, the CCO is able to generate timely reports on cost, utilization, quality and trends and gaps in care (e.g., patients in need of screening). EOCCO produces reporting packages tailored for individual counties or provider groups to assist in finding opportunities to improve care and eliminate waste, for example. • EOCCO currently sends out provider report cards tracking performance by secure email. Moda is planning to distribute these provider report cards via their provider portal.. • Moda is considering expansion of their risk score tool to allow for the identification of members whose utilization rate they could influence. They are interested in becoming more sophisticated with respect to the stratification of their population. • In 4th quarter 2014 EOCCO began providing primary care practices a report of their top 15 utilizing members which includes the members prospective risk score. This information is provided with the report cards. This new report is an additional tool for providers to use to help manage the most costly members assigned to their clinic/practice. **Incorporating Clinical Data:** • EOCCO is highly interested in extracting clinical data from their providers' EHRs and are therefore in discussion with a vendor for these services, potentially in early 2015. • Building a process to store and analyze clinical information. It is anticipated that providers will deliver information in standard HL7 data format, which would allow for consistency and efficiency in information processing. EOCCO will then be able to run analytics against this information and validate the data against the utilization in claims data.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** • EOCCO continues to express concern about being able to meet the Year 2 depression screening CQM target. This is not due a technical barrier, but a workflow-related one, as many practices have not yet implemented the depression screening process into their clinical workflow. • The CCO is currently performing outreach to practices in an attempt to get them to incorporate proper depression screening processes into their EHR workflows. The focus

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	has been on the larger practices in order to ensure collection of sufficient data. • EOCCO is pursuing the collection of clinical and other HEDIS data for the purpose of expanding their data repository and improved reporting as well as providing practices with more meaningful and actionable reports. **Longer-term CQM Strategy:** The CCO and Moda are in discussions regarding their strategy for addressing the CCO incentive measures moving forward, which includes contracting with an outside vendor to provide analytics tools/capabilities and/or guidance around collecting and reporting on CQM data. • EOCCO is in discussions with vendors who could access various systems, review and assist with adjusting workflows, and collect clinical data directly out of the EHRs. • Note: any vendor solution will also be expected to support Moda performance/quality related initiatives outside of the CCO, e.g., HEDIS reporting.
Technical Assistance to Practices for EHRs and MU	CCO is embarking on a technical assistance program, which may include staff that goes out to support practices. Providing assistance with workflow modifications to facilitate the collection of clinical data is a priority. EOCCO plans to begin TA to assist with CQMs at their high-priority practices in early 2015.
Patient Engagement through HIT	EOCCO plans to expand the use of the MyModa member portal to the EOCCO population. The MyModa portal provides members customized on-line access to real time health information such as claims, eligibility, current PCP/Medical home assignment, the ability to search for network providers along with other health related tools and resources. We expect the portal to be available to the EOCCO population in 2015.
Telehealth	EOCCO providers have telehealth equipment and technology, but lack an implementation partner. They are very interested in telehealth and requested access to the OHA-sponsored telehealth inventory, once compiled.
Other	**Local Provider Directory:** EOCCO maintains a provider directory within their administrative systems.
Barriers to Implementation of HIT Tools/ Services	EOCCO's provider network contains many small practices. This presents challenges on multiple levels. Having many small practices on disparate systems complicates efforts to implement HIE or collect clinical data. This also makes the CCO's process of providing practice-level assistance around EHR workflows longer and more complex. • Small practice size is a barrier to increasing CQM collection. EOCCO is finding it challenging to get clinical data out of EHRs effectively, particularly with its rural providers. • There are over 25 different EHRs being used by practices in the CCO's region, and a lack of EHR interoperability. • Challenges related to geographical and logistical technology capabilities. • Some providers are waiting on vendors for needed MU Stage 2 updates, while those owned by hospitals/health systems are relying on their parent organization to proceed. EOCCO is finding it challenging to distribute provider report cards to practices and providers., It is difficult to get accurate, up-to-date e-mails for secure email distribution. Having an email address does not ensure distribution to the correct individual.
Barriers to Behavioral Health Information Sharing	Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: _X__ Confusion over compliance with state or federal laws ____ State or federal laws prohibit the type of sharing I want/need to do _X__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not

	segment or separate data). _X__ Concerns over privacy and confidentiality protection for the patient ____ Concerns over liability if information you share is later improperly shared ____ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

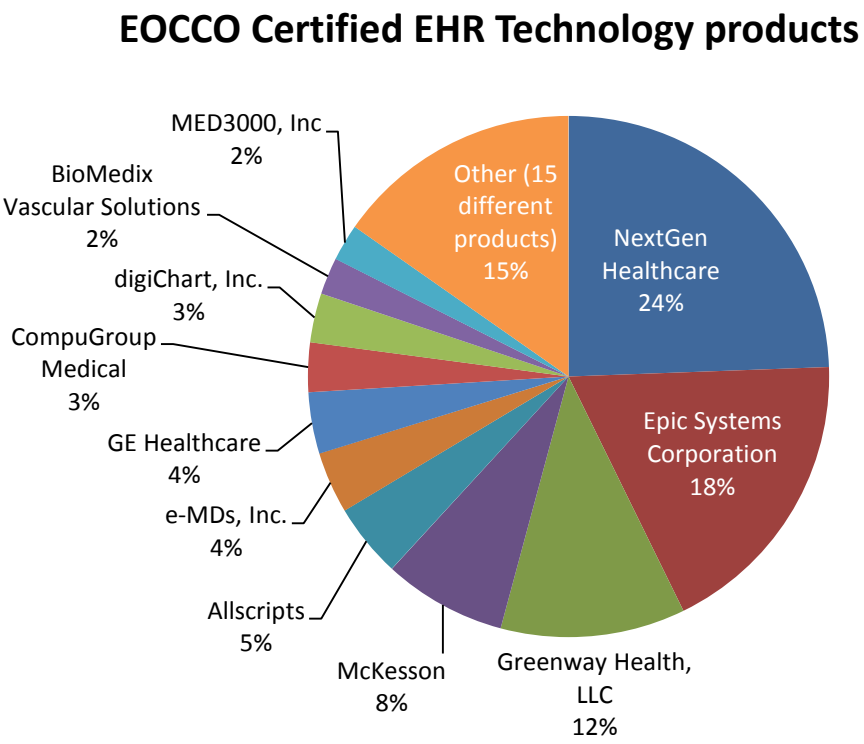
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Blue Mountain Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Good Shepherd Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Grande Ronde Hospital	McKesson	Stage 1	Feed is live for ED and in patient data—receiving notifications to fax.
Harney District Hospital	McKesson	Stage 2	Feed is live for ED and inpatient data—receiving notifications to fax.
Lake District Hospital	CPSI	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Pioneer Memorial Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
St. Alphonsus Medical Center – Baker City	Cerner	AIU	Contract with vendor has been signed.
St. Alphonsus Medical Center – Ontario	Cerner	Stage 1	Contract with vendor has been signed.
St. Anthony Hospital	Meditech	AIU	Feed is live for ED and inpatient data—receiving notifications to fax.
Wallowa Memorial Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for EOCCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 131 unique providers affiliated with EOCCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 26 different EHRs in use within the CCO. The top 11 products are in use by 111 unique providers.



FamilyCare CCO HIT/HIE Profile

117,316 members[1]

CCO Description:

- Services Medicaid members in Clackamas, Multnomah, and Washington counties, and a small number in Marion.
- Primary care network providers are generally PCPs in small to medium-sized group practices and within FQHCs throughout the tri-county area (pre-2014 enrollment was 70% children).
- 74% of patients are assigned to Tier 3 Patient Centered Primary Care Homes (PCPCH).
- A significant number of FamilyCare providers' compensation will be tied to outcomes in 2015.
- Technology strategy involves supporting local entities that have developed their own HIT/HIE tools, while also developing and implementing centralized tools in two phases
    - Based on a gaps assessment, quickly procured best of breed tools to support care management, population management, utilization and analytics,
    - Longer term strategy – in 2015, select an integrated solution for sharing clinical information with the CCO's provider network to support patient care and population health

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			Quality Improvement, Population Management, Data and Analytic Tools	
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	McKesson	CMT	TBD	Milliman	Inovalon
Product Name	VITAL	PreManage		MedInsight	Indices
Version	7.2	Complete		10.3	4.04
Comment	Care management system; attributes available clinical data with individual member records	Provider clinics have begun to establish direct connections with CMT for ED and inpatient notifications	Pursuing an integrated solution for sharing member information to support care delivery with the CCO's provider network	Analytics tool for utilization management and quality improvement; has ability to benchmark and compare performance from provider and population perspectives	Quality analytics platform with Medicare HEDIS tracking/reporting; will have ability to track many CCO measures

[1]As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Overall approach:** • FamilyCare has reported a trend in their region of provider groups (e.g., IPAs, ACOs) taking the lead in investing in, designing, and developing certain HIT/HIE-related tools and services on their own. These groups want to be able to assume risk and need the tools to support care and manage risk, and are thus investing in HIT/HIE. o Two major examples - an organization representing 22 pediatric practices and an association of large adult care practices outside of health systems have each invested in population management platforms, and want to connect to patient information within other provider, hospital, and CCO/health plan systems. • FamilyCare's strategy is to track such investments to understand providers' needs and the expectations or opportunities for FamilyCare to support provider groups and facilitate access to important member-level data for providers. Providing the right patient information to support practices and groups accepting risk is part of FamilyCare's strategy to recruit and retain providers. • In 2015, FamilyCare will select an integrated solution for care management and sharing member information to support care delivery with the CCO's provider network. An ideal solution would simplify data exchange (HIE) with providers and integrate information with the CCO's care management activities. Tools for member engagement will be part of this solution as will additional analytics and population health capabilities. **Health Information Exchange:** FamilyCare CCO's overall HIT/HIE strategy includes taking a decentralized approach, by supporting the development/adoption/use of HIT/HIE at the provider-level, and being a conduit of information to providers, but not serving as a central consolidator of information or services related to HIE. FamilyCare is an early adopter of the Emergency Department Information Exchange (PreManage) and will facilitate provider access to this information and integrate the data into care management and other operational processes. **Direct Secure Messaging[2]:** FamilyCare is interested in supporting the use of Direct secure messaging for sharing patient information between physical health providers and others such as CCO case management, home health, developmental screenings happening outside of pediatric practices, etc. **Hospital Notifications[3]:** FamilyCare has implemented the PreManage solution from CMT comprising both ED and inpatient notifications. As part of this service, provider clinics in FamilyCare's network have begun to establish direct connections with CMT for this data.

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	Care Management and CCO-Provided Information to Provider/Care Teams: In March 2013, FamilyCare licensed and implemented McKesson's VITAL system, for use internally by the CCO's care management teams. VITAL is a coordinated care management system for utilization, disease and case management. It includes clinical data and decision support tools integrating data from disparate sources and combining it into a single, member-centric workflow which enables use of one system in managing the health needs of each member. The tools support emergency room follow up and help reduce readmissions for hospital care: • The assessment tool supports case management staff working with the member to create a care plan and goals. • The disease monitoring tool sends alerts to care managers based on needs or gaps in care for members within certain chronic conditions.
Quality Improvement, Population Management, Data and Analytics Tools	FamilyCare has two tools for analytics, quality improvement, and population management (in addition to VITAL, described above): • In 2014, FamilyCare began implementing the Milliman MedInsight platform as an internal analytics tool for utilization management and quality improvement, which includes consolidated medical and pharmacy claims, prospective risk scoring, and CCO metrics tracking for provider performance. • Inovalon Indices is an analytics platform that FamilyCare will utilize for HEDIS tracking/reporting for their Medicare population, which may be applicable to other populations/initiatives in the future (e.g., quality reporting for Medicaid). This is a sophisticated tool that helps to identify gaps in care and prompt care teams when interventions are needed. • Longer term strategy – as described above, FamilyCare is pursuing an integrated HIT/HIE/analytics solution that can support shared care management/planning, clinical information sharing, member engagement and analytics, etc. **Incorporating Clinical Data:** • FamilyCare develops or participates in data warehousing initiatives to enable aggregation of clinical and claims information to inform conversations about quality, cost and value. FamilyCare has programmers on staff who develop point-to-point data sharing, although this is labor intensive. • FamilyCare has engaged a handful of labs, and is pursuing additional ones, in data sharing arrangements. One of their long-term goals is for lab data to be fed directly into VITAL and Inovalon where it can be used for analytics and CQMs.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** • For its OCHIN clients FamilyCare utilizes OCHIN-supplied aggregated data for CQM reporting. However, FamilyCare sees the most value reporting patient-level, actionable data. • For non-OCHIN clients, FamilyCare is pursuing a strategy of developing individual connections/interfaces to enable the collection of (individual-level) clinical data. The CCO commented that this process can be a tedious one-by-one effort to set up the customized connections, and perform the necessary patient attribution processes once the data is flowing. • As described above, FamilyCare is bringing lab data into VITAL and Inovalon for CQMs, and is developing the ability to obtain clinical quality data from the provider network. However practices have varying capacity to send clean, structured clinical quality information for state quality measures.

	Longer-term CQM Strategy: Investigating market options (as described above), and considering the state clinical quality metrics registry for data collection from providers.
Technical Assistance to Practices for EHRs and MU	OCHIN supports some key FamilyCare practices. FamilyCare is considering using OHA-sponsored technical assistance, however the amount of assistance available does not address the needs of FamilyCare's relatively large provider network.
Patient Engagement through HIT	FamilyCare is pursing strategies for connecting with members and engaging them in improving their health through HIT. This includes short-term implementation of stand-alone services for member communication and medium-term implementation of systems for members integrated with CCO databases. Longer-term solutions will be tightly connected with the care management system as part of the larger integrated systems strategy.
Telehealth	Lots of interest in telehealth, but no current activities. FamilyCare would like clarification on operational issues around telehealth such as billing, what constitutes a visit, etc.
Other	PH Tech, FamilyCare's third-party claims administrator (TPA), offers web-based tools through the Clinical Information Manager "CIM" system for FamilyCare practices related to eligibility and prior authorization requests. **Local Provider Directory:** FamilyCare maintains a provider directory (Applied Statistics & Management, Inc.'s "MDStaff") within their administrative systems, and provider information is included in their case management program, McKesson VITAL. An online provider directory is also available to all members and providers on FamilyCare's website.
Barriers to Implementation of HIT Tools/ Services	• Challenging to identify when and what are the right investments for the CCO to make related to supporting health information exchange, given the investments that local provider groups and health systems are making. • FamilyCare's network is changing – more adult-focused practices. Providing the right patient information to support practices and groups accepting risk is part of FamilyCare's strategy to recruit and retain providers. • Obtaining clinical quality metrics data is tedious, and there are challenges with managing patient attribution for the provider, because in some cases their EHR is not linked to their practice management system, and assigned PCP is not tracked in EHRs. Some complexity around providers ensuring that submitted information only goes to the appropriate health plan. Providers will want more automated (and reliable) patient attribution once they are taking on risk. • Some providers do not utilize EHR technology, and/or are not able to share patient information outside their organization or connect to an HIE. FamilyCare faces challenges related to assisting providers to become ready and willing to participate in HIE. • Difficult for some clinics to see the value of altering their workflows to accommodate CQM reporting requirements. • Providers are being asked to consume and share data with payers, hospitals, peers, government, and an increasing number of complex risk sharing entities. In the Portland Metro area, providers frequently work with multiple CCO's. Coupled with what is expected to be relatively low Meaningful Use Stage 2 technology adoption, requiring them to transmit CQM data to multiple CCO's could increase overhead even further and make caring for Medicaid patients less attractive.
Barriers to	Barriers /challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include:

Behavioral Health Information Sharing	_x_ Confusion over compliance with state or federal laws ___ State or federal laws prohibit the type of sharing I want/need to do ___ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). ___ Concerns over privacy and confidentiality protection for the patient _x_ Concerns over liability if information you share is later improperly shared ___ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

(Hospitals in the CCO's service area)

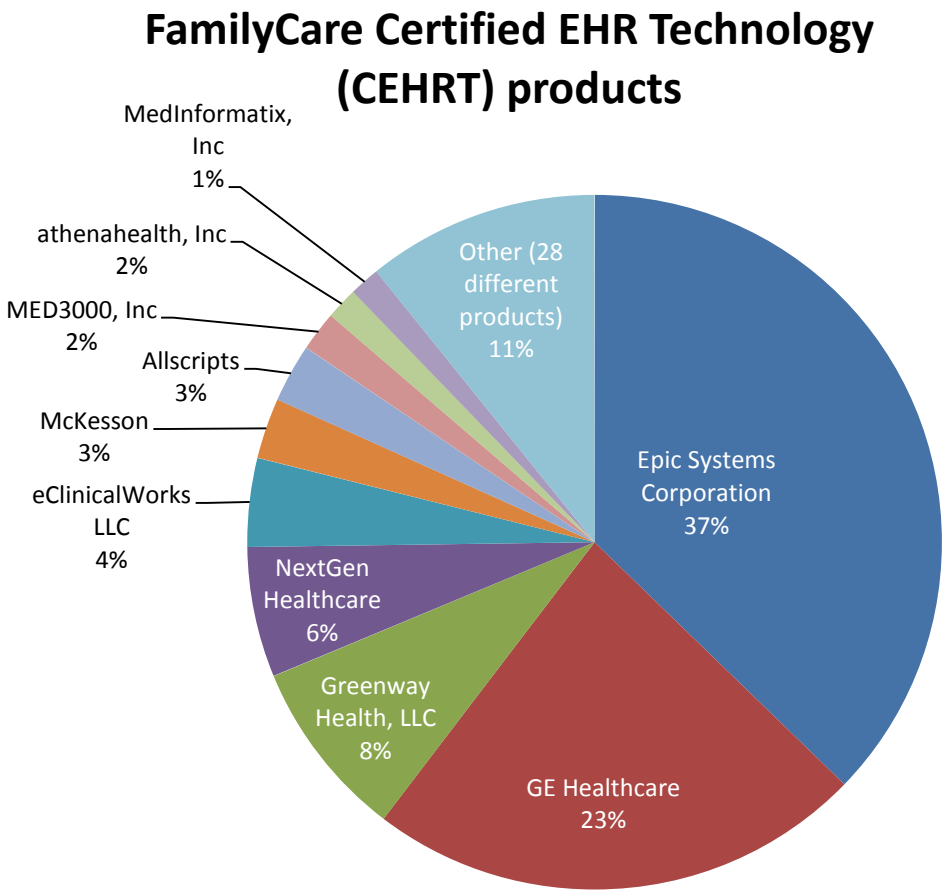
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Adventist MC	Cerner	Stage 1	Feed is live for ED data—receiving notifications by fax.
Kaiser • Sunnyside MC • Westside MC	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Legacy • Emanuel MC • Good Samaritan MC • Meridian Park MC • Mount Hood MC	Epic	Stage 2	Feed is live for ED and inpatient data—receiving notifications to EMR.
Oregon Health & Science University	Epic	Stage 1	Feed is live for ED data—receiving notifications to EMR.
Providence • Milwaukie MC • Portland MC • St. Vincent MC • Willamette Falls MC	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Tuality • Forest Grove Hospital • Healthcare	Cerner	Stage 2	Feeds are live for ED and inpatient data—receiving notifications by Fax.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for FamilyCare

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 1138 unique providers affiliated with FamilyCare that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 38 different EHRs in use within the CCO. The top 10 products are represented in the chart, which are in use by 1015 unique providers.



Health Share CCO HIT/HIE Profile

238,517 members[1]

CCO Description:

- The state's largest CCO serving members in Clackamas, Multnomah, and Washington counties.
- Delivers services through its risk accepting entities (RAEs) and partners including the following: CareOregon, Kaiser Permanente, Providence Health Plan, Tuality Health Alliance, Clackamas County Mental Health, Multnomah County Mental Health, Washington County Mental Health, Access Dental Care, Capital Dental Care, CareOregon Dental, Family Dental Care, Kaiser Permanente Dental, Managed Dental Care of Oregon, ODS Community Health Dental Plan, Willamette Dental Group, and Access2Care. Health Share's contracted provider network exceeds 17,000 providers.
- More than 60% of Health Share's members receive physical health care services from one of 11 provider organizations, all of which have implemented Meaningful Use certified EHRs: Adventist Health, Clackamas County Health Department, Kaiser Permanente, Legacy Health System, Multnomah County Health Department, Neighborhood Health Center, OHSU, Providence Health and Services, Tuality Healthcare, and Virginia Garcia Memorial Health Center in the context of more than 120 related practices, most of which are PCPCH certified.
- Technology strategy involves coordinating across local entities that have developed their own HIT/HIE tools, while also developing and implementing centralized HIT including
  - an electronic data interchange infrastructure supporting the bi-directional secure exchange of data between OHA, Health Share, and its partners,
  - a Provider Portal enabling web-based and programmatic member eligibility inquiries, and
  - a robust data aggregation, analysis, and reporting solution ("the Big Kahuna").

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools	
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	RAEs employ Epic, Certify, Medicity, Cerner*	Collective Medical Technologies	Internally/Self-developed	
Product Name		EDIE, PreManage, PopIntel	The Big Kahuna, PopIntel	
Comment	*In addition to developing and leveraging its centralized HIT solutions, Health Share supports and facilitates alignment across the HIT tools that its partners and providers use. Examples include standardized or aligned configuration and use of Epic CareEverywhere, Epic MyChart OpenNotes, EHR-agnostic Discharge Summaries, etc.			

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** • For organizations using Epic EHR, CareEverywhere has been configured to enable optimal health information exchange (HIE) among providers using Epic EHRs. • Supports private enterprise HIEs. Most hospital-based delivery systems contracted with

[1] 9/15/2014 www.oregon.gov/oha/healthplan/DataReportsDocs/September2014CoordinatedCareServiceDeliverybyCounty.pdf

	Health Share have implemented private, enterprise HIEs such as Certify, Medicity, and Cerner while some rely upon interface engines such as Mirth, Cloverleaf, and eGate to exchange health information between internal and external systems for the benefit of related stakeholders. • Patient information is shared across physical health care teams that are either using Epic EHR and/or within a hospital-based delivery system, as described above. • Health Share is exploring approaches for supporting information sharing with behavioral health providers and other members of the care team. **Direct Secure Messaging[2]:** Some providers utilize Direct secure messaging to exchange secure messages with other providers as well as patients. Health Share is considering how to support and facilitate this more broadly, including considering Direct secure messaging pilot around behavioral health information sharing potentially using CareAccord. **Hospital Notifications[3]:** As is true in other parts of the State, Health Share providers are beginning to leverage EDIE and many expect to use Pre-Manage when available. **Care Management and CCO-Provided Information to Provider/Care Teams:** One of Health Share RAEs, CareOregon, shares information with relevant providers and intervention teams about Health Share members engaged in one or more intervention programs aimed at high utilizers of health care services in order to better coordinate and manage care. In this context, information is shared via **PopIntel**, an internally developed web-based centralized care coordination registry for teams to manage their intervention cohort and collect relevant data about intervention processes and outcomes.
Quality Improvement, Population Management, Data and Analytics Tools	**The "Big Kahuna":** Health Share's data aggregation, analysis, and reporting solution , known as the "Big Kahuna," aggregates and correlates information at a member-level sourced from 32 distinct data feeds, maintaining more than 500 data elements per member, totaling more than 100,000,000 data elements refreshed monthly within a data warehouse. The solution has been in use for 16 months and sheds light on: Health Share's members: demographics, RAE assignment, chronic conditions, their utilization of healthcare services and related costs; providers' performance; prescribed medications; Quality Improvement Project (QIP) and Performance Improvement Project (PIP) outcomes; and key performance indicators. Forty distinct "slicers" predicated on member-specific attributes enable analysis of sub-populations. Member-level data enables population risk management, health management, and care coordination. • The solution offers a variety of functions, including, but not limited to: receiving and reporting on CQM data, risk-stratifying and tracking member populations, and managing population health. It o is based on administrative data and CQM data o can drill down to member-level details

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	○ identifies CCO metrics ○ allows for sub-population analysis and drill-down • This solution will provide CQM reporting capabilities for year 2 and beyond, and also give providers the ability to track practice-level CQM scores. • Clinical data: the Big Kahuna incorporates data from a variety of sources, including clinical metrics data aggregated at the provider level (see below). **PopIntel** (described under "Information Sharing" above) supports analysis and evaluation of targeted interventions.
Clinical Quality Measure (CQM) Collection and Reporting	• Health Share looks forward to receiving and aggregating data for the CQMs through the QRDA standard, as it will enable the CCO to calculate the actual CQM measures in-house instead of at the actual practices themselves. • For Year 1 CQM reporting, Health Share utilized aggregate practice level data (Numerator/Denominator), in structured, CSV format from 11 organizations. • Health Share is concerned that the opportunity costs of further expanding the infrastructure to collect and report on CQMs using new technology (i.e., requiring organizations to report CQM data using QRDA standards) may disrupt providers' efforts to achieve MU stage 2. To that end, Health Share does not plan to implement any new technologies/methods for reporting Year 2 metrics
Technical Assistance to Practices for EHRs and MU	OCHIN is providing technical assistance to some Health Share providers with OCHIN Epic EHR. Partner organizations and larger integrated health systems are providing technical assistance support to practices.
Patient Engagement through HIT	• Most large provider organizations actively participate in the NW OpenNotes Consortium sponsored by We Can Do Better and either have or will shortly enable OpenNotes features within their respective patient portal solutions – e.g. Epic MyChart. • Interested in leveraging a "backbone" similar to CareEverywhere for consumer access across the Health Share population – currently My Chart is a portal tethered to a single clinic or practice. Would like a single point of consumer access facilitated through Epic Lucy.
Telehealth	**Project ECHO**: Expanding Primary Care Capacity with Telementoring • Focused on management of psychiatric meds in primary care for adults. • Lead: OHSU dept. of psychiatry. Partnering with OHSU telemedicine • Implementation to date enthusiastically embraced by contracted healthcare providers
Other	• Health Share provides an internal electronic data interchange infrastructure supporting the bi-directional secure exchange of member-related data between OHA, Health Share, and its numerous partners including RAEs. • Health Share provides a Provider Portal enabling web-based and programmatic member eligibility inquiries • Health Share and its RAEs maintain provider directories within their administrative systems, EHRs and private enterprise HIEs, and a provider directory for analytics exists within the Big Kahuna
Barriers to Implementation of HIT Tools/ Services	• Health Share has opted to table certain discussions for HIT/HIE enhancements at the community level in order to avoid disrupting efforts happening at the individual entity/organization level (e.g., coordinating EDIE Plus/PreManage implementation, or building connections between private enterprise HIEs and/or EHR systems). • Difficulty for the provider community to understand what the common credentialing database is. Health Share suggested that more visible marketing efforts towards providers

	be launched in parallel to the development of the service itself.
Barriers to Behavioral Health Information Sharing	Barriers are limited to 42 CFR Part 2 restrictions governing PHI related to substance abuse treatment. However, challenges regarding the electronic sharing of behavioral health information are numerous including: _x__ Confusion over compliance with state or federal laws _x__ State or federal laws prohibit the type of sharing I want/need to do _x__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). _x__ Concerns over privacy and confidentiality protection for the patient _x__ Concerns over liability if information you share is later improperly shared _x__ Lack of proper consent forms from the patient

CCO Provider Environment

Hospital Engagement in HIT

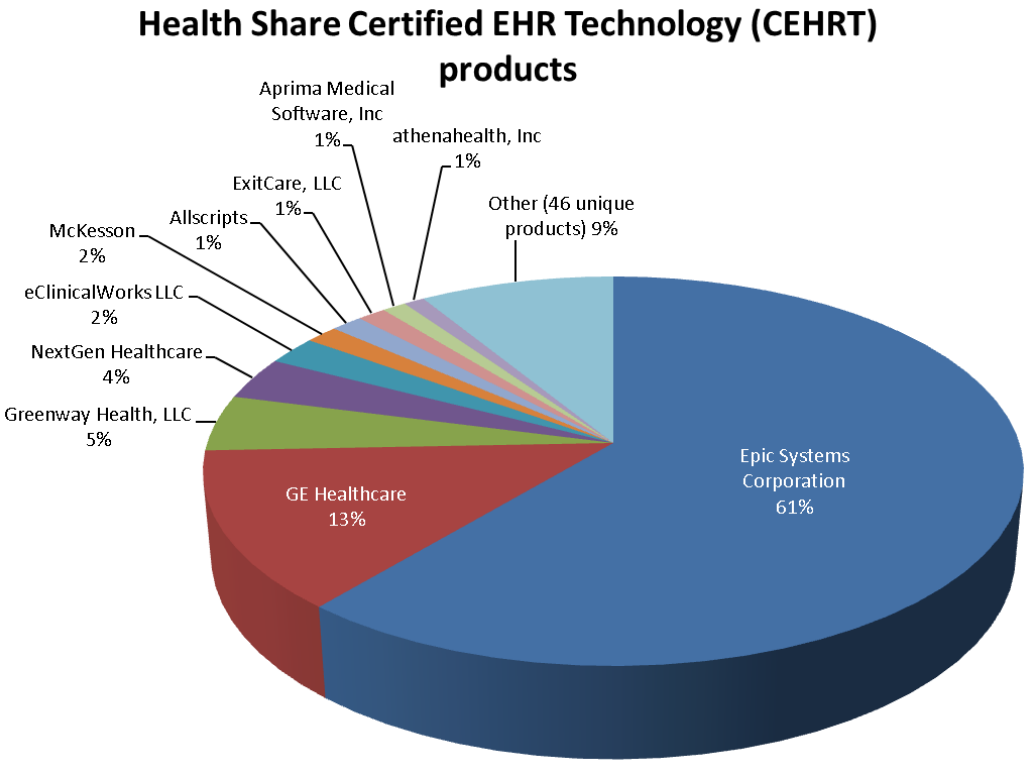
Hospital Name	Direct Secure Messaging Flat File Participation (as of 12/2014)	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Adventist MC	Anticipated	Cerner	Stage 1	Feed is live for ED data—receiving notifications by fax.
Kaiser • Sunnyside MC • Westside MC		Epic	Stage 1	Feed is live for ED inpatient data—receiving notifications to EMR.
Legacy • Emanuel MC • Good Samaritan MC • Meridian Park MC • Mount Hood MC	Currently participating	Epic	Stage 2	Feed is live for ED inpatient data—receiving notifications to EMR.
Oregon Health & Science University	Currently participating	Epic	Stage 1	Feed is live for ED data—receiving notifications to EMR.
Providence • Milwaukie MC • Portland MC • St. Vincent MC • Willamette Falls MC		Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Tuality • Forest Grove Hospital • Healthcare	Currently participating	Cerner	Stage 2	Feeds are live for ED and inpatient data—receiving notifications by Fax.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for Health Share CCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 2,553 unique providers affiliated with Health Share that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 56 different EHRs in use within the CCO. The top 10 products are represented in the chart, which are used by 2,328 unique providers.



Intercommunity Health Network (IHNCCO) HIT/HIE Profile

57,132 members[1]

CCO Description:

- InterCommunity Health Network CCO was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Benton, Lincoln, and Linn Counties.
- Samaritan Medical Clinics provide primary care services to 70% of CCO membership. Other providers in the IHNCCO primary care network include IPAs, FQHCs and several independent primary care clinics.
- IHNCCO is affiliated with Samaritan Health Services as its parent corporation which includes other health care providers via its hospital/health system.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	InterSystems	IBM
Product Name	HealthShare	Cognos Data Marts, Business Intelligence, Query Studio
Version	Cache: 2014.1.3 HealthShare modules: Core: 12.07 Linkage/Index: 13.04 Clinical viewer: 12.0	
Comment	Regional Health Information Collaborative (RHIC) will collect patient data from various sources, organize it, and make it available to providers within a provider clinical viewer	Analytic solutions

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** • IHNCCO is currently participating in the collaborative development of a regional health information exchange tool, known as the Regional Health Information Collaborative (RHIC). o RHIC will collect patient data from various sources (EHRs, claims, others), organize it, and make it available and easily accessible to providers at the point of care within a provider clinical viewer. The vision is for there to be a link within the EHRs to allow for single sign-on access into RHIC. o The clinical viewer will provide a quick overview of patient information (organized within specific categories, such as allergies, latest visits, etc.) with the ability to drill

[1]As of 10/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

down to the depth of detail the provider needs.
    - IHNCCO selected InterSystems as the vendor at the end of May. IHNCCO developed an Implementation Project Plan in August 2014. Contract was signed on October 8th and IHNCCO expects to conduct a pilot in fall/winter 2014/5.
    - Following a successful pilot, IHNCCO will add Epic data from Lincoln and Benton counties supplied by OCHIN, Linn county data from their Raintree EHR, and AllScripts data from The Corvallis Clinic into RHIC in early 2015.
- IHNCCO aims to bring myriad data into RHIC to support care coordination
    - IHNCCO has assembled a Delivery System and Transformation committee within RHIC including members from long-term care, public health, county health, mental health community, and dental. They are using this forum to help identify the data needs that RHIC may be able to address.
    - IHNCCO is sponsoring a pilot with the long-term care communities across Linn, Benton, and Lincoln counties including all 5 hospitals. It involves LTC partners providing follow-up care for members discharged from any participating hospital within 24 hours. Several issues have come to light including a lack of information regarding when the member is going to be discharged and their insurance (e.g., only 25% were IHNCCO members who are the only patients for whom IHNCCO can pay). The plan is to have all of the data feed into RHIC. The hospitals that have been successful in implementing this program have documented particularly low readmission rates as well as a lower risk across their population.
- Samaritan Health Services has promoted the use of Epic CareLink with its participating providers.
    - Several providers have begun to use the product; future efforts will focus on expanding the use of this product.
    - All IHNCCO Case Managers have been trained and use Epic CareLink. Plans are in development for case managers to educate providers on ways to access available information within Epic CareLink.

Direct Secure Messaging[2]:

- IHNCCO's major provider partners will have Direct secure messaging in their EHRs (e.g., OCHIN, Samaritan).
- RHIC could have Direct capabilities, but IHNCCO has not yet determined when they will initiate this.

Hospital Notifications[3]:

The IHNCCO reported that emergency departments in their region have faced some operational barriers in integrating EDIE capabilities into EHR workflows. The IHNCCO plans to have discussions about their potential use of PreManage after they have received and analyzed additional feedback from ED managers around the value of EDIE.

- Samaritan chose to receive EDIE notifications via fax. They are in the process of determining

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	the utility of the information at the point of care. • IHNCCO met internally and with emergency departments to discuss leveraging EDIE and evaluate PreManage and it was found neither service would be beneficial to assisting with IHNCCO members. **Care Management and CCO-Provided Information to Provider/Care Teams:** • (See RHIC description above)
Quality Improvement, Population Management, Data and Analytics Tools	• IHNCCO has multiple analytical solutions available for in-house analytics staff (e.g., utilizing Cognos data marts, Business Intelligence, and Query Studio, as well as Crystal Reports server and reports). o Currently have an analytics department of 5 staff, as well as access to Samaritan Health Services Information Services staff, for programming and development services, and occasionally work with contracted vendors to provide additional analytical capability. • Future phases of the RHIC will support federal, state and local quality reporting initiatives as well as other population health analysis and reporting, evidence-based clinical notices and alerts, and improved population health management capabilities. • Continuing work to expand internal analytic capabilities o Staff recruiting and training, implementing procedures and policies to ensure data integrity, etc. o IHNCCO is engaging in discussions with their community partners regarding the most meaningful way to risk-stratify their patient population. They have determined that one risk-stratification method will not suffice for their entire member population. o IHNCCO is also interested in identifying the socio-economic factors they can affect. **Incorporating Clinical Data:** RHIC integrates various types of data from numerous sources, including clinical data extracted from EHRs.
Clinical Quality Metrics (CQM) Collection and Reporting	Lack of HIE across the provider network makes it particularly complex and burdensome to collect CQM data. **Current CQM Strategy:** • IHNCCO leveraged the Samaritan Health Services system for reporting on CQMs in Year 1, and plans to do so again for Year 2. **Longer-term CQM Strategy:** • RHIC may be used as a tool for reporting on CQMs in the future (beyond Year 2), but details around such functionality have not yet been envisioned.
Technical Assistance to Practices for EHRs and MU	IHNCCO provider network may receive TA already from within their organizations - Samaritan supports its providers, as does OCHIN.
Telehealth	IHNCCO has a high interest in telehealth: • IHNCCO is in the early stages of a telehealth pilot implementing KANNACT at Corvallis clinic o Involves giving tablets to high-risk individuals and surrounding them with 24/7 high-performance health team to improve their care. o The goal of the program is to keep high-risk members out of the inpatient setting, if possible, to cut down those costs.

Other	**Local Provider Directory:** IHNCCO maintains a provider directory within their administrative system and will include one in RHIC.
Barriers to Implementation of HIT Tools/ Services	• Rural and diverse provider community. The hospital system, county health departments, and larger clinics manage data in disparate EMR systems. • Lack of a standardized and central data repository for patient health information across the provider network (RHIC is meant to address this, at least in part). • Some providers can only send and receive data files (e.g., Excel spreadsheets), unable to share data in HL7 standardized formats. • IHNCCO's provider network has some clinics with broadband connectivity limitations in parts of their region, mainly in rural areas and away from the I-5 corridor (e.g., Lincoln county). • The CCO expressed some concerns about meeting the Year 2 (and beyond) for depression screening CQM requirements, indicating they've faced challenges getting providers to adjust their workflows to be able to properly collect/report on data for the depression screening measure. • The long-term governance model/strategy of the RHIC HIE system is under development. • IHNCCO is considering how to include important data in RHIC for the full care team, but is finding concerns/uncertainty about data sharing policies and adequate consent procedures to allow for the sharing of data: o Connecting homecare members into the remaining care community, o Connecting with the educational and penal systems. o Foster children are of significant concern; developmental screenings happening in multiple locations but not getting back to the PCP. • IHNCCO has been engaged in a pilot with Benton county involving the real-time connection of three facilities to allow for the monitoring of who is assigned to the members. PCP reconciliation between the plan, provider records, and provider providing services is only 33% correct. The goal of the pilot is to reconcile the information, for which they have found that member involvement is needed.
Barriers to Behavioral Health Information Sharing	The IHNCCO identified a disconnect between behavioral/mental health EHRs and RHIC. CCO attributes challenges to differing incentives/motivations between the behavioral and physical medicine communities. Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: __X__ Confusion over compliance with state or federal laws __X__ State or federal laws prohibit the type of sharing I want/need to do __X__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). __X__ Concerns over privacy and confidentiality protection for the patient __X__ Concerns over liability if information you share is later improperly shared __X__ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

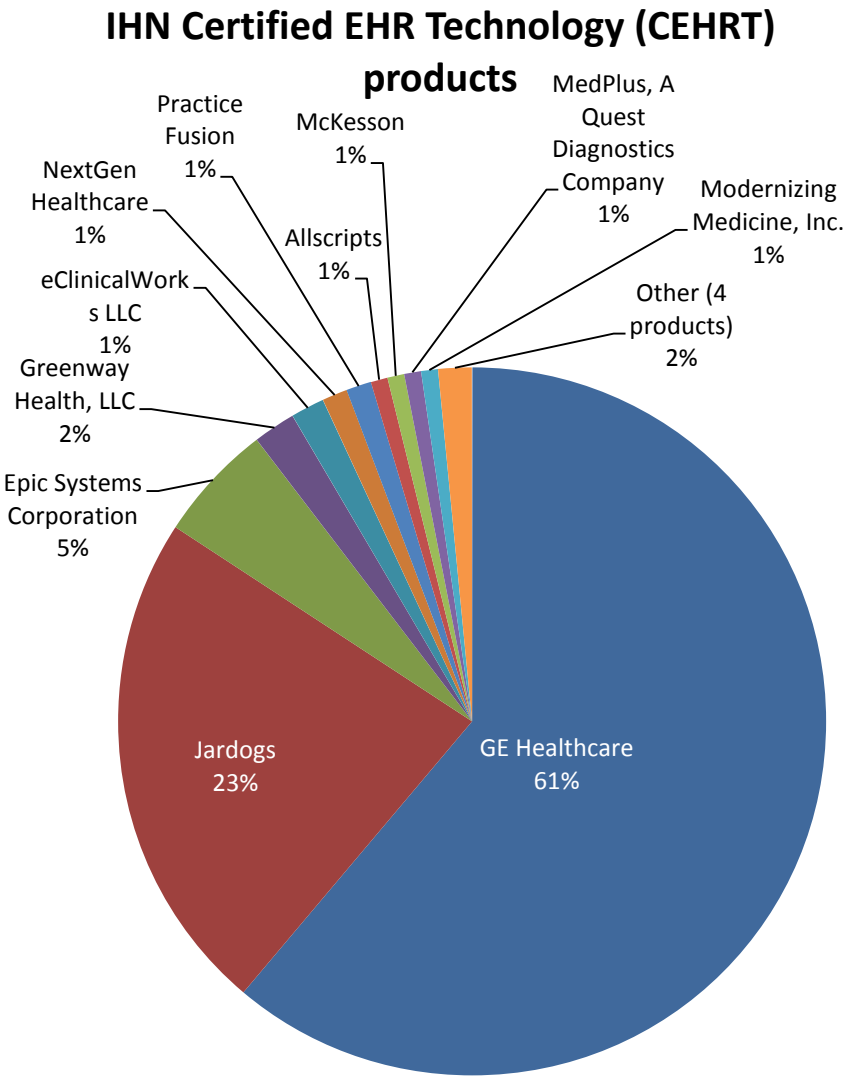
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Samaritan • Albany General • Lebanon • North Lincoln • Pacific Communities • Samaritan Regional	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for IHNCCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 260 unique providers affiliated with IHN CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 15 different EHRs in use within the CCO. The top 11 products are represented in the chart, which are in use by 256 unique providers.



Jackson Care Connect CCO HIT/HIE Profile

31,054 members[1]

CCO Description:

- 51 contract clinics and 2 hospital systems
- 2 primary care clinics are licensed FQHCs and the majority of the clinics are small private practices.
- Approximately 40% of JCC members are empaneled to the two FQHCs in Jackson County, La Clinica and Community Health Center. Both clinics are PCPCH Tier 3 clinics, have certified EHRs (OCHIN Epic) and participate in Meaningful Use.
- Jackson Care Connect is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).
- Jackson Care Connect is also supporting Community Connected (C2) Network – led by the county agency, in partnership with 2 CCOs, education and social services stakeholders, to develop a database and system for coordinating and integrating information related to social services assessment and delivery in Jackson County

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	Medicity	Vistalogic	SAS
Product Name			Business Intelligence software
Comment	Provided by Jefferson HIE	Provided by Community Connected Network for social service delivery	Claims-based analytic reporting

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	Jackson Care Connect is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area. **Health Information Exchange:** • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing "phase 2" to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution.

[1]As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. • In addition, **c**linics who have implemented Epic have access to HIE through CareEverywhere. Jackson Care Connect is also supporting Community Connected (C2) Network – a committed group of organizations working together to change the way individuals access and receive social service support in Jackson County; startup funding supported by county and 2 CCOs; other partner organizations from social services, education sectors. Launch expected in 2015. Intersections with JHIE are under discussion. • Goals include: to support sharing of information and coordination of services amongst community partners, to provide tools to help integrate and coordinate the existing social service delivery infrastructure including identifying service providers for common clients, and to provide a mechanism to connect existing systems within social service, health care, and education sectors. • C2 database will include centralized contact registry, resource/referral module, onboarding tool, release of information module, record capabilities, survey/assessment module, auto-populating forms/summary sheets, integrated calendar and discussion forum, aggregate data reporting. **Direct Secure Messaging[2]:** • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. • The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. **Hospital Notifications[3]:** • JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of "phase 2" and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. **Care Management and CCO-Provided Information to Provider/Care Teams:** The CCO anticipates using JHIE data to inform care management and support provider information sharing through JHIE.
Quality Improvement, Population Management, Data and	• JCC and CareOregon have developed and implemented claims-based analytic reporting through SAS Business Intelligence software. • Current reporting capability includes aggregate reporting for CCO level data, provider level data, and member level data for demographics, utilization, and gaps in care. • Jackson County Mental Health shared behavioral/mental health data for members with SPMI in 2013; this will continue in 2014. In 2015, JCC plans to integrate mental health

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Analytics Tools	claims for JCMH services into the JCC / CareOregon data warehouse which feeds into SAS BI. • During the 2014 calendar year, JCC will continue to explore the ability to expand reporting to other clinics using Epic. **Incorporating Clinical Data:** • Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE. • CareOregon is exploring a partnership with OCHIN to create reporting capability for claims and clinical data.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** JCC has relied on OCHIN for their current CQM reporting strategy. **Longer-term CQM Strategy:** Utilizing JHIE is part of JCC's long-term strategy for CQM reporting. JHIE member CCOs will be able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR
Technical Assistance to Practices for EHRs and MU	JCC is currently assessing CareEverywhere use and identifying any clinics/provider training needs.
Other	**Local Provider Directory:** JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards. In addition, JCC maintains a provider directory within their administrative systems.
Barriers to Implementation of HIT Tools/ Services	• Large number of private practices utilizing different EHRs and some without EHRs will continue to be a challenge until all providers are enrolled with JHIE. • Needing to educate providers on workflow and process changes needed to maximize effectiveness of current JHIE functionality. • Current lack of understanding among clinics/providers about optimal use of CareEverywhere. • Though metrics data are being collected in non-PCP environments (e.g., developmental screening (ASQ) data being collected within the educational environment), there is currently no EHR or other structured means by which to capture these data, particularly across the school-based health, behavioral health, and dental systems. This can lead to duplication of services (e.g., ASQ being collected numerous times across settings to meet assessment need and/or various agency or funder requirements) as well as underrepresented rates of achievement (e.g., ASQ being conducted on CCO member within school setting, but CCO metrics do not reflect this). • JCC has experienced challenges in getting some of the organizations in their region to share clinical (EHR) data for the purposes of CQM reporting. JCC perceives this to be primarily a political/relational barrier, and not necessarily a technical barrier. • For C2 and sharing individual-level data between non-health providers – many issues around FIRPA (laws regulating sharing of student data within the education system) and HIPAA arise. C2 and JHIE are sharing HIPAA resources. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral	Uncertainty among JCC staff as to how to best address the HIT and analytics needs of their mental/behavioral health clinics.

Health Information Sharing	• JCC experiences the disparity in EHRs for behavioral health as a challenge to population management, care coordination, and quality and analytics. In an effort to contribute to progress in this area, the CCO invested significant funds into an EHR for the two largest alcohol and drug treatment providers in their community. In addition, the CCO has requested TA for behavioral health EHRs, as not having TA support is a significant barrier. • JCC has requested guidance from the state regarding privacy, as its absence is a barrier to health information exchange and care coordination. They would like specific guidance regarding relevant state policies that could inform their efforts. • JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE's community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges.

CCO Provider Environment:

Hospital Engagement in HIT

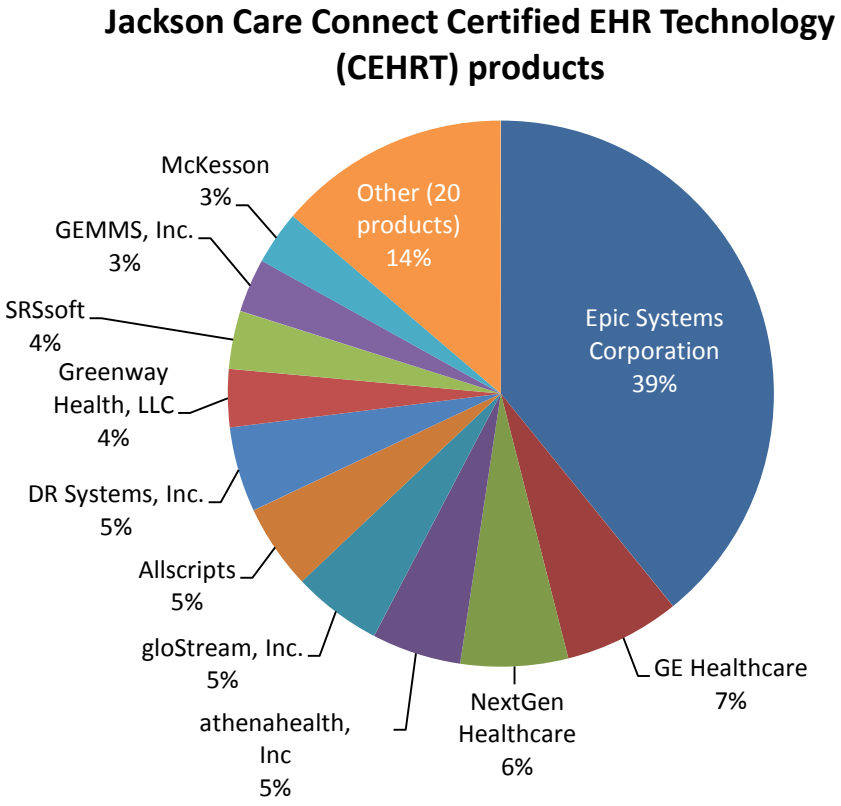
Hospital Name	EHR Vendor	Stage of Meaningful Use*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Asante Three Rivers Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Ashland Community Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Rogue Regional Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Providence Medford Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Jackson Care Connect

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 378 unique providers affiliated with Jackson Care Connect CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 31 different EHRs in use within the CCO. The top 11 products, represented in the chart, are in use by 326 unique providers.



PacificSource Central Oregon CCO HIT/HIE Profile

52,137 members[1]

CCO Description:

- Services members in Crook, Deschutes, Jefferson and part of Klamath Counties.
- Majority of care takes place in the population hubs of Bend and Redmond.
- The region has a high rate of electronic health record (EHR) use in clinics and hospitals
- The CCO is supporting and planning to participate in Central Oregon Health Connect.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			Quality Improvement, Population Management, Data and Analytic Tools	
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name		Collective Medical Technologies	IMA Technologies	Truven Health Analytics	Internally developed tools, SAS, Tableau, Microsoft BI
Comment	Provided through Central OR Health Connect	PreManage hospital notifications for entire CCO population	CaseTrakker Dynamo	Analytic tool for population management, analytics, etc.	Data marketplace, analytic tools for population health and engagement

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** The CCO is supporting and planning to participate in CO Health Connect, which operates a community data repository CO Health Connect. The goal for CO Health Connect is to function as a clinical tool for providers, and ultimately to support the CCO needs for clinical data. CO Health Connect covers the central Oregon region inclusive of Crook, Deschutes, Jefferson and part of Klamath counties. • COHIE's community data repository includes data from the majority of St. Charles medical groups and hospital, as well as lab and results data. • COHIE is in the process of working with its stakeholders to solidify its strategic plan and sustainable business model. • CO Health Connect is supported by partner organizations including: St. Charles Health System, PacificSource Community Solutions, Adaugeo Health Care, Central Oregon IPA, OCHIN, Mosaic medical clinic (an FQHC), and Bend Memorial Clinic. **Direct Secure Messaging[2]:** • CO Health Connect is considering options for Direct secure messaging, including potentially

[1] As of 9/15/2014 www.oregon.gov/oha/healthplan/DataReportsDocs/September2014CoordinatedCareServiceDeliverybyCounty.pdf

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	working with RelayHealth (their vendor for CO Health Connect, who also operates a HISP). [RelayHealth and CareAccord are both nationally accredited within the same trust bundle (DirectTrust), allowing for the secure exchange of information.] • CareAccord would be available as an option for entities that are not using CO Health Connect. The CCO is interested in assisting long-term care organizations to get on CareAccord. **Hospital Notifications[3]:** CO Health Connect is planning to include hospital event notifications from the St. Charles Health System to all CO Health Connect members. The CCO has implemented the PreManage solution from CMT comprising both ED and inpatient notifications for the entire CCO population, enabling its members to send and receive hospital alerts from hospitals beyond the CO Health Connect region across the state. **Care Management and CCO-Provided Information to Provider/Care Teams:** • Primary care providers get care plan and progress/data, including information from the CCO. The CCO uses Truven for population management (see below), which informs the care management team within the CCO and supports the CCO connecting to the provider team. • In addition, CO Health Connect is working to establish the scope of work for supporting the CCO data needs for case management, operations management, and as a data source for analytics and population management efforts within the CCO's HIT tools (see description below).
Quality Improvement, Population Management, Data and Analytics Tools	<u>CCO-support for provider/network systems</u>: The CCO is working to support its provider groups by providing information on CCO members, referring high risk members for follow up, and supporting provider connections to CO Health Connect. Provider groups vary in their analytics capabilities: • Provider groups with EHRs have analytic capacity of varying degrees and types—some use analytics to meet the standard business operations and finances needs, others use analytics for data-driven decision-making and informing planning of internal operations and programs. • Two key partners, St. Charles Health System and Mosaic Medical have robust technological infrastructure, tools and staff to extract and analyze data, as well as to create and run reports. • Adaugeo Healthcare, which is a PCPCH provider, has been successful in their transitional care management initiative which involves a data analyst sifting through ED discharge notifications and identifies cases needing to be referred to nursing resources. The nurse immediately arranges a Transitional Care Management visit. The goal is that these members are seen at a primary care office within 48 hours. Physicians and patients alike have expressed satisfaction with this program. • Regionally, the Central Oregon Independent Practice Association (COIPA) is an analytical asset for COIPA providers who are located in both Central OR and Gorge regions. Their Health Quality Program Director performs several analytical tasks in that role. <u>CCO internal systems:</u> • Supported by a team of database, IT, and data modeling specialists, PacificSource actively applies data analytics in numerous areas with a goal of improving population health and engagement. The Analytics Department is able to create and run routine and ad hoc data

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	reports on member experiences, utilization and expenditure trends, and cost comparisons, as well as other data analyses. The IT department aims to enable self-service to allow end users to access a data marketplace, and quickly answer questions and gain insights into populations. • Specific tools/capabilities include: o Data Marketplace includes various cubes of data on claims, members, prescriptions, etc. o Truven is used to identify high risk populations and then the PacificSource team outreaches and connects members to the health team. o Tableau supports data visualization o Suite of self-developed tools, SAS, Microsoft BI support metrics, self-service reports and population management, etc. A Member 360 module provides a complete view of members for use in predictive modeling and "micro –targeting" in achieving health outcomes. **Incorporating Clinical Data:** PacificSource is seeking to incorporate clinical data in their internal analytics systems. In addition, the CCO is working with CO Health Connect to establish the scope of work for supporting the CCO data needs for case management, operations management, and as a data source for analytics and population management efforts within the CCO's HIT tools. • This will include role-based access to the community data repository in CO Health Connect, pushing hospital ADT data to the CCO, and providing the data to support the CCO's analytic capabilities. • Using the HIE to supply clinical data provides the CCO a one-stop place for labs, hospital data, and other clinical information, reducing the administrative burden and duplication of effort on the part of the CCO that they would otherwise face, for example, by working to establish data feeds from each lab or entity directly.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** PacificSource is working directly with practices to meet its CQM reporting requirements. They are able to leverage a small number of clinics to meet the population threshold, including their OCHIN clinics and other key practices. **Longer-term CQM Strategy:** The CCO is working with CO Health Connect to determine whether CO Health Connect is a viable and/or appropriate route for the management of clinical quality metrics.
Technical Assistance to Practices for EHRs and MU	Several of the key practices are supported already with technical assistance, such as OCHIN-supported practices, and the larger groups /health system practices. The CCO is interested in exploring state sponsored TA for practices.
Other	**Local Provider Directory:** PacificSource maintains a strong provider directory within their administrative systems; CO Health Connect includes a provider directory within its Relay Health platform.
Barriers to Implementation of HIT Tools/ Services	Data challenges: • Pressure to meet diverging regulatory and reporting requirements that compete for priority, time, resources, and employee bandwidth. • Clinics/providers need implementation training and technical assistance to help them get the data, coordinate the data, find the data, as well as learn to use new systems. • Looking for clinical data integration solution and a solution to manage clinical data. PacificSource operates across commercial and Medicare lines of business, in multiple states with multiple HIEs, and would like to find one consistent way to bring clinical data in.

	CQMs: • Not sure a goal of CMQ reporting for 100% of CCO population is feasible in current EHR/HIE environment – very cumbersome to retool each EHR interface when new CQMs are released. Technology needs to become flexible to adapt to measurement changes. • CQM reporting opens up workflow and quality considerations. Data quality is limited by workflow. Data relying on lab values is easiest to get and use. • Will be challenging to get CQM reporting in place beyond leveraging OCHIN and a small number of key practices who overall cover 60-70% of the CCO population. • Experiencing difficulty in engaging EHR vendors about getting certain information into the CCDA, even if the vendor's product is MU2 certified, causing concern regarding CQM reporting and effectiveness of relying on QRDA. EHR vendors "don't think you need it". HIE: • CO Health Connect and its partners identified several barriers or challenges relating to the following areas: interoperability and Meaningful Use, establishing an HIE business model, agreements/consent management, and Direct secure messaging. Direct secure messaging: • Many practices lack knowledge and understand regarding Direct secure messaging, the smaller of whom rely on their vendor to inform them. This is an opportunity for the state to support education and information about Direct secure messaging to providers.
Barriers to Behavioral Health Information Sharing	Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: __X__ Confusion over compliance with state or federal laws ____ State or federal laws prohibit the type of sharing I want/need to do __X__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). __X__ Concerns over privacy and confidentiality protection for the patient __X__ Concerns over liability if information you share is later improperly shared ____ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

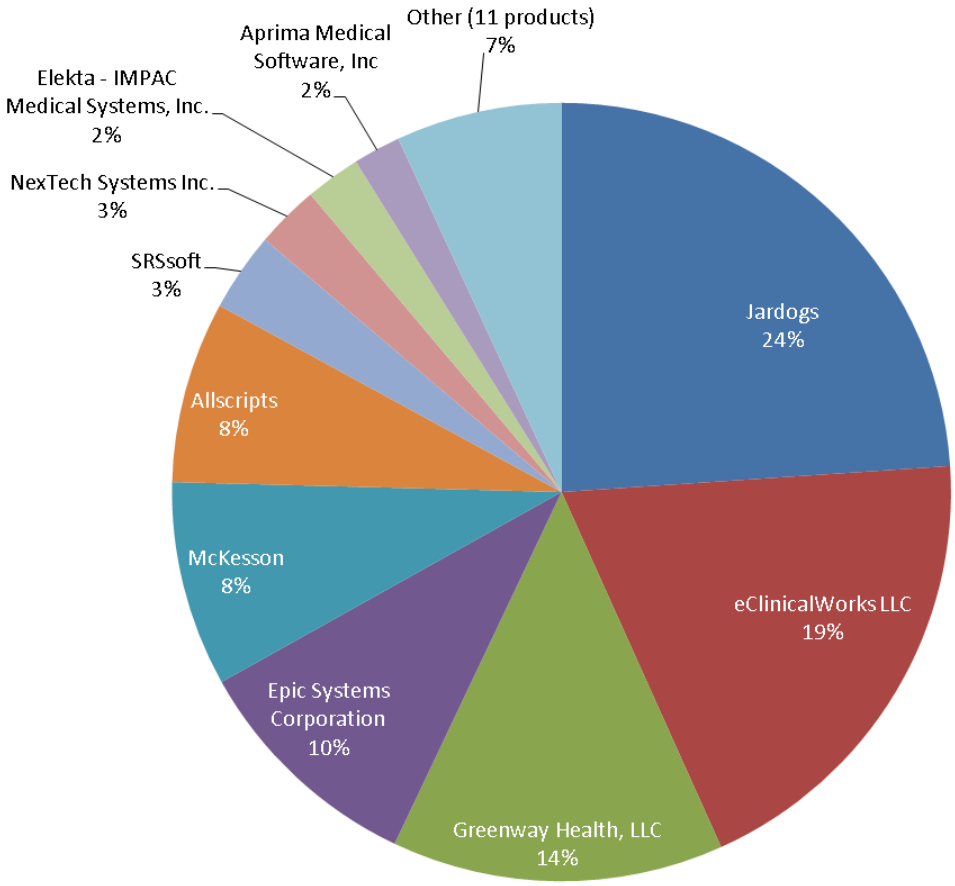
Hospital Name	Direct Secure Messaging Flat File Participation (as of 12/2014)	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Pioneer Memorial Hospital – Prineville		McKesson	Stage 1	The St. Charles feeds are live, as is Prineville – both are sending both ED and inpatient data. All are receiving notifications by print with the exception of Redmond which is receiving fax notifications.
St. Charles Medical Center – Bend	Currently participating	McKesson	Stage 1	
St. Charles Medical Center – Madras	Currently participating	McKesson	Stage 1	
St. Charles Medical Center – Redmond	Currently participating	McKesson	Stage 1	

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for PacificSource Central Oregon CCO

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 305 unique providers affiliated with PacificSource Central Oregon CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 21 different EHRs in use within the CCO. The top 10 products are in use by 284 unique providers.



PacificSource Columbia Gorge CCO HIT/HIE Profile

12,693 members[1]

CCO Description:

- Services members in Wasco and Hood River Counties.
- The CCO is located in a small community with a history of partnerships across organizations.
- The majority of members receive their primary care in 4 organizations: Mid-Columbia, One Community Health (FQHC), Columbia Gorge Family Medicine, and Providence,
- Due to the varied terrain in this region, Broadband and cell service connectivity are barriers outside of Hood River/The Dalles. Providers largely provide services at practices in The Dalles and Hood River, however a large portion of the population lives outside the cities.
- Pacific Source Columbia Gorge CCO is joining the 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools	
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	Medicity	IMA Technologies	Truven Health Analytics	Internally developed tools, SAS, Tableau, Microsoft BI
Comment	Provided by Jefferson HIE	CaseTrakker Dynamo	Analytic tool for population management, analytics, etc.	Data marketplace, analytic tools for population health and engagement

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** The CCO is joining Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added the Columbia River Gorge area. **Health Information Exchange:** • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing "phase 2" to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member

[1]As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. The CCO is very interested in integrating and connecting social services and community health workers in a meaningful way, including DHS/local agencies, non-emergency medical transportation, long term care and behavioral health/DD residential care settings, schools and school based health centers, etc. Interested in understanding what systems may be in use by these organizations that could be leveraged by the CCO. The CCO has concerns around behavioral health information sharing (see barriers section below). **Direct Secure Messaging[2]:** • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. • The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. • PS Columbia Gorge CCO is considering how to support and facilitate Direct secure messaging more broadly and expressed an interest in ensuring that non-medical members of care teams have the ability to securely exchange information and communicate using Direct secure messaging. CareAccord would be available as an option for entities that are not using JHIE. **Hospital Notifications[3]:** • JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of "phase 2" and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. • PacificSource Gorge has a strong interest in EDIE and PreManage, as it commonly has patients that seek care at hospitals outside of the CCO network, including OHSU and hospitals in Washington state. **Care Management and CCO-Provided Information to Provider/Care Teams:** • The CCO's established community practices have care managers, so the primary care provider gets care plan and progress/data, including information from the CCO. The CCO uses Truven for population management (see below), which informs the care management team within the CCO and connecting to the provider team.
Quality Improvement, Population	CCO-support for provider/network systems: The CCO is working to support its provider groups by providing information on CCO members, referring high risk members for follow up, and supporting provider connections to JHIE. Provider groups vary in their analytics capabilities:

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Management, Data and Analytics Tools	• The CCO's board has been having discussions around providing centralized data analytics and reporting solution/support as opposed to having each organization/practice doing these tasks themselves, and is considering various options. • Provider groups with EHRs have analytic capacity of varying degrees and types, such as analytics to meet the standard needs for business operations and finances, for data-driven decision-making and/or for informing internal operations and program planning. • Regionally, the Central Oregon Independent Practice Association (COIPA) is an analytical asset for COIPA providers who are located in both Central OR and Gorge regions. Their Health Quality Program Director performs several analytical tasks in that role. • Both FQHCs also have analytic capacity through employees who are able to extract, summarize, and analyze EHR data on a routine and ad hoc basis; and, because both FQHCs are on OCHIN's Epic platform, they benefit from having access to the reporting and analytic tools that OCHIN makes available to its users. <u>CCO internal systems:</u> • Supported by a team of database, IT, and data modeling specialists, PacificSource actively applies data analytics in numerous areas with a goal of improving population health and engagement. The Analytics Department is able to create and run routine and ad hoc data reports on member experiences, utilization and expenditure trends, and cost comparisons, as well as other data analyses. The IT department aims to enable self-service to allow end users to access a data marketplace, and quickly answer questions and gain insights into populations. • Specific tools/capabilities include: o Data Marketplace includes various cubes of data on claims, members, prescriptions, etc. o Truven is used to identify high risk populations and then the PacificSource team outreaches and connects members to health team. o Tableau supports data visualization o Suite of self-developed tools, SAS, Microsoft BI support metrics, self-service reports and population management, etc. A Member 360 module provides a complete view of members for use in predictive modeling and "micro –targeting" in achieving health outcomes. **Incorporating Clinical Data:** PacificSource is seeking to incorporate clinical data in their internal analytics systems. In addition, defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE. The CCO is interested in moving more toward clinical data and away from claims/administrative data for population management, metrics, etc., especially given the lag time with claims data which can make those data not actionable. "We want to get [data] further upstream to be able to impact care."
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** The CCO expects to be able to meet the CQM reporting requirements using either the JHIE platform and/or OCHIN's reporting solution with the One Community Health FQHCs (Hood River and The Dalles). Most key practices without current CQM reporting capabilities state that system upgrades have been scheduled and/or teams have been dedicated to develop clinical data reporting by the end of 2014. **Longer-term CQM Strategy:** Utilizing JHIE is part of the CCO's long-term strategy for CQM reporting. JHIE member CCOs will be

	able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.
Technical Assistance to Practices for EHRs and MU	CCO plans to assist with TA for HIE connectivity and Direct Secure messaging with funds from their transformation grant.
Telehealth	Interested in tracking telehealth opportunities. At least one hospital/health system in their area uses telemedicine and home health visits – where connectivity can be an issue. Like the idea of kiosks, which might work due to the concerns around Broadband connectivity in some parts of the Gorge.
Other	**EHR investment** – the CCO is funding an EHR for one of the County health departments **Local Provider Directory:** PacificSource maintains a strong provider directory within their administrative systems; JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards.
Barriers to Implementation of HIT Tools/ Services	• Clinics and providers across the network have a need for technical assistance to help them get, find, share, and use the information in the new system. • Looking for clinical data integration vendor and a solution to manage clinical data. PacificSource operates across commercial and Medicare lines of business, in multiple states with multiple HIEs, and would like to find one consistent way to bring clinical data in. • Change fatigue as a result of constant change in recent years and competing demands of multiple initiatives. • Provider organizations are at the mercy of their vendor for expanding interfaces, interoperability, and clinical quality reporting. Many have little or no influence in the direction the product goes. • Gorge CCO's provider network has some clinics with broadband issues outside of their metro areas (Hood River and The Dalles). • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral Health Information Sharing	The CCO emphasized that behavioral health information should be shared as appropriate for care coordination. Concerns include providers focusing on metrics (including mental health assessment metric), misinformation about HIPAA/42 CFR Part 2. JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE's community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges. Barriers/challenges experienced in sharing behavioral health data include: __X__ Confusion over compliance with state or federal laws ____ State or federal laws prohibit the type of sharing I want/need to do __X__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). ____ Concerns over privacy and confidentiality protection for the patient __X__ Concerns over liability if information you share is later improperly shared __X__ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

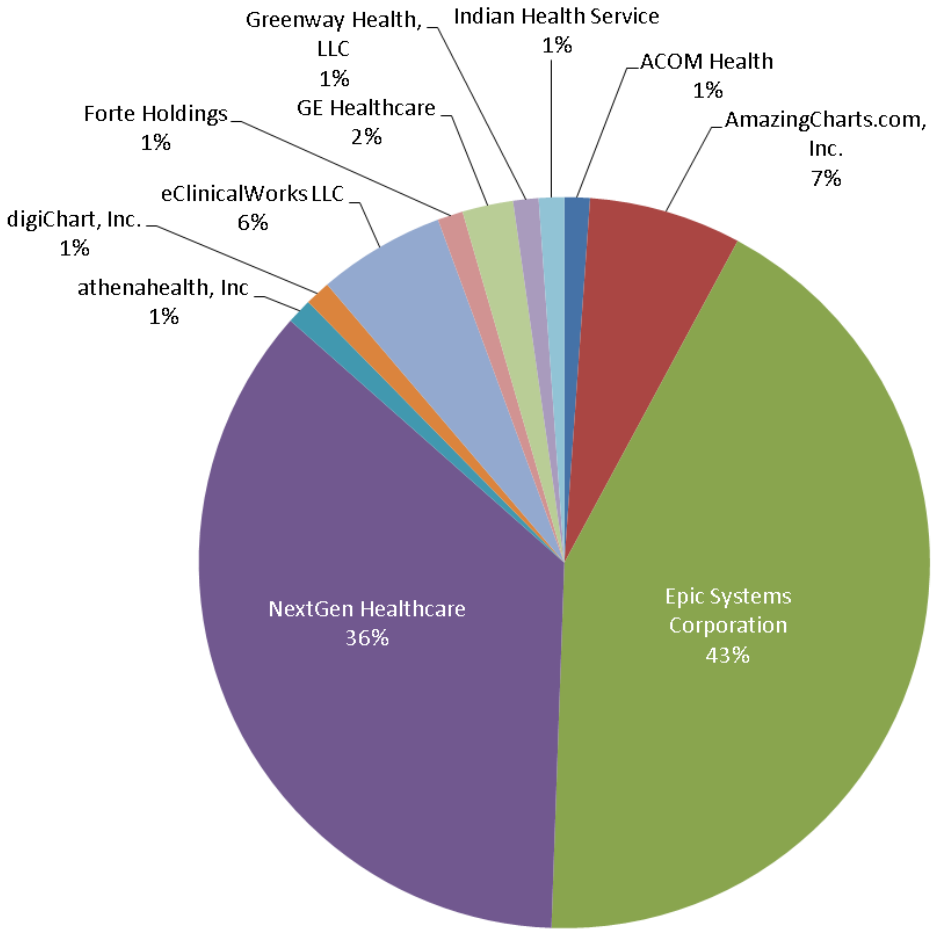
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Mid-Columbia Medical Center	Meditech, Iatric	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Providence Hood River Memorial Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Hospitals in Washington State (of particular interest to PacificSource Columbia Gorge CCO)	Varies	Varies	Nearly all hospitals in Washington are live for ED data and are receiving notifications**

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.
**As of January 2015, CMT has agreements with all of the Washington Hospitals. However, Skyline and Tri-State are not yet implemented. Also, Garfield and Cascade Medical Center Hospital are manual entry and are not set up for Notifications.

Certified EHR Technology Products for PacificSource Columbia Gorge

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 89 unique providers affiliated with PacificSource Columbia Gorge CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 11 different EHRs in use within the CCO.



PrimaryHealth of Josephine Co. CCO HIT/HIE Profile

11,408 members[1]

CCO Description:

- Services members in Josephine County and is made up of a multi-specialty group, two FQHCs and 6 one to two provider offices. Primary care provider locations include Grants Pass, Cave Junction and Medford.
- 90% of PrimaryHealth members are served in a Tier III PCPCH.
- PrimaryHealth is one of 4 Southern Oregon CCOs participating in the Jefferson Health Information Exchange (JHIE).

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	Medicity	TBD	Inteligenz
Product Name			CCO Metrics Manager
Version			2.1
Comment	Provided by Jefferson HIE	Currently exploring a more robust case management solution	CCO metrics-oriented analytics

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	PrimaryHealth is participating in the Jefferson Health Information Exchange (JHIE) which aims to provide the care team with access to patient-centered health information at the time and place of care to improve timeliness, quality and coordination of care. JHIE covers a three county region in Southern Oregon inclusive of Jackson, Josephine, and Klamath Counties, and recently added partnerships with a 5th CCO and providers in the Columbia River Gorge area. **Health Information Exchange:** • JHIE currently offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. These features support health information exchange and referrals among behavioral, physical, and dental health providers and with CCO Care Coordinators. • JHIE is in the process of implementing "phase 2" to include additional functions/services including clinical alerts, 30-day readmission alerts, patient search, and a consolidated clinical inbox to be accessible to any enrolled provider or CCO with a patient/member relationship. Patient matching and record location supports patient/provider attribution. EHR integration and connectivity will be supported as well, including single sign on for patient search of HIE, results delivery to the EHR and receipt of CCD/care summary to the EHR. • The Grants Pass Clinic is currently using JHIE and Siskiyou Community Health Center is planning

[1] As of 10/01/2014
http://www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	to enroll. • Case managers will utilize JHIE as an information source and as a tool for information exchange. **Direct Secure Messaging[2]:** • JHIE offers Direct secure messaging and a provider-to-provider closed-loop referral system through its technology vendor Medicity. • The JHIE Medicity HISP is DirectTrust accredited, and thus interoperable with CareAccord and other Direct secure messaging users across the state. JHIE participates in the flat file directory sponsored by OHA, to share Direct secure messaging addresses across Oregon organizations using accredited HISPs to support cross-organizational exchange. **Hospital Notifications[3]:** • JHIE will include hospital event notifications from its member hospitals (Asante, Providence, Sky Lakes, Mid-Columbia Medical Center) to JHIE members as part of "phase 2" and is contemplating connecting to PreManage to enable its members to send and receive hospital alerts from hospitals beyond the JHIE region across the state. • CCO receives both a 30-day Admit/Discharge/Transfer (ADT) list and a separate last 24-hour file from one of their hospitals. The 24-hour file is of greater value and is more often and broadly utilized than the 30-day data. **Care Management and CCO-Provided Information to Provider/Care Teams:** • The CCO is currently investigating a new case management tool/application. • PrimaryHealth has a secure email system that it uses to support some care coordination functions. o Using secure email to share information about high-risk patients. Though Direct secure messaging provides added value, getting the information-receiving entities enrolled with JHIE or CareAccord would require additional time and effort. o Receiving information regarding long-term care patients via secure email. Integrating this information with other systems has not yet been defined and is still in process.
Quality Improvement, Population Management, Data and Analytics Tools	As discussed in greater detail below, there is an evolving use of data by PrimaryHealth and their providers. Data Access/Availability and Analytic Tools • From their EZCap claims system, PrimaryHealth obtains a mapped data feed in addition to which encounter data files are obtained from MedImpact (pharmacy benefit manager) and PHTech (mental health claims manager). • PrimaryHealth has contracted with Inteligenz for their CCO Metrics Manager tool. The CCO Metrics Manager provides a data warehouse with web-based presentation layer, which reports on the status of target metrics, including gap analysis and gap closure workflow. The flexibility of the system allows users to further define criteria to generate custom reports to facilitate population health management. For example, CCO Metrics Manager compiles a 'high utilizer list' which is used by PrimaryHealth to identify potential

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	outreach/case management members. • PrimaryHealth uses the CCO Metrics Manager for incentive metric progress monitoring, improvement planning, and bonus distribution. Their process has involved sending a list to each clinic with CCO metrics evaluation results informing them whether they have met relevant metrics. The distribution of incentive bonuses is tied to these results/reports. Clinics were rewarded for their performance on metrics. Incentive payment checks were hand-delivered with metrics evaluation results, including (but not limited to): o the quality metrics measures overall and per provider, with a comparison to other providers o advice on the coding for certain measures o gap list of patients needing screening o top 10 medical utilizers within the clinic's patient registry o diabetes registry • The CCO's primary key practice, Grants Pass Clinic, has requested to receive monthly dashboard reports on the incentive metrics in an electronic format. There seems to be an interest among the larger clinics to improve their metrics scores. o In general, medical clinics and providers are becoming accustomed to accessing, examining, and utilizing their data for the purpose of population management, decreasing their reliance on the CCO to fulfill this role. o Some examples of insights that have resulted from providers' newly developed relationship with data include: ▪ Congestive heart failure – providers were surprised at the unexpectedly high mortality rate when looking at the data ▪ Screenings in general – providers believed they were conducting adequate screenings and were surprised to learn of existing gaps o CCO is working with Grants Pass Clinic to increase the credibility of the data and ensure the metrics they track are credible and something that the provider can affect. o Providers becoming increasingly involved with and invested in their data and outcomes has fostered some healthy competition among them. • PrimaryHealth used a learning collaborative for the medical homes for training on data, This evolved into a leadership group that gathers to discuss data-related topics, including how to effectively and meaningfully distribute data to providers. **Incorporating Clinical Data:** Defining tools for data analytics and population health management are anticipated for 2015 with services available in 2016 through participation with JHIE.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy** • PrimaryHealth utilizes CCO Metrics Manager for a number of purposes related to CQM reporting, including educating practices about specific incentive metrics, and determining and distributing incentive bonuses. See more complete description above. • Most CCO members are seen at one of two clinics, both of whom were included in the Year 1 sample; the Year 2 sample will remain the same. **Longer-term CQM Strategy:** Utilizing JHIE is part of the CCO's long-term strategy for CQM reporting. JHIE member CCOs will be able to collect CQMs from providers using JHIE and are exploring using JHIE to submit data to the CQMR.
Technical Assistance to	Transformation funds have supported PrimaryHealth in providing technical assistance to Grants Pass Clinic, which serves 60% of the CCO's members. TA has included workflow modification

Practices for EHRs and Meaningful Use	guidance, as in developing a process for capturing the depression screening data that were being collected but not entered into the medical record. This involved a training program to assist nurses with keeping track of every depression screening. At the end of the day, the medical home assistant manually confirmed that the screenings were properly recorded. This approach leverages an assistant to take the burden off of the provider. Within the context of current clinic staffing levels, though there may be a need for TA, finding time to take advantage of it is challenging.
Patient Engagement through HIT	Grants Pass Clinic offers a secure patient portal on their website. This portal facilitates access to some medical records, scheduling and secure correspondence with primary care providers.
Telehealth	PrimaryHealth is currently working with OHSU and Asante Health Systems to facilitate Genetic Counseling via Telehealth in Josephine County.
Other	**Local Provider Directory:** The CCO maintains a provider directory within their administrative systems; JHIE includes a provider directory based on user enrollment and clinical results attribution expected to be compliant with anticipated HPD standards. **Support for Behavioral Health EHR** PrimaryHealth's chemical dependency treatment center, Choices, is collaborating with OnTrack addictions recovery center and community corrections on the implementation of an EHR/billing software called Echo. They are collaborating on forms development and various other aspects to simplify implementation as well as provide a community standard.
Barriers to Implementation of HIT Tools/ Services	• Prioritizing staff, coordinating system upgrades, and ensuring that data collection is consistent across providers is key. • Providers are currently involved in numerous healthcare transformation activities and therefore feeling overwhelmed and reluctant to engage in additional initiatives. • Bringing many people and systems together across a common platform to report clean, meaningful data takes time, work, and a lot of testing. • JHIE and its partners would like to include access to the Prescription Drug Monitoring Program data to support efforts to reduce inappropriate prescribing and abuse of prescription drugs.
Barriers to Behavioral Health Information Sharing	JHIE and its partner CCOs would like mental health agencies in their network to be able to contribute data to JHIE's community health record for patient search, but data management concerns resulting from the sensitivity of mental/behavioral health information (and the potential co-mingling of that information with physical health data) present challenges. Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: ____ Confusion over compliance with state or federal laws ____ State or federal laws prohibit the type of sharing I want/need to do ____ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). _X__ Concerns over privacy and confidentiality protection for the patient ____ Concerns over liability if information you share is later improperly shared _X__ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Asante Three Rivers Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Ashland Community Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Asante Rogue Regional Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Lower Umpqua Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data – receiving notifications by printer.
Providence Medford Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Sky Lakes Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

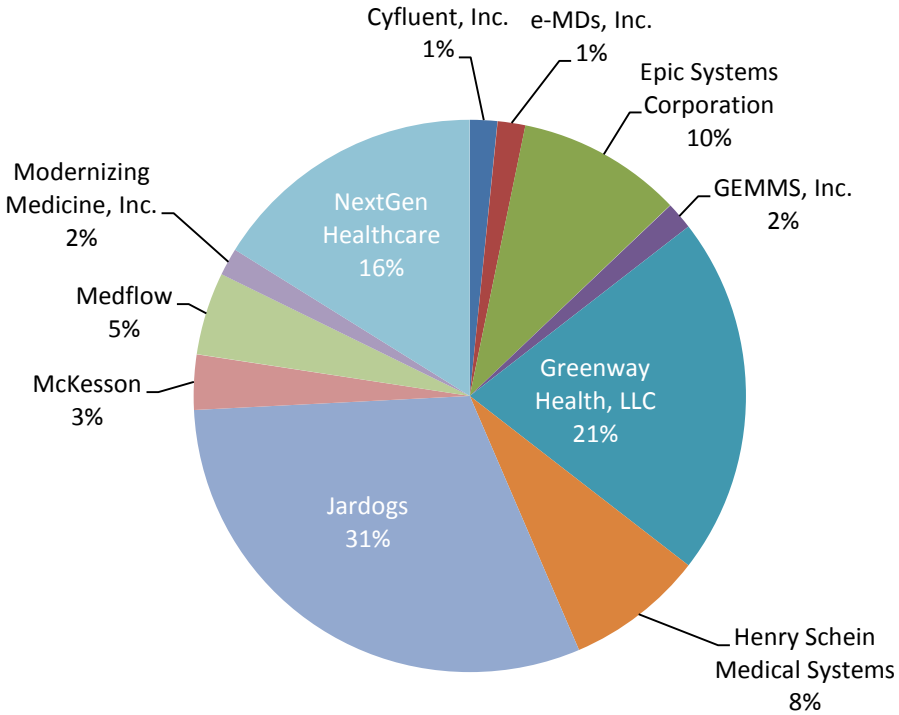
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Certified EHR Technology Products for PrimaryHealth of Josephine County

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 62 unique providers affiliated with PrimaryHealth CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 11 different EHRs in use within the CCO.

PrimaryHealth CCO Certified EHR Technology (CEHRT) products



Trillium Community Health Plan CCO HIT/HIE Profile

92,020 members[1]

CCO Description:

- About 80% of members are assigned to one of four main medical groups: Community Health Center of Lane County, Lane Independent Primary Physicians, Oregon Medical Group, and PeaceHealth Medical Group
- 83% of members are assigned to Tier 3 PCPCH clinics.
- In addition to its Medicaid plan, Trillium operates a Medicare advantage plan, and became a PEBB plan in 2015.
- Trillium took major action in 2014 to address capacity for the expansion population, including supporting the creation of a new clinic, supporting expansions at 4 clinics, technical assistance for practice efficiencies, and other efforts.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination			Quality Improvement, Population Management, Data and Analytic Tools	
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	The Advisory Board	Collective Medical Technologies	(Trillium developed in-house)	Optum	SAS, IBM
Product Name	Crimson Care Management (CCM)	PreManage	Care Timeline	Impact Intelligence, Impact Pro	SAS, SPSS
Comment	Care management tool	In conversations with CMT about ED/inpatient notifications	Graphical representation of a member's medical history, for care team	Cost, utilization, and quality analysis and risk stratification based on claims	Supports in-house analytics

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** See Care Coordination section below. **Direct Secure Messaging[2]:** Not currently interested in leveraging Direct secure messaging given other efforts to share information with providers. **Hospital Notifications[3]:**

[1] As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Trillium is currently receiving ED utilization and ADT notifications from the local hospitals, however these data are currently being hand-entered into Crimson (see "care management" section below). The CCO is in conversations with CMT about PreManage as a way to automate information collection into Crimson.

Care Management and CCO-Provided Information to Provider/Care Teams:
Trillium is completing its launch of the Crimson Care Management tool to support several care management projects.

- The tool:
  - includes actionable clinical information to support care management
  - provides providers and the CCO care managers a full picture of their patients or members, defined sub-populations, and individual patients through integrated data.
  - includes psychosocial risk factors when calculating patient risk and prioritizing tasks, giving care managers the information needed to act effectively.
  - targets various factors, depending on the member's specific situation.
- If there is a certain risk level associated with a member when they come in, they are further assessed and if warranted, are sent to Trillium's complex case management team and entered into the program within Crimson.
- When running a given "program" in Crimson, a particular population is identified for the purpose of setting up a protocol in the Crimson system to trigger alerts in order for that identified population to receive a call. "Basically, Crimson is programmed to perform interventions."
- Working with Crimson to customize the tools so they will set up programs/projects within the Crimson system and accurately identify members of the project.
- Projects/care management programs include:
  - The "Trillium Integration Incubator Project," (TIIP) in which the Crimson platform will be used as a case management tool in four PCP clinics that have a behavioral health physician(s) embedded in the clinic (integration), and four behavioral health clinics with an embedded PCP(s) (reverse-integration).
    - Trillium continues to examine and suggest improvements to clinic workflows. They have attempted to identify effective handoff protocols.
    - The CCO is also making progress with assessing the TIIP associated results, trends and outcomes.
  - Crimson has been rolled out to two county perinatal programs that are actively using and having a good experience with the program. The CCO is planning to use the data to examine and monitor: members with care plans (monitoring progress towards goals), prenatal care coordination, demographic information, as well as other information not available through claims.
  - Trillium has launched an internal perinatal program within Crimson which includes programs for (a) conditions related to pregnancy, (b) pregnancy involving chronic conditions, (c) postpartum, (d) tobacco cessation, and (e) Interfacing with the county programs.

Care Timeline is a tool developed by Trillium in house that presents providers with a graphical representation of a member's entire medical history.

- Trillium intends to roll this tool out first to ED providers and/or as a package with their Crimson Care Management tool (working with Crimson to develop use cases for integrating Care Timeline) for PCPs.
- The web-based application depicts every encounter the member as a dot on a graphical timeline. Users can select dots to have access to all the information for each claim including

	diagnoses, labs, etc.
	
	Member lists – Trillium also provides 'hot spotter lists' (which will eventually be part of Crimson solution), generated by Impact Intelligence (see description below), to each PCP and each BH practitioner.
	• Includes members who have any of the ACA conditions or are 10% riskiest
	  o Includes risk score, amount paid, ED visits, In-patient visits.
	  o Care management program will work with these members.
	• The list is viewed as critical information by some providers, who use the information to follow up with patients.

Quality Improvement, Population Management, Data and Analytics Tools	In addition to Crimson Care Management (described above), the CCO utilizes Optum's Impact Intelligence and Impact Pro to analyze cost, utilization and quality of both members and practitioners using claims. • Impact Intelligence and Impact Pro assign risk scores, quality indexes, episodes and confinements, allowing the CCO to assess the burden of disease, identify populations to target for complex case management and disease management. • Every single member gets risk assessed when loaded into the system. Risk scores are used for prioritizing care coordination. • Trillium uses Impact Intelligence to generate patient lists for providers (see description above), and Impact Pro to identify potential candidates for special case management programs. **Incorporating Clinical Data:** In 2014, Trillium also piloted bringing clinical (EHR) data into the Crimson tool: Community Health Center (CHC): EHR can pull data at patient level, excluding information as needed. Trillium conducted validation with the CHC last year before submitting data including comparing EHR reported numbers against what Trillium showed for basic claims data. CHC conducted a demo of their EHR functionality, identifying potential issues.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** Trillium has utilized EHR data extracted by and provided to Trillium by CHC. **Longer-term CQM Strategy:** Trillium expects to extract individual-level clinical data (including lab values, blood pressure, etc.) out of EHRs and integrate within Crimson, which would be available for pushing out to the CQMR.
Technical Assistance to Practices for EHRs and Meaningful Use	Trillium has been actively providing technical assistance to their practices in several ways. • The CCO has conducted training about meaningful use for their practitioners. • Trillium hired a community integrator to work with provider offices as well as provide a connection between the provider offices and Trillium. • Trillium encourages providers to use the data in their EHRs, rather than rely on the claims data the CCO has available. Trillium is a significant source of support for providers, offering IT and analytic resources to help them interface with their EHR vendor or work with their IT systems to set up reporting tools needed to pull relevant information out of their own system. • Trillium hired a Performance Metrics Coordinator whose job it is to make PCPs experts on the CCO metrics and to offer assistance to help meet them. This coordinator will assist with configuring EHRs, helping with workflow, etc. • Trillium implemented a Clinic Performance Assistance program, embedding Trillium employees at clinics to assist with data extraction from EHRs for the purposes in closing gaps in care. Currently there are eight Clinic Performance Assistants at 11 clinics. • Trillium convenes an HIT Group of providers, sharing information and providing support

Telehealth	Trillium allocated transformation funds for telehealth/telemedicine. The CCO is supporting a pilot telehealth program involving community health workers being given tablets/laptops for performing needs and health risk assessments. Based on the collected data, PCP can make a referral request for care coordination services. The care coordination team then assesses each case and determines the appropriate plan of action. Trillium is also in the research phase of a pilot project they funded which provides tablets/laptops to patients upon hospital discharge. This is to help ensure that when patients are discharged, they have the means by which to contact a care support person electronically for questions or help on medications or post discharge issues. The expectation is that this will help reduce hospital re-admittance. This project involves a partnership between Trillium, the hospitals and the home health agency with telemonitoring capability. Trillium has allocated up to $50,000 for Behavioral Health telemedicine implementation to support primary care medical home implementation and practice. We are particularly interested in behavioral health services integrated with primary care practices that are not able to imbed a clinical behavioral health provider as a part of team based care; in providing access to integrated behavioral health services provided by a clinician to members living in rural communities; in developing efficient consulting relationships with psychiatric prescribers and primary care providers; and in developing efficient use of psychiatric prescribers in outpatient behavioral health clinics.
Other	**Local Provider Directory:** Trillium has invested resources into developing and maintaining a provider directory within their administrative systems and their HIT tools including Crimson.
Barriers to Implementation of HIT Tools/ Services	• Disparate EHRs of which many are in the middle of reinstalling, reconfiguring, and/or changing data hosts. • Trillium has found that EHR workflows needed to properly collect CQM data are not consistent across disparate PCP clinics, and in some cases not implemented correctly at all. This is particularly a problem with capturing data for the depression screening measure. With regards to clinics that are part of a large health system, getting the workflows altered presents a greater challenge as the EHR workflows are set at the corporate level. Additionally, some providers do not follow all prescribed corporate workflows exactly. • The CCO expressed challenges related to dealing with weekly data dumps that Crimson sends to the CCO for various uses, including data manipulation through SAS. They are finding it difficult to perform verification of such a large amount of data each week. • Trillium has experienced difficulty in getting practices in their provider network to participate in surveys regarding Meaningful Use, CQMs, etc. • Trillium is experiencing some challenges with obtaining clean and complete data from Crimson. More specifically, they are having difficulties reading the data files and validating that the expected data is being accurately brought into its assigned location. • Challenging to identify who needs complex case management simply using logic and examining existing data. Though reviewing diagnoses to assist with this process is helpful, it is often insufficient. • Though there are no concerns regarding Broadband connectivity, the CCO community health works do occasionally experience wireless network coverage issues in rural areas. They have been using iPads to conduct surveys and have not been able to access online survey tool when needed.

CCO Provider Environment

Hospital Engagement in HIT

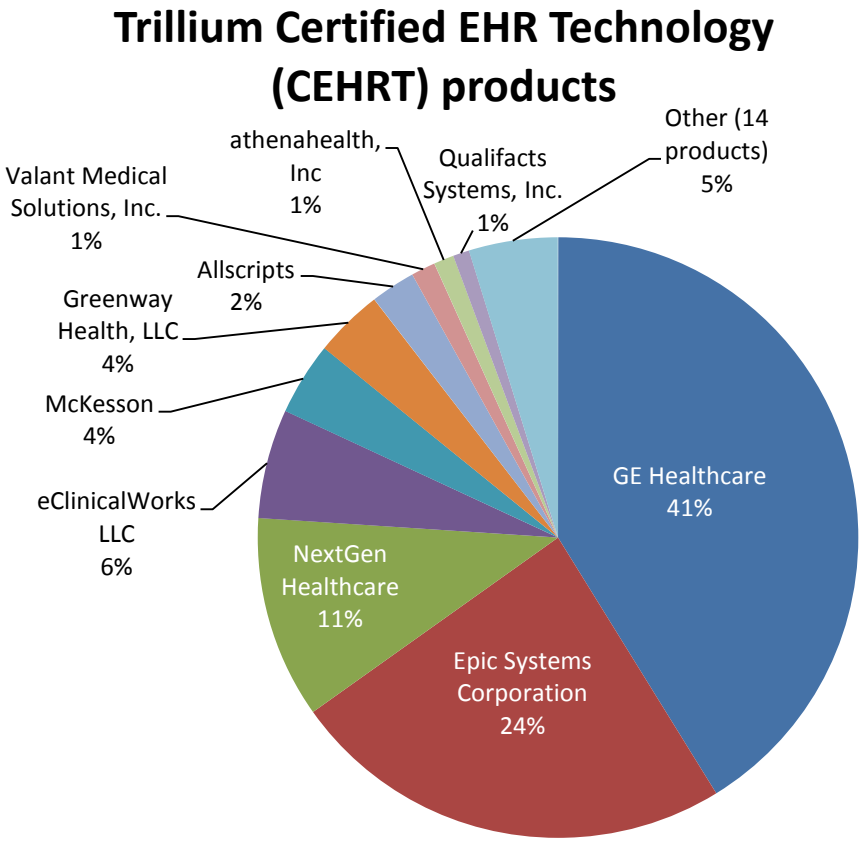
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Cottage Grove Community Hospital	Cloverleaf, Healthwise, MU Quality Manager, PeacehealthEHR	Stage 1	Feed is live for ED data—receiving notifications to printer.
Peace Harbor Hospital	Cloverleaf, Healthwise, MU Quality Manager, PeacehealthEHR	Stage 1	Feed is live for ED data—receiving notifications to printer.
Sacred Heart • River Bend • University District	Cloverleaf, Healthwise, MU Quality Manager, PeacehealthEHR	Stage 1	Feed is live for ED data—receiving notifications to printer.
McKenzie-Willamette Medical Center	Medhost	Stage 1	Contract with vendor signed—IT interface work in progress.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for Trillium

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 459 unique providers affiliated with Trillium CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 24 different EHRs in use within the CCO. The top 10 products are represented in the chart, which are in use by 437 unique providers.



Umpqua Health Alliance CCO HIT/HIE Profile

26,432 members[1]

CCO Description:

- Geographically more than an hour from any larger city, resulting in a variety of primary care practices: sole practitioners, group practices, rural clinics, and FQHCs. There is one community hospital in the area.
- 65% of members are served in rural clinic and FQHC clinics settings; the rest are seen by small 1 - 2 doctor practices.
- Majority of members are assigned to practices that are either certified PCPCHs or in the process of becoming certified.
- 92% of providers are using a certified EHR.
- Umpqua Health Alliance CCO formed out of the Douglas County IPA (DCIPA) Medicaid managed care organization. In 2013, DCIPA partnered with the hospital system to form a new parent company, Architrave, which has several components, including owning several practices, providing support for the CCO, owning an IT subsidiary which owns/operates Umpqua One Chart (community-wide EHR), and contracting with Inteligenz for analytic tools.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools	
Status	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	GE Centricity	Inteligenz	Inteligenz
Product Name	Umpqua One Chart	Architrave 2.1 (aka Inteligenz 2.1)	CCO Metrics Manager
Version	2014 certified		
Comment	Community-wide Electronic Health Record	Analytics and data mining	Population health management

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** • Umpqua's community-wide GE Centricity EHR tool, Umpqua One Chart, operates as a community health record for the Douglas county area. The EHR is utilized by the vast majority of providers in their community, and includes data on more than 85% of the CCO's members. The EHR is available to both physical and mental/behavioral health providers. • Established connections to share information from four local labs (Quest, OML/Peace Health, Labcorp, and Mercy) and radiology providers at Mercy Medical Center, and have bidirectional exchange set up with Oregon's immunization registry, ALERT. • Umpqua has had capability to export and import a care summary in CCD format since 2010. **Direct Secure Messaging[2]:**

[1] As of 10/01/2014
http://www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	Direct secure messaging is available via Umpqua's HISP, Surescripts. However, the CCO reports that there is infrequent occasion to use it, given the high percentage of providers using One Chart and the fact that the hospital's EHR interfaces with Umpqua One Chart. Rather than use Direct, they 'flag' each other, which is also used for communication between providers and the hospital. **Hospital Notifications[3]:** In collaboration with local hospital Mercy Medical Center, Umpqua One Chart developed bridging of pertinent ER and admission documentation. **Care Management and CCO-Provided Information to Provider/Care Teams:** [See description below under population management]
Quality Improvement, Population Management, Data and Analytics Tools	Umpqua employs two Inteligenz products: • Architrave 2.1 is an analytics and data mining tool that extracts, analyzes, and reports on clinical and claims-based data in their data warehouse. o The tool calculates retrospective and prospective risk scores, diagnoses, prescription drugs use, costs, and premium received and spent. o Data can be grouped by age, disease, registry, provider, and eligibility o Umpqua uses the resulting reports to work with providers. In addition, they help Umpqua identify high-risk patients so they can dedicate case managers to the highest risk people. o Umpqua has used the tool for the last year, and staff are still learning how to use it for population management. • CCO Metrics Manager is a claims-based population health management product from Inteligenz focused specifically on the CCO incentive measures. The tool allows Umpqua to track CQM performance across patients, providers, clinics, etc., and identify areas that need improvement. o One example of Umpqua's use of the tool for assisting them in meeting a CCO metric involves well-child visits, which are to occur once a year. The Metrics Manager allows Umpqua to identify who across their population is subject to that measure as well as who has met the measure (by patient, by doctor, by plan, by address). Umpqua has a team of navigators who then work with the providers to encourage and support their efforts for getting the visits done. For example this support team has relevant information about foster children's need for completing a dental visit, mental health visit, and medical visit within 60 days of entering foster care. o Umpqua staff hand-delivered incentive payment checks to providers, during which visit she also asked them to help by doing well child visits. The payment was significant enough to warrant attention and ensuing cooperation. • The two tools have enabled Umpqua to maximize their performance on metrics. o They can use the Inteligenz tools within the EMR, with relevant information populating the chart. o The CCO has added additional internal metrics for next year, including specialty provider metrics.

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	o The analytic and predictive abilities of Architrave 2.1 will continue to be fine-tuned, based on population healthcare and individual case management needs. • Umpqua learned that no system off the shelf would do the things they needed to do as a CCO in Oregon, and so they worked to develop the solution they needed. Umpqua considers themselves an 'information company' as they "have Information coming in and better information going out." **Incorporating Clinical Data:** • Architrave 2.1 is in the process of being programmed to mine clinical data in the required CCO metrics format. • Clinical data can be collected from any provider utilizing Umpqua One Chart, as long as the data is captured in the correct discreet format. This data can be fed into a data warehouse, and then extracted utilizing a proprietary database mining tool developed by Inteligenz.
Clinical Quality Metrics (CQM) Collection and Reporting	• The CCO is in good shape technologically to be able to report on the CQM measures in Year 2. Similar to Year 1, Umpqua will report on CQMs using clinical data that is fed into Umpqua's database from Umpqua One Chart. • Umpqua credits their relative success of achieving CCO incentive metrics to having everybody in the community on the same EHR system. • The CCO was able to work in a new workflow for depression screening into the latest One Chart upgrade in 2014. They built in a PHQ-2, PHQ-9, AUDIT, DAST, and SBIRT screenings into the system.
Technical Assistance to Practices for EHRs and Meaningful Use	Umpqua has dedicated resources to assisting providers with meeting Meaningful Use. They track each provider's progress toward MU1 and MU2, including what their MU status is likely to be for this attestation year. The CCO is investing considerable effort into ensuring providers are well prepared for attestation. They have also invested resources into the IT aspect by confirming that their system is ready to help facilitate the process of providers receiving credit for their accomplishments, while not actually helping providers attest. • Umpqua has inquired regarding the state's role in and expertise with MU. They are interested in receiving any information the state has available on MU. • Umpqua has engaged Sage, a computer consultant group knowledgeable about MU. They plan to discuss next steps, including the most effective ways to support the providers.
Patient Engagement through HIT	Umpqua One Chart currently includes a limited-feature patient portal. Though Umpqua considered working together with Mercy to create a community patient portal, after some review it was decided to improve and optimize their current Kryptiq patient portal.
Telehealth	• Developing a CAHPS survey tablet application to allow patients to complete the survey in the waiting room. • Umpqua has provided mental health Skype sessions, but the patients seemed generally unsatisfied with the experience.
Other	**Local Provider Directory:** Umpqua maintains a provider directory within their administrative systems including within the Inteligenz tools.
Barriers to Implementation of HIT Tools/ Services	• A few providers are on alternate EMR systems and a smaller few not on any EMR, leaving approximately 13% of members for whom data is not being collected. • Increased demand on providers to collect and enter data has become a major barrier as there are ever growing and conflicting requirements. • Need for implementation of workflows to ensure entry of consistent and accurate data. • General challenges getting information from disparate systems, like OHSU, or the VA in Portland. The CCO is interested in any state-coordinated efforts that help Umpqua One Chart connect to external systems around the state.

	• Umpqua pointed out the financial burden on smaller providers who may need to work with their EHR vendor or other folks to configure their systems to produce clinical quality metrics
Barriers to Behavioral Health Information Sharing	Umpqua would like clarification concerning 42 CFR Part 2, specifically regarding what is and is not allowable. For example, can they treat depression the same way they treat diabetes in their EHR? The CCO would like to know what information they can and cannot share.

CCO Provider Environment:

Hospital Engagement in HIT

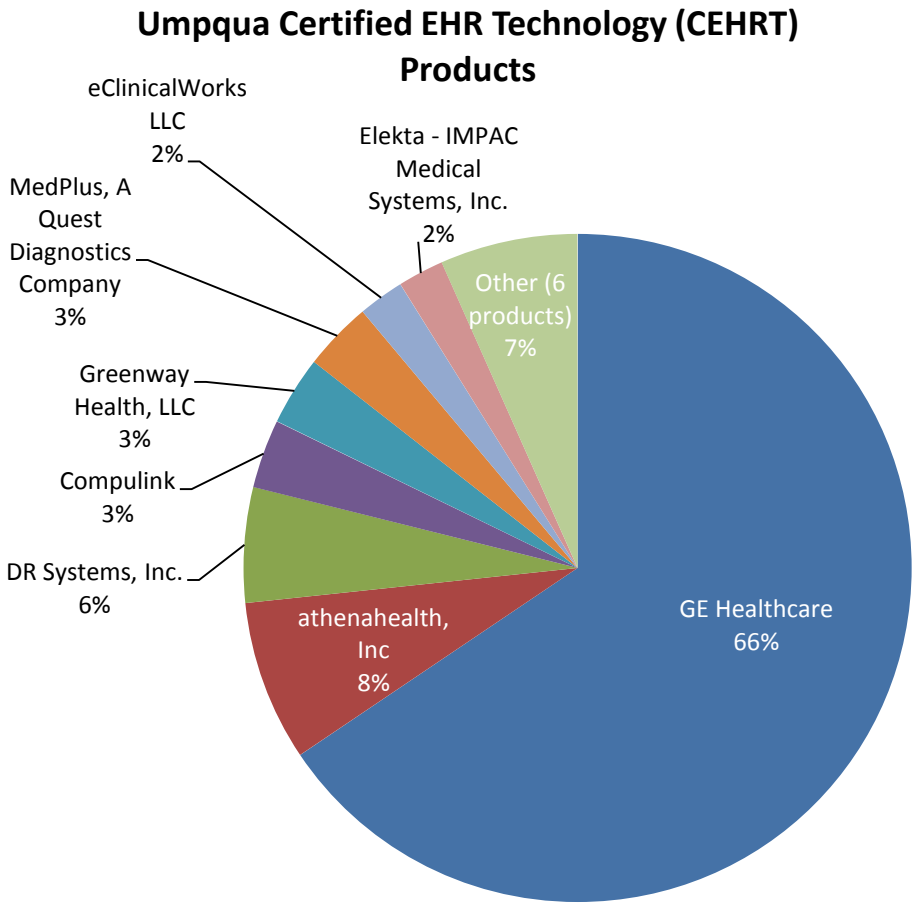
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Mercy Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Umpqua Health Alliance

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 90 unique providers affiliated with Umpqua Health Alliance CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 14 different EHRs in use within the CCO. The top 8 products are represented in the chart, which are in use by 84 unique providers.



Western Oregon Advanced Health (WOAH) CCO HIT/HIE Profile

21,341 members[1]

CCO Description:

- Over 80% of members are managed by a few large group practices, serving members in North Bend, Coquille, Myrtle Point, Bandon, Gold Beach, and Coos Bay.
- The Waterfall Clinic, a small FQHC, serves approximately 5% of member population.
- The CCO evolved from a physician-owned IPA.
- The region experiences some challenges with broadband connectivity (i.e., geographical limitations). Reaching some rural communities is difficult.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☒ Planning/Developing ☐ Not Pursuing
Vendor Name	TBD	TBD	Milliman
Product Name			Patient Relationship Manager (PRM)
Version			Gen 1: launched Gen 2: in development
Comment	Solution in development to exchange clinical data in concert with the Milliman solution	Coordination with Bay Area Hospital HIE efforts through participation in governance: BACIA	Analytics, quality metrics, population/ care management solution

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** The Bay Area Community Informatics Agency (BACIA) is a governance and policy-making body, coordinating health information exchange efforts across Coos Bay and the Southern Oregon Coast. Participants in BACIA include: Bay Area Hospital, North Bend Medical Center, Bay Clinic, Southwest Oregon IPA, and WOAH CCO. Soon to include South Coast Orthopedics and Waterfall Clinic. BACIA and WOAH have brought together the relevant partners and established trust and a shared commitment, which they feel is essential to the success of a community-oriented venture around HIE. • In 2007, BACIA started with an investment in the Medicity HIE solution, and decided in 2013, to replace this solution with a combination of solutions operated by the hospital and CCO, which are under development. • Bay Area Hospital is implementing Mobile MD, which will offer a number of enhancements to their provider workflow, as well as a patient portal for their EHR. The hospital may expand to the full HIE component offered by Mobile MD over time.

[1]As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

	• WOAH expects to add an HIE component to its Milliman Patient Relationship Manager (PRM) solution (see description below). The PRM tool is having a significant impact on how the community HIE evolves. BACIA/WOAH are considering the possibility of having WOAH as the focal point for the community HIE and case managers across the community becoming principal users. **Direct Secure Messaging[2]:** The WOAH solution and BACIA efforts do not currently support Direct secure messaging, although the hospital and providers in their community that seek meaningful use incentives will need to employ it. Further exploration of the role that Direct secure messaging and CareAccord might play may be warranted. **Hospital Notifications[3]:** WOAH expects to be receiving clinical data into the PRM tool from the regional hospital in the next few months, and are interested in the potential to bring PreManage data into their tool. BACIA representatives expressed interest in exploring whether PreManage may relate to their HIE efforts in the future. **Care Management and CCO-Provided Information to Provider/Care Teams:** • WOAH envisions using the Milliman PRM tool to support provider workflows, and ultimately the care management model using PRM could be used more broadly than Medicaid in the community. • Care Coordinator reports and PCP/Provider Management Reports offer EHR-like information about patients. Offers a new way to view patients and brings to the care provider's attention patients they may not have been considering.
Quality Improvement, Population Management, Data and Analytics Tools	The PRM Gen 1 tool includes predictive analytics/risk assessment, care coordinator and PCP/Provider management reports, quality metrics and care gaps information, and business intelligence tools. • A principal goal of the PRM is to ensure that the CCO or provider is able to communicate with patients/customers, to be able to impact their decision making at the time that they are about to make a decision that may be adverse to their health. • Another goal is efficiency of care, ensuring the tool can quickly and easily inform the CCO or provider about where/how to prioritize efforts across a population or patient panel • Milliman Advanced Analytics are used to risk-stratify patients in order to target case management with a goal of reducing potential volatility of risk/cost across a population, not merely high cost patients. This process involves: (1) benchmarking against the average, (2) discovering where the highest risk is and identifying the portion that is controllable, (3) examining healthcare expense volatility and potentially avoidable healthcare expenses (rather than average cost), (4) patients with the greatest area of potentially avoidable costs are ranked as a priority for additional ambulatory care management (not based on 'risk-factors').

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	• The PRM tool helps the CCO and providers target which patients they should actively manage, and then assists in identifying what issues should be actively targeted for each patient, including what has been avoidable historically. • Data currently used in the PRM tool are claims/administrative data including prescriptions (mental health prescriptions and prescriptions for which the patient paid with cash are not included). PRM Gen 2 would include clinical data integration and aggregation. **Incorporating Clinical Data:** WOAH is evaluating the PRM Gen 2 tool, which includes clinical data.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** WOAH is working directly with its provider network for CQM reporting, not through the PRM tool at this time. **Longer-term CQM Strategy:** Depends on their decision about whether to implement Milliman's PRM Gen 2 product, which would incorporate clinical data and calculate CQMs.
Technical Assistance to Practices for EHRs and MU	In an effort to strengthen provider relations, WOAH plans to establish several best practices to help improve clinic workflow and outcomes.
Telehealth	WOAH is supporting the following telehealth initiatives: • Providers who have left the community but are still interested in providing behavioral health through videochat • A multi-discipline, non-profit entity overseeing a feasibility study cataloging the location of the telehealth medicine equipment and developing a plan for its use • PeaceHealth's telehealth project: consult care
Other	WOAH maintains a provider directory within their administrative systems including within their PRM tool.
Barriers to Implementation of HIT Tools/ Services	• Experienced, trained IT staff and analysts are difficult to hire and retain. Some outsourcing efforts by community partners have resulted in frustration and lack of performance. A multitude of competing demands (e.g., every IT department in the region is extremely taxed by EHR adoption/upgrades, MU2 deadlines, and other state and federal requirements). • One challenge of the CCO taking a more central role in managing the community HIE is that there are different needs for the hospital than for the CCO. For example, the hospital is working around provider workflow to ensure consistent metrics and data, and the CCO is focused on population management. o Other areas that would need development were the PRM tool to become more central in the community include questions regarding the management of access to patient information; the means by which case managers would coordinate data; and clarification regarding data needs. • WOAH indicated they faced challenges with CQM reporting in Year 1 on both the front-end (requisite physician workflows) and back-end (extracting the data). Lack of consistent workflows that allow for accurate reporting of data.
Barriers to Behavioral Health	Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: ____ Confusion over compliance with state or federal laws ____ State or federal laws prohibit the type of sharing I want/need to do

Information Sharing	__x__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). ____ Concerns over privacy and confidentiality protection for the patient ____ Concerns over liability if information you share is later improperly shared __x__ Lack of proper consent forms from the patient __x__ Other: Mental Health providers use a record that is significantly different from the medical EHR.

CCO Provider Environment:

Hospital Engagement in HIT

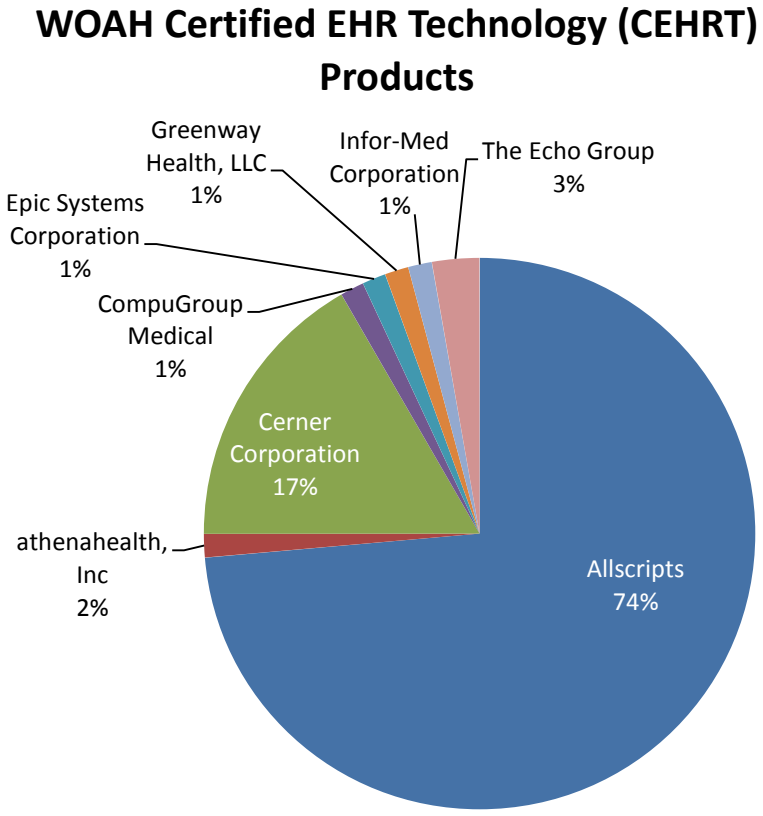
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Bay Area Hospital	Siemens	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Certified EHR Technology Products for Western Oregon Advanced Health

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 72 unique providers affiliated with WOAH CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 8 different EHRs in use within the CCO.



Willamette Valley Community Health CCO HIT/HIE Profile

100,574 members[1]

CCO Description:

- Served by about 62 primary care practices, which includes two Federally Qualified Health Centers (FQHCs), and many practices are members of the Mid-Valley IPA (MVIPA).
- Of the primary are practices, 38 have achieved at least Tier 1 PCPCH status, with 22 practices at Tier 3.
- Over 80% of the practices are very small with 4 providers or less. There is one large practice of over 40 providers and a handful of medium-sized practices with 10-15 providers.
- MVIPA hosts NextGen EHR for many of its members.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination	Quality Improvement, Population Management, Data and Analytic Tools
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing
Vendor Name	Collective Medical Technologies	Arcadia Solutions
Product Name	PreManage	Community Data Warehouse
Comment	In conversations with CMT about bringing ED and inpatient notifications to their community.	Working in conjunction with community partners

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	**Health Information Exchange:** Health care stakeholders in the community have considered a regional community solution to HIE in the past, and the CCO and its HIT committee continues to be interested in how best to support a community HIE solution, however, there are no concrete plans for a community-wide HIE currently . **Direct Secure Messaging[2]:** Although WVCH promoted Direct secure messaging and a significant number of organizations have registered with CareAccord, many of these folks are not using CareAccord at this time, in some cases because it is not embedded in their EHR/workflow. As providers need to meet Meaningful Use, many will use a HISP embedded in their EHR, including the MVIPA members using MVIPA's NextGen (with Mirth as the HISP). The CCO commented that CareAccord is likely to be most useful for providers not seeking to meet Meaningful Use, and those that do not have an EHR.

[1] As of 10/01/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

	Hospital Notifications[3]: Though hospital data will be included in the Community Data Warehouse (see description below), WVCH is not otherwise engaged in providing hospital notifications to PCPs. WVCH is in the process of exploring options for bringing PreManage to its community. **Care Management and CCO-Provided Information to Provider/Care Teams:** WVCH expects that Case Managers will likely be primary users of the Community Data Warehouse tool (see description below) for reaching out to patients, creating reminders, and metrics, among other uses.
Quality Improvement, Population Management, Data and Analytics Tools	Community Data Warehouse: An overarching goal for the CCO is to connect clinical data from disparate EHRs, hospital data, pharmacy data, and health plan claims data for use at the point of care for primary care providers, and case management staff to help with care coordination and the health care decision making process. To that end, WVCH is proceeding with the Community Data Warehouse, a pilot project involving the development and implementation of a population health management, data aggregation, and analytics tool. This effort will be a proof of concept for the CCO board to consider whether to implement more fully. • The Warehouse is spearheaded by Silverton Health in collaboration with Yakima Valley Farm Workers, independent of WVCH. WVCH decided to adopt the Warehouse as its own in a pilot phase, as the Warehouse project met many of the CCO's HIT objectives, with the exception of HIE capabilities. In addition, the Warehouse project was underway, with the vendor, Arcadia, selected and agreements/governance established. • The project currently comprises over 15% of WVCH's member population – and is scalable should the CCO want to expand after the initial implementation. • Participants in the project include a hospital and approximately ten PCP clinics using at least two different types of EHR software/versions. • The tool is expected to integrate hospital, ambulatory EHR, pharmacy, and claims data. • One of the key objectives of the Community Data Warehouse project is to improve analytic capability at a community level. o Existing analytic capability is generally limited by the measurement and reporting capabilities provided by the EHR vendors. Some practices have developed additional reporting capabilities in-house or via MVIPA. **Incorporating Clinical Data:** The expectation is that clinical EHR data will be integrated into the Community Data Warehouse for a variety of purposes.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** • WVCH intends to leverage capabilities provided by the participating practices' EHR systems (primarily MVIPA's NextGen providers) for Year 2 CQM measurement and reporting. • WVCH indicated a concern that they won't have a complete year of data for the depression screening measure for Year 2, as the NextGen EHR systems were not upgraded to include the ability to enter a depression screening until July 31st, 2014. **Longer-term CQM Strategy:** WVCH does not yet know what level of clinical information will be supported by the Data Warehouse project, and how it might support the CCO incentive metrics moving forward.

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

Technical Assistance to Practices for EHRs and MU	• The CCO is exploring ways to increase the efficiency of EHRs including the use of Scribes for their veteran providers. • MVIPA provides technical assistance to providers using NextGen EHR. In fact, O-HITEC subcontracted with MVIPA to deliver TA services.
Other	**Local Provider Directory:** WVCH maintains a provider directory within their administrative systems. The collaborative will maintain provider information in the Community Data Warehouse.
Barriers to Implementation of HIT Tools/ Services	• WVCH is aware that providers do not experience EHRs as increasing their productivity, efficiency, or cost savings, bringing the value of EHRs into question. • WVCH is interested in supporting dental care use of EHRs and HIT. The CCO ascertained that dental care providers are lagging behind physical health in terms of EHR adoption, although dental providers are eligible for the EHR incentive program and certified dental EHRs exist. The CCO expects to closely monitor and support efforts in this area. • The majority of practices are primarily dependent on the measurement and reporting capabilities inherent to their EHR systems and do not have the resources to develop improved data analytic capabilities on their own. • Each new measurement and reporting requirement brings with it the necessity to evaluate and enact data entry workflows, which result in structured data being available for reporting purposes. EHR system usability is a constant barrier to reliable data entry and therefore accurate measurement. • While the Community Data Warehouse project will provide WVCH with population management, care coordination, quality, and analytics capabilities, it does not address the CCO's HIE and/or query-response needs. • WVCH expressed concerns regarding making significant investment in HIE given challenges related to interoperability, including the limitations of CCDA integration, and challenges related to message delivery via Direct secure messaging.
Barriers to Behavioral Health Information Sharing	Barriers/challenges experienced in sharing behavioral health data (including mental health, substance abuse, and addictions) include: __X__ Confusion over compliance with state or federal laws ____ State or federal laws prohibit the type of sharing I want/need to do __X__ Our organization's technology system does not have the technical interfaces and applications needed to exchange sensitive data (e.g., EHRs do not segment or separate data). __X__ Concerns over privacy and confidentiality protection for the patient __X__ Concerns over liability if information you share is later improperly shared ____ Lack of proper consent forms from the patient

CCO Provider Environment:

Hospital Engagement in HIT

Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Salem Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
West Valley Hospital	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.
Santiam Memorial Hospital	Healthland	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Silverton Hospital	Meditech, Optuminsight	Stage 1	Feed is live for ED and inpatient data—receiving notifications to printer.

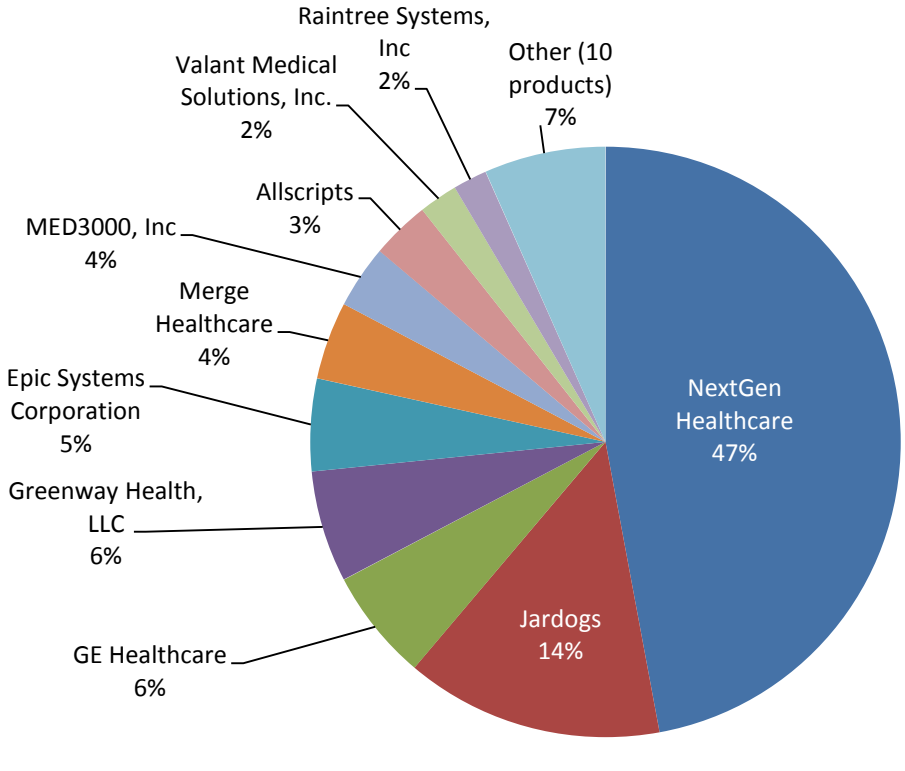
*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top 10 Certified EHR Technology Products for Willamette Valley Community Health

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 376 unique providers affiliated with WVCH CCO that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 20 different EHRs in use within the CCO. The top 10 products, represented in the chart, are in use by351 unique providers.

WVCH Certified EHR Technology (CEHRT) Products



Yamhill CCO HIT/HIE Profile

24,661 members[1]

CCO Description:

- Two major hospital systems: Providence Medical Group Newberg and Willamette Valley Medical Center (WVMC) McMinnville with closely affiliated primary care and specialty care clinics with largely employed providers;
- One large independent primary care clinic: Physicians Medical Center (McMinnville) seeing a majority of pediatric patients.
- One FQHC: Virginia Garcia serving a large portion of Spanish speakers and adults.
- Remainder of Yamhill CCO network: small independent primary care and specialty care clinics.
- Yamhill County DHHS supplies the majority of behavioral health services.
- Yamhill CCO formed out of community partners and is supported by a partnership with CareOregon who provides administrative foundation and support.
- Prior to the CCO forming, the majority of Medicaid members were fee for service.
- Yamhill CCO was awarded the Early Learning Hub for their region.

Pursuit of HIT Initiatives

	Health Information Exchange and Care Coordination		Quality Improvement, Population Management, Data and Analytic Tools		
Status	☐ Currently supporting ☒ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing	☒ Currently supporting ☐ Planning/Developing ☐ Not Pursuing
Vendor Name	The Advisory Board	Collective Medical Technologies	The Advisory Board	The Advisory Board, Milliman	SAS
Product Name	Crimson Care Management (CCM)	PreManage	Crimson Care Registry (CCR)	Crimson Population Risk Management (CPRM)	Business Intelligence Software
Comment	Care management tool	Hospital notifications	Identifies gaps in care	Population management, Risk stratification, with Milliman analytic support	Claims-based analytic reporting (provided by CareOregon)

[1]As of 10/2014
www.oregon.gov/oha/healthplan/DataReportsDocs/October%202014%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf

Description of HIT/HIE Initiatives

Information Sharing and Care Coordination	Overall, the CCO is investing in a suite of tools within the Crimson Care Ambulatory tool, which was selected in part because one local hospital had invested in it, and two major clinics are already connected. The suite has three tools – 2 that Yamhill CCO is implementing (CPRM and CCR – see next section below), and 1 that the CCO is considering (CCM) for care management. **Health Information Exchange:** See "Care Management" section below **Direct Secure Messaging[2]:** The CCO has not engaged in many conversations around using Direct for their CCO needs, and is using a secure email service when necessary. However, Yamhill CCO has identified radiology (echocardiogram) image transfer type platform as a significant need, which could be supported by Direct secure messaging/CareAccord. **Hospital Notifications[3]:** One clinic already receives a daily feed of emergency department visits for their patients, but it is limited to their area (one hospital). YCCO is supportive of EDIE and is interested in exploring the integration of PreManage into the Crimson Care Management tool. **Care Management and CCO-Provided Information to Provider/Care Teams:** The CCO is exploring the possibility of implementing the Crimson Care Management (CCM) tool, which would include more real-time, actionable clinical information to support care management. With Crimson Care Management, providers and the CCO care managers get a full picture of their patients or members, defined sub-populations, and individual patients through integrated data. Crimson includes psychosocial risk factors when calculating patient risk and prioritizing tasks, giving care managers the information needed to act effectively. See below for a description of the Crimson Care Registry and Crimson Population Risk Management tools which also support providers in care delivery and managing their populations. For example, Yamhill CCO's aim is that behavioral health services providers could utilize the CPRM tool for case management and to facilitate the coordination of services.
Quality Improvement, Population Management, Data and Analytics Tools	The CCO invested in the Crimson Care Registry (CCR) and Crimson Population Risk Management (CPRM) tools. • The Crimson Care Registry component allows for gathering/aggregating/sharing of clinic level EHR data to identify gaps in care and specific health data points in the population (e.g., identifying members in need of colorectal cancer screening). The CCR can also produce the three CQM CCO metrics. • The Crimson Population Risk Management tool pools, processes (by Milliman), and analyzes medical claims data from CareOregon and OHA to risk stratify and score members to allow for the identification of members with high medical costs. • YCCO considers the Crimson PRM tool a critical component of developing alternative payment models. Their strategy has involved using the CPRM to risk score members

[2] Direct secure messaging provides a HIPAA-compliant way to encrypt and send any attachment of patient information electronically, for example, shared care plans, patient histories, and more sophisticated attachments such as x-rays and echocardiograms. As EHRs evolve in 2014 to meet federal Meaningful Use requirements, Direct secure messaging will be a core service within each EHR and national standards will support interoperability between Direct secure messaging providers (HISPs).

[3] Hospital notifications fill information gaps around expensive transitions of care by providing real-time alerts to providers, health plans, CCOs and health systems when their patients are seen in the Emergency Department, are admitted to inpatient care, or discharged from the hospital.

	assigned to various clinics, and then base the global budget those clinics receive for that population on the risk score of the members. • Yamhill CCO supports the Community Hub, which is a referral-based program to which any provider can refer members they feel are high utilizers in order to establish a relationship with a community health worker. The Crimson Population Risk Management tool is being considered for integration into the Community Hub program that works with high-utilizers of ED and may be used as a way to identify high-risk score members for inclusion in the Community Hub. Care Oregon supports Yamhill CCO with claims-based analytic reporting is conducted via SAS Business Intelligence software, including metrics and dashboards for the CCO to use. • Current reporting capability includes aggregate reporting for CCO level data, provider level data, and member level data for demographics, utilization, and gaps in care **Incorporating Clinical Data:** • The Crimson software includes the capacity to include EMR data within their analytics.
Clinical Quality Metrics (CQM) Collection and Reporting	**Current CQM Strategy:** CCO relied on OCHIN for the Year 1 CQM submission. However, given the increases in the required population on which to report, this approach will likely not suffice for Year 2. CCO is exploring a multi-pronged approach, including the use of Crimson Care Registry as well as OCHIN and Providence, to meet the needed percentages. **Longer-term CQM Strategy:** The vision for longer term reporting is that data would be collected in, and reported from, the Crimson Care Registry to the CQMR.
Telehealth	• Yamhill CCO is pursuing a teledermatology pilot, as part of their participation in OHA/Transformation Center's Council of Clinical Innovators. Due to the lack of access to dermatology care, they are bringing a teledermatology provider into the community which involves putting an iTouch in primary care exam rooms to support teledermatology consults during a primary care visit. The remaining challenge is to resolve billing for such a service. • Partners within the Yamhill CCO community previously utilized tele-mental health. • Yamhill CCO supports and encourages providers' use of the *Oregon Psychiatric Access Line about Kids* (Opal-K), which provides free, same-day child psychiatric phone consultation to primary care clinicians in Oregon. • Additional telehealth/telemedicine being considered include after hours crisis intervention and services within the CCO pain clinic.
Other	**Common Core Referral/Early Learning:** YCCO sponsors the Yamhill County Early Learning Hub. They were the only CCO in the state that applied and was awarded the status and is therefore under some scrutiny regarding how CCO is approaching the integration of early childhood interventions. The CCO already had a Common Core Referral process in place for the Maternal Child Health (MCH) population. That is, any provider or (non-profit) entity in the community that sees a child, family, or pregnant woman of concern, they only need to fill out the basic common core referral form and fax it to the CCO. The CCO then conducts an assessment and determines the services available to meet the needs. The process is low-tech (handled via paper and fax) and includes basic information, but is very effective in getting individuals the assistance they need. **Local Provider Directory:** Yamhill CCO maintains a provider directory within their administrative systems and Crimson systems.

Barriers to Implementation of HIT Tools/ Services	• Presence of multiple EHR systems across the provider network. • Crimson integration administrative barriers include lack of clinic interest in participating and lack of staff to devote to the process. • Clinic staff stretched thin dealing with technical and regulatory requirements. • Current CCO staffing limitations, specifically the lack of technology and/or analytics-dedicated employees. YCCO is exploring the possibility of hiring a data/analytics staff person. • YCCO has experienced challenges with getting some providers organizations involved with Crimson. This has been due in part to concerns regarding HIPAA including having correct business agreements that identify who would have access to the data and lack of clarity regarding acceptable 'pushing and pulling' of data between organizations (i.e., what information is acceptable to share). • Once the data was pooled from CareOregon and OHA and processed by Milliman, they found a significant rate of duplicate records in Crimson. A data validation effort ensued, involving a joint effort between Crimson and Milliman. • Starting ACO in McMinnville being run through Regence (Regence Active Care – devoted to fostering ACOs). They have 123 patients already enrolled. The challenge with this is that Regence has their own HIT/HIE platform (Lumeris). This adds to the complexity of establishing a community-wide HIT/HIE infrastructure. • Uncertainty among CCO staff as to the status of dental practices with regards to Meaningful Use and other state HIT/HIE goals/metrics.

CCO Provider Environment:

Hospital Engagement in HIT

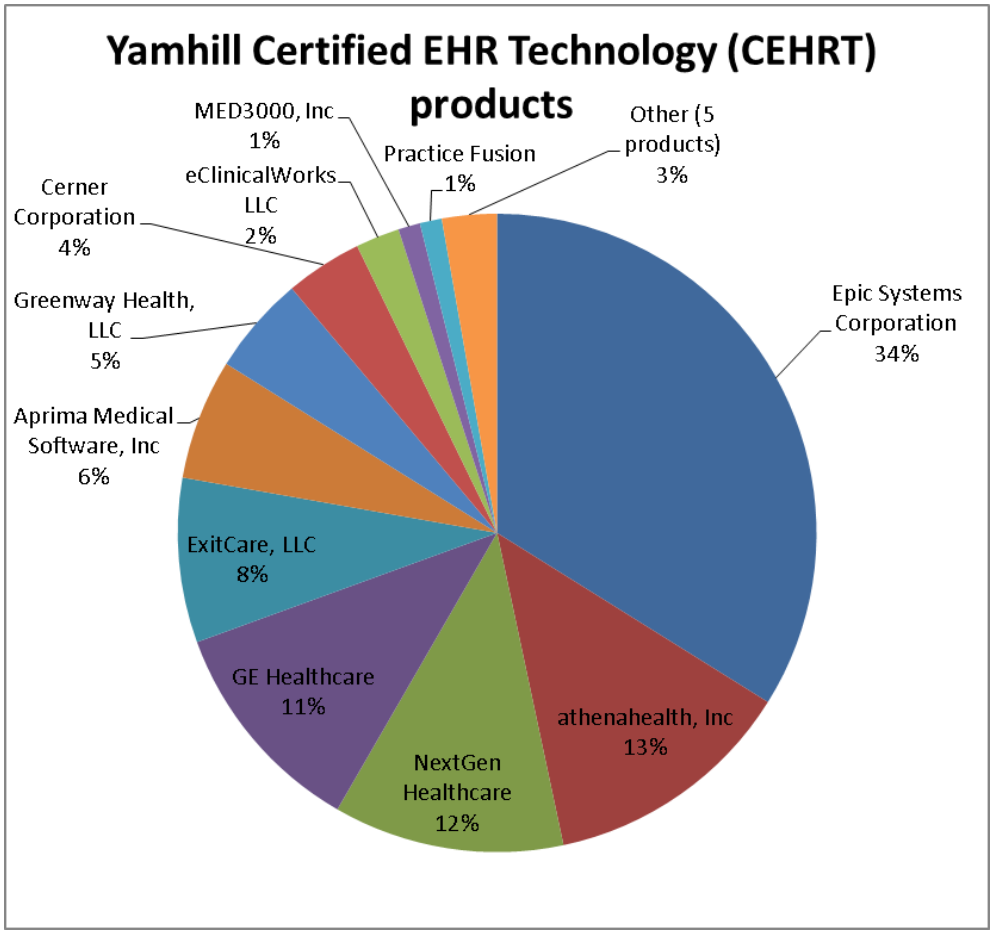
Hospital Name	EHR Vendor	Stage of Meaningful Use Achieved*	Emergency Department Information Exchange (EDIE) Status (as of 5/2015)
Willamette Valley Medical Center	Meditech	Stage 1	Feed is live for ED and inpatient data—receiving notifications to fax.
Providence Newberg Medical Center	Epic	Stage 1	Feed is live for ED and inpatient data—receiving notifications to EMR.

*Note: Stage of Meaningful Use is based on most recent Medicaid payments as of 04/15 and Medicare payments as of 12/14.

Top Certified EHR Technology Products for Yamhill Service Area

(in use by eligible professionals receiving Medicare or Medicaid EHR Incentives)

There were 180 unique providers in Yamhill CCO's servicing area that received payments for either the Medicaid or Medicare EHR Incentive Programs from 2011 – Nov 2014. If multiple payments were received, CEHRT represented in data is based on the most recent information. There are a total of 16 different EHRs in use within the CCO. The top 11 products are represented in the chart, which are in use by 175 unique providers.



Oregon Health Authority's comments on ONC's Shared Nationwide Interoperability Roadmap
April 3, 2015

General Comment Summary:
Overall, the Oregon Health Authority's Office of Health Information Technology finds the Roadmap to be a positive step forward in moving the nation toward true interoperability for health information exchange and technology. It provides a framework for how interoperability can move forward with specific calls to action around governance, and identifying areas specific to the federal and state levels. We believe that there is space within the Roadmap to further clarify the coordination and facilitation role of ONC and how it relates to the different activities and diverse stakeholders.

We are pleased to see nationwide efforts focused on interoperability; we want to emphasize the importance of this being carried through to detailed levels of federal programs and to stakeholders outside of the federal government system, including states, private sector actors, and the end-user—providers and clients. Oregon has experienced considerable challenges in achieving true interoperability, and the next five-year period is critical to advancing HIT. We are excited to see that many of the areas in which we have been focusing are key components of the Interoperability Roadmap. The emphasis on this being the Roadmap for the nation, encompassing all players, is well appreciated. It would be good for there to be further delineation of roles and broad scopes of responsibility, and a strengthening of the role of States in furthering interoperability.

We appreciate the increased focus on the individual within the Roadmap. We believe that there is space to clarify the roles of the different federal, state, and private stakeholders in the outreach to and advancement of the use of HIT/HIE by individuals. The motivations, needs, and perceived value for individuals could be defined more clearly within the Roadmap. As the client end-user is a critical component of the success of interoperability, it will be key to clearly delineate in future actionable plans the parties responsible for direct engagement with the individual and the strategy under which that work will take place.

We also agree with the overall definition of interoperability as proffered within the document: "…the ability of a system to exchange electronic health information with and use electronic health information from other systems without special effort on the part of the user." Moving into the practicable actions that will move the Roadmap forward, there needs to be a consensus around what interoperability means at the actionable level and the specific long-term goal(s) for those delivering solutions. This should take into consideration multiple factors including: those who need access for care coordination; what are the use cases beyond MU; what is "whole person" care; and technical support capabilities and capacities in small clinics.

As the Roadmap is executed, it will be important for ONC to coordinate and collaborate with key stakeholders including private providers, health plans, and vendors on communications, standards, services, policies, practices and incentives through the process of outlining tactical steps to carry actions forward that have been delineated within the Roadmap. Throughout the document, the word "nation" is used to encapsulate all stakeholders vested in this effort. However, it is imperative to ensure that roles and responsibilities are delineated. We agree that we as a nation need to move forward in this effort. However, without further specificity as to how the different components come together, interoperability will remain a challenge. The seven governance points begin to flesh this out, and it is good to see such an emphasis on governance.

We look to ONC to facilitate these discussions around governance. ONC plays a critical role in bringing parties together, particularly at the national level. ONC should provide specifics as to how intends to fulfill that role in the near, medium, and long term. We see this process moving forward with the involvement of both public and private sectors—including trust communities, with ONC coordinating and overseeing the discussion and assuring that all players are brought to the table, including States.

Communication, education, and sustainable incentives (monetary and otherwise) at each level around the goals and the implementation will be critical to ensuring the greatest level of success, particularly as solutions have already been or are in the process of development and there will be a tension between the ideals of competition in the private sector and that of interoperability throughout the system. It may be necessary to create incentives or push points for the private sector to ensure that their focus remains on interoperability. The common set of standards, services, policies and practices needs to be inclusive of public and private entities.

Within Oregon, key stakeholders have had discussions around common themes related to interoperability. Common points of concern for our stakeholders are as follows:

- **Cost** – the technologies are emerging and they are expensive to adopt and operate. When vendors change or update their products they push these costs onto providers and organizations. Particularly as organizations experiment and learn what works within their community, these costs are considerable.
- **Value** – demonstrating the value of HIE tools is difficult and directly tied to the scope of each solution. Big encompassing solutions are too costly and complicated to get off the ground; small solutions do not always demonstrate enough value across the various sectors of the health care system. Therefore, the strategy for implementation of a solution is key and sufficient incentives need to be put into place to encourage users as the system is growing but prior to it reaching a critical tipping point in number of users that will provide a broad enough reach to bring value to the users. If the system grows too quickly, it can be overcomplicated and too expensive for potential users to buy in. If the system is too small, users may not see the value of the system or solution. Balance is critical in demonstrating the value of a system.
    - In Oregon, the Emergency Department Information Exchange (EDIE) is a good example of how clear value drives adoption of these technologies
- **Clinical Need** – standards need to be more closely aligned with the needs of clinicians. Existing standards (e.g. HL7, CCDA, etc.) do not give clinicians everything they need to do their jobs.

We appreciate and commend the recent federal efforts to provide clear and timely plans to advance HIT across the country. We will continue to look to HHS and ONC for HIT plans and guidance to ensure continually aligned efforts in Oregon.

About the Oregon Health Authority's Office of Health Information Technology:

The Oregon Health Authority's Office of Health Information Technology (OHIT) was established in 2011 as a part of the state's health agency to support the adoption of electronic health records, the secure exchange of health information, and supporting meaningful use initiatives in the state. OHIT is a resource for both state programs and other public and private users of health information, providing planning, coordination, policy analysis and the development of public/private partnerships to further health IT in Oregon. Health IT is a key part of Oregon's efforts to create a system of better health, better care and lower cost for all Oregonians.

Specific Comments:

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
11	**Current Context**	Last paragraph: HHS will consider where additional guidance may be needed to clarify the current legal framework, including Health Insurance Portability and Accountability Act (HIPAA) Rules, to effectively support individual privacy in a learning health system	This will be a critical component moving forward, as interoperability has been challenged in its advancement in part due to the lack of clarity around regulations surrounding information sharing, consent, and authorization.
13-14	**Critical Actions for Near Term Wins**	4. Clarify privacy and security requirements that enable interoperability: Many organizations have misinterpreted HIPAA rules and other regulations and therefore refrain from sharing health information, even with individuals themselves. Federal agencies and other stakeholders should work to provide the Office for Civil Rights, which enforces and issues guidance on the HIPAA Rules, with information it needs to determine whether additional guidance is needed to support interoperability while maintaining the crucial privacy protections on which interoperability relies.	There is a disconnect between what is actually permitted to be shared and what organizations perceive to be permissible to be shared. Inclusion of this paragraph leads the reader to believe that ONC may take on a role in assisting to clarify the rules, but this is not specifically stated. As mentioned above, this would be an incredibly useful and critical step toward increased interoperability. It would also be beneficial to see this work expand to include 42 CFR part 2 as well.
15	**Figure 2**	Timeline of Select High-Level Critical Actions for Near-Term Wins: Privacy and security requirements to enable interoperability	We have concerns that the timeline for the clarification of privacy and security requirements may take longer than the amount of time anticipated in the Roadmap, which appears to be by the end of 2015. Given the complexity of the issues surrounding privacy and security requirements, we would anticipate

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			that this would bleed over into the following years, continuing even into the policy and funding lever discussions. There are, however, those that have implemented new pay for performance models of care delivery and this immediate timeline is appropriate for those groups.
22	**Figure 5**	Stakeholder Perspectives	The clear outline of stakeholders types and definitions with symbols is much appreciated. We encourage ONC to provide a succinct label (1-2 words) for each type that flows well in narrative documents and can be re-utilized by others as universally accepted labels and definitions.
30	**Moving Forward and Milestones**	First paragraph: While the various organizations with their varying governance methods (policy, operational and technical) described above play an important part in the governance landscape, there is no single process or mechanism to bring them all together in a coordinated manner or in a manner that can reconcile differences.	We have concerns that ONC does not present as having a role in helping to coordinate the governance efforts on some level. We believe ONC could play a role in cataloguing governance methods and convening like stakeholders who need assistance in working through governance models and barriers.
30	**Moving Forward and Milestones**	First paragraph: Furthermore, additional networks will likely emerge as customer needs evolve.	"Furthermore, additional networks will likely emerge as customer needs and health care service models evolve."
30	**Moving Forward and Milestones**	Second paragraph: It is important that there be a set of "rules of the road," a multi-stakeholder process to address operational issues to support the rules of the road and a mechanism for demonstrating and identifying compliance with the rules, as well as	We believe that ONC has a key role, in coordination with other partners, in overseeing compliance in a multi-stakeholder process, such as trust communities, to represent the interest of federally funded activities, government advocacy, and to monitor for bad actors. While ONC is

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
		addressing non-compliance. A coordinated governance mechanism must support a transparent and inclusive process for identifying operational issues and making decisions to support electronic health information exchange for individual and population health. The process should be inclusive of public and private actors and must hold true to the principle of person-centeredness.	not the sole actor in this regard, we believe that as the coordinator at the national level, the voice and influence of the ONC will be critical in these activities.
31	**Moving Forward and Milestones**	Last paragraph: The public and private sectors must work together to identify and address operational issues that currently inhibit interoperability. The public and private sectors must establish a mechanism for compliance and accountability to governance criteria.	We should ensure that this also takes into account and applies to not only those vendors offering the exchange solutions (EHRs, HISPs, etc.) but also for those offering trust networks for exchange. It would be beneficial to see what the anticipated role of ONC or other federal agencies to go beyond implementation specifications to examine and address issues that inhibit interoperability.
31	**Governance Principles**	Policy – Access to Personal Health Information: No policy, business, operational, or technical barriers that are not required by law should be built to prevent information from appropriately flowing across geographic, health IT developer and organizational boundaries in support of patient care.	We appreciate ONC's identification of this principle. However, barriers are usually built unintentionally or a result of a series of disconnected efforts resulting from policy, business, operational, or technical activities. This is our interpretation - "Policies, business/operational processes, or technical solutions and standards should promote the flow of patient care information across geographic, health IT developer and organizational boundaries. Barriers to these efforts, unless required by law, should be identified and removed."
32	**Governance Principles**	Policy – Transparency: Data holders and entities facilitating electronic exchange of health information should provide easily understandable and accessible information about	We support this effort, but acknowledge that the granular level of the examples may be difficult to make transparent for every scenario and easily understandable.

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
		organizations' data practices.	
33	**Governance Principles**	Operations – Inclusive Governance: Entities facilitating interoperability of health IT should promote inclusive participation and adequate stakeholder representation (especially among individuals and patient advocates) in the development of data policies and operations policies..	We strongly support the inclusion of individuals and patient advocates in governance.
33	**Governance Principles**	Operations – Open Exchange: An entity engaged in the exchange of electronic health information shall treat all personal health information exchange requests, services and efforts in roughly the same way and not erect barriers to the authorized flow of information. For instance, a health IT developer that has health information exchange applications shall not prevent a user from using health information exchange applications developed by competitors.	In addition: ...a health IT developer that has health information exchange applications shall not prevent a user from using health information exchange applications developed by competitors and should make applications that have configurable data points to align with law (42 CFR Part 2, adolescent health information, etc.).
33	**Governance Principles**	Operations – Open Exchange: Provide open access to exchange services, such as access to an organization's provider directory that would enable local, regional and/or nationwide organizations and individuals to identify with whom they can electronically exchange information and how such exchange would have to be completed, pursuant to applicable laws and regulations.	We strongly support this principle and would encourage that this would explicitly apply to trust communities, along with other pertinent organizations.
34	**Table 1**	A1. Establishment of Coordinated Governance - 2015-2017: 1. ONC will define a nationwide governance framework with common rules of the road for trust and interoperability and a mechanism for identifying compliance with common criteria. These rules will first focus on interoperability of a common clinical data set for purposes of treatment.	We encourage ONC to initially focus on interoperability issues related to Mu Stage 2. We've heard from our providers that the technology that is tested and certified to meet certain objectives does not always work as it is supposed to. An example is for the transitions of care MU 2 measure – An electronic clinical summary is supposed to be able to be sent from one provider's EHR and automatically

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			ingested into another provider's EHR with no intervention by the receiving provider. This does not always happen. Reasons we've heard is that if a CCD is not attached, a message will not go through or there are workflow issues - members of the care team who do not have NPIs, may not have Direct Addresses to send the proper message
34	**Table 1**	A1. Establishment of Coordinated Governance -2015-2017: 3. Call to action: Public and private sector stakeholders across the ecosystem should come together to establish a single coordinated governance process to establish more detailed policies regarding business practices, including policies for identifying and addressing bad actors and to identify the technical standards that will enable interoperability for specific use cases 4. Call to action: Federal agencies that provide or pay for health services should align their policies for interoperability with the nationwide governance framework.	We agree that a coordinated governance process and policies are needed, and will participate as a state governmental entity when appropriate. We believe ONC should serve in this role, including convening and coordinating, and be specifically identified in the call to action. We would encourage that there be a means by which appeals and exceptions can be brought forward related to standards. As ideal as it would be to have a *single* governance process, it is more realistic to have a coordinated governance process to address multiple types of issues. If the coordinated governance process that establishes more detailed policies is also being developed in the same timeframe (2015-2017), then we believe the outcomes for this item may not be completely fulfilled by 2017 and - federal agencies may not have adequate time to fulfill aligning their policies for interoperability to the framework.

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			Are there operational processes that this group will also be expected to cover? If so, we believe this should be called out to prevent confusion since both business and technical were specifically addressed. In addition to identification of bad actors, which is appreciated, processes for addressing corrective plans of action should be included. Flexibility in standards adoption, and adherence to the letter versus the spirit of specific use cases is important. While much of the focus on health reform initiatives has appropriately been on improved health and access to care, public health prevention activities should also highlighted. Providers participating in meaningful use have told us that their systems do not always perform as tested and their vendor may not be responsive to complaints.
35	**Table 1**	A2. Policies & Operations -4: ONC and stakeholders participating in the coordinated governance process, human service providers and health-related device overseers should define policies for interoperability of health information from non-clinical sources.	Given new payment models there are current barriers related to these areas now, we believe this should be moved to the 2015-2017.
36	**Table 1**	A3. Standards - 3: The coordinated governance establish an ongoing evaluation process for the efficacy of standards and testing tools.	We believe this should shift to 2015-2017 as an ongoing evaluation process should be established when standards are identified to have feedback look from the start.
36	**Table 1**	A3. Standards - 5: The coordinated governance process should use the standards evaluation process on an ongoing basis to coordinate the roll out of software and service changes	Federal efforts must keep state- and jurisdiction-level legislative and policy mandates and data requirements in mind. Adoption of new standards and

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
		so as not to disrupt established interoperability.	software must not disrupt current public health clinical or surveillance activities.
41	**Supportive Business, Clinical, Cultural and Regulatory Environments**	States: Entire section	We applaud ONC and CMS for their coordinated efforts to adjust the conceptual model of how Medicaid funds can be used to increase interoperability. Oregon has and will continue to utilize this path to subsidize interoperable infrastructure, where appropriate and needed, to support new delivery systems and payment models across the state. We will continue our efforts to implement state programs and policy levers to further promote interoperability, and participate in wide-spread governance models and utilize nationally recognized standards.
44	**Table 2**	B2. State Actions –Entire section	We applaud ONC and CMS for their coordinated efforts to align policy levers specific to states. We acknowledge the state calls to action; Oregon will continue to align our current and future policies and efforts, when and where appropriate, to support new delivery systems and payment models across the state. We look to ONC and CMS to provide further clarification and detail on these calls to action so Oregon can best align our efforts.
44	**Table 2**	8) A significant portion of active federal grants and contracts that include provisions related to health IT adoption and exchange align with national standards for health IT.	Most of the funds for public health activities come from federal grants. Many of these projects are siloed and time limited activities, and efforts to sustain valuable projects are thwarted by the lack of coordination across federally funded activities. Staff turn-over is high, and

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			infrastructure is fragile because we are not able to retain resources. This is neither efficient nor sustainable. We hope that this alignment is not just with regard to adoption of nationally recognized standards, but also coordination within federal agencies of aligning funding opportunities to build sustainable infrastructures for awardees.
44	**Table 2**	1) Call to action: All states should have an interoperability roadmap articulated in their health-related strategic plans (including their Annual Medicaid Health IT Plan). 2) Call to action: All states should take appropriate steps to implement policies that are in alignment to the national, multi-stakeholder approach to coordinated governance for interoperability. 9) Call to action: The vast majority of states should enact state-autonomous policies to support interoperability.	Public Health entities should be called out in each state's interoperability road map and HIT strategic plans. Informatics should be recognized as distinct discipline that is supported by state agencies working toward implementation of interoperability policies.
47	**Table 3**	1) Call to action: A majority of individuals and their caregivers should demand access to their electronic health information in a format that they can use to manage their health or that of others. 3) Call to action: Individuals should contribute clinically relevant patient-generated health data and request corrections to their electronic health information to effectively manage their interactions with the care	Although we support individual access to individual data, standards are needed to ensure uniform authentication and authorization for on demand record requests. With regard to public health data, much of what is collected is either surveillance data and aggregated reports are readily available upon request. Rather than accessing public health surveillance systems, better interoperability between public health systems and EHRs should be

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
		delivery system and to manage their health and wellness where they live, work and play.	supported such that data are available to individuals through existing systems.
48	**C.2 Providers and technology developers supporting individual empowerment**	2015-2017: 3. Call to action: Providers and technology developers should provide a majority of individuals with the ability to send and receive their health information and make decisions with the providers of their choice, including but not limited to their existing care team based on their preferences.	Specifying only providers and technology developers as a part of this call to action seems limited; delivery systems, healthcare purchasers, organizations and government all may be a part of this. We hope that the operationalization of this call to action would include education and outreach. Is this section focused on trying to ensure availability of these systems for sending health information, but not necessarily access?
48	**Table 3: C.2. Providers and technology devlopers supporting individual empowerment**	8. Call to action: Providers should welcome and use information from other providers to avoid duplication of tests and ensure coordinated care. 9. Call to action: Providers and health IT developers should provide a majority of individuals/caregivers the ability to contribute as needed to their electronic health information and support the incorporation of patient-generated health data.	Public health supports individual access to data, however, standards are needed to ensure uniform authentication and authorization for on demand record requests. Furthermore, individual record requests should be done through health record systems and not public health systems – though, public health entities should provide consistent access to aggregate data whenever possible. Standards for patient generated data need to be in place to protect the integrity of the clinical data, and corrections to clinical data based on patient generated information should be made in a patient's health record to ensure that corrected information also populates external systems (e.g., immunization registries, laboratory

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			information systems, etc.).
52	**Table 4**	D2. Providers embrace a Culture of Interoperability and work with vendors and other supporting entities to improve interoperability	In the past, providers have both allowed vendors to drive implementation and interoperability strategies. We hope that these strongly worded calls to action will encourage providers to both take an active role in their health IT implementations and also provide them with language and resources to hold their vendors to the highest standards. We would also encourage a broader concept of those who work with vendors, and explicitly include mention of provider organizations, health delivery systems, and health purchasers. Providers are not solely responsible and while the Roadmap does mention other supporting entities, it would be beneficial to provide a broader range of examples beyond providers.
56	**Ubiquitous, Secure Network Infrastructure**	Background and Current State: Encryption of data is a second component of a ubiquitous, secure network infrastructure. Encryption is a method of scrambling or encoding data, so that it cannot be read without the appropriate key to unscramble the content."	Is ONC saying this is the only method or "gold standard" of protection/security?
56	**Ubiquitous, Secure Network Infrastructure**	A learning health system's cybersecurity program encompasses, but is not limited to, the following:	We interpret and recommend that a learning health system includes trust community organizations.
59	**Verifiable Identity and Authentication**	Background and Current State: …the health care industry has not standardized its LOA requirements	We appreciate ONC acknowledging the inconsistent applied methods and criteria for identify proofing and authentication in the healthcare

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
	of All Participants	for identity proofing and authentication. The lack of consistently applied methods and criteria for both identity proofing and authentication has significantly hampered the exchange of data across organizations. For example, Direct was intended to work much like email and lower the barrier for exchange for providers and hospitals by eliminating the need for complex legal agreements between individual organizations. However, many health information service providers (HISPs) have different identity proofing and authentication policies and requirements. Or, HISPs may not acknowledge the identity proofing and authentication undertaken upstream by another organization. This variation has led to the creation of multiple trust organizations and individual agreements between organizations. Ultimately, providers and hospitals are limited to exchanging data only with those individuals or organizations with whom they (or their HISP) have created an agreement. In a learning health system, in contrast, the providers and hospitals should exchange with any other provider or hospital appropriately identity proofed and authenticated and especially with providers or hospitals that a patient directs them to share with.	industry. We appreciate ONC acknowledging that Direct was intended to work much like email and lower the barrier for exchange for providers and hospitals by eliminating the need for complex legal agreements between individual organizations. We strongly encourage ONC to address activity that goes outside the intent with appropriate advocacy and policy levers. Given Direct was seen as a means to lower the barrier for exchange, we support HISP policies that allow organizational level identify proofing and authentication. HISP efforts that require individual level identity proofing and authentication are cost-prohibitive and do not align with the intention of Direct.
60	**Verifiable Identity and Authentication of All Participants**	Background and Current State: Additionally, HITPC's recommendations have strongly encouraged providers to use multi-factor authentication for provider remote access to PHI and for patient access to patient portals." Based on the NSTIC's work, as well as	The Background and Current State assessment includes the use of trust organizations. It is unclear if this section is advising entities that are currently in trust organizations to look to moving to multi-factor authentication instead of relying on

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
		wide agreement across various sectors (financial, health, defense, etc.), multi-factor authentication and solid identity proofing process have been acknowledged as the new norm.	trust organizations. Also, unclear from ONC narrative if there is an anticipated time in the future when multi-factor authentication will be more widely in place.
60	**Verifiable Identity and Authentication of All Participants**	Moving Forward: To prepare, the nation can take some simple steps to pave the way today: establish common identity proofing practices at the point of care; require multi-factor authentication for all patient and provider access to health IT systems in a way that aligns with what is required in other industries; leverage existing mobile technologies and smart phones to provide efficient, effective paths for patient or provider identity authentication; and integrate the RESTful approaches to authentication in anticipation of that vision of tomorrow.	Within this context, it is unclear who would be the responsible party or governing body for this component. In specific: • Which industry? Cell phone? Software? • What technology? • Who is the identified user(s)? This section appears to rely heavily on the private sector engaging in and directing these steps. Is this the intention of ONC? Or is this envisioned as shared between public and private sector. We would see this process moving forward with the involvement of both public and private sectors, with a role for ONC in facilitation and assuring that all players are brought to the table, including States.
61	**Table 6**	Critical Actions for Verifiable Identity and Authentication of All Participants	This section could benefit from the addition of a component in looking at provider input and workflow in order for this to be practically applied.
62	**Consistent Representation of Permission to Collect, Share And Use**	Background and Current State: The success of health IT and interoperability is dependent on individuals' trust that their health information will be kept private and secure and that their rights with respect to this information will be	Though this section focuses on the individual, it might be pertinent to add that this is also dependent on providers and organizations: having the capacity to fully explain the utilization of personal health information in HIT; feeling confident

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
	Identifiable Health Information	respected."	that IT products, services, and policies are capable of keeping information secure; and that they understand the regulations under which they can/cannot share information.
65-66	**Consistent Representation of Permission to Collect, Share and Use Identifiable Health Information**	Basic Choice v. Granular Choice: "Basic choice" is the choice an individual makes about the use and disclosure of their health information generally, including electronic exchange of health information that is not subject to heightened use and disclosure restrictions under state or federal law. "Granular choice" refers to the choice an individual makes to share specific types of information, including (1) information that fits into categories to which, by law, protections in addition to HIPAA apply; (2) the choice afforded an individual based on their age; and (3) the choice to share health information by specific provider or payer types.	This section is good to simplify HIPAA disclosure "categories" to make it digestible for everyone. However, ONC should include some language in this roadmap to make expressly clear that this is not the terminology that is used in regulations. Stakeholders have already expressed much confusion in this area. This section could use a clearer introduction because it does not flow well from the FIPPs section immediately prior.
67	**Consistent Representation of Permission to Collect, Share and Use Identifiable Health Information**	Moving Forward: To ensure consistent… In particular, the following three areas of policy will require attention before addressing technology standards to capture, communicate and process individual choice across the learning health system:	This section only has 2 numerals for the "three areas" of policy. It looks like the "third" area of policy is the standardization of the meaning of sensitive health information laws.
69	**Table 7**	G2 and G3	There aren't provisions to create guidance for the public regarding

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			alignment of policies. Does this fall on stakeholders to provide this guidance? In G3 – there is not an action item for ONC to facilitate the alignment of regulations and policies for electronic health information that is protected by laws in addition to HIPAA. As written, it appears that stakeholders and state governments are on their own to promulgate this action. It is important to consider that state public health policies and legislation may dictate what is required to be both reported and maintained. Individuals may be unable to opt out of both "basic" and "granular" choices based on local laws. Federal stakeholders, and non-public health stakeholders should be mindful of potential conflicts.
70	**Table 7**	G4 and G5	These activities in the 2015-2017 column and 2018-2020 are aggressive for these time periods.
73	**Table 8**		In this table, there is no activity that addresses the "diverse legal and regulatory environment" identified in the first paragraph on page 72. This needs to be addressed if an "Authorization Framework" (as identified on Page 72, second paragraph) is to be realized.
76	**Table 9**	I2 - 5: ONC and other industry certification programs will focus on including more stringent testing such as scenario-based testing and post-implementation testing to ensure interoperability while health IT is in use.	Post-implementation testing seems critical to ensure that interoperability standards are implemented by vendors, rather than meeting the bare requirements for certification. Our experience with stakeholders has

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			identified a discrepancy between the functionality 'advertised' by 2014 CEHRT and that which is truly available to an end-user (e.g. QRDA). Our assumption is that this could be impacted by the support models that each vendor has in place as well as characteristics of the end-user (e.g., large vs. small organizations and their respective IT capacity), but smaller practices may be purchasing CERHT and not realizing how much additional effort is needed to get the 'out of the box' product to support these standards.
76	**Table 9**	I1 – 1: ONC, NIST and other health IT stakeholders will provide testing tools necessary to support the criteria in ONC's certification program.	Are the testing tools referenced here in addition to the tools already provided by ONC that support the criteria in ONC's certification program? Who are the tools for?
76	**Table 9**	I2 - 2: Other existing industry certification programs will continue to complement ONC's Certification program to ensure that different aspects of HIT conform to the technical standards necessary for interoperability.	It would be helpful moving forward to understand in a more granular way what the ONC's plan is to hold vendors accountable to conforming to the technical standards necessary for interoperability.
76	**Table 9**	I1. Testing Tools and I2. Certification programs	Certification and testing processes are detailed enough to support interoperability. Certification assumes that a product has demonstrated successful testing, such that during implementation the amount of customization is limited to inclusion of optional attributes and variations in local requirements. We encourage ONC to continue working with public health and NIST

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			to develop appropriate test suites for public health interoperability.
82	**Consistent Format: C-CDA**	Moving Forward and Critical Actions: HL7's Fast Healthcare Interoperability Resources (FHIR) effort is one that is emerging and exploring ways to accommodate new methods of exchanging information.	Would like to understand where ONC sees this effort going and the impact on Direct secure messaging "critical mass" (page 90)?
84	**Table 10. J1.**	4) ONC will annually publish an updated list of the best available standards and implementation specifications.	ONC should work closely with CDC and national public health organizations to minimize local variations in implementation specifications. While many programs have adopted nationally supported standards as the base of their guides, there are many local modifications. While many of these specifications denote optional versus required elements, vendors have had the authority to pick and choose how to implement the specifications. We encourage ONC to convene public health authorities and their partner organizations to work toward reducing discrepancies between standards.
85	**Table 10.**	J3. Develop and pilot new standards for priorities J4. Vocabulary approach J5. Maintain and improve standards J6. New standards that support new and evolving requirements and priorities	We support the ONC's commitment to working with stakeholders across the ecosystem to pilot new formats and standards, while retaining existing standards when appropriate. We encourage the ONC to include a timeline for deprecation of locally maintained (i.e., not nationally recognized) code sets for public health reporting, including adoption and use of NPI for providers. We encourage the ONC to include

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
			public health stakeholders to discuss natural language processing as appropriate so that even unstructured data can be treated more systematically across the ecosystem.
90	**Table 12. L2**	1) Public health agencies should converge on the use of standardized web services to support data submission as well as data query from registries and other systems. 2) Providers (including hospitals, ambulatory providers, long-term care centers and behavioral health providers) should adopt and use DIRECT to reach critical mass.	We strongly support the use of standardized web services to support both data submission as well as query data. The immunization registry community has demonstrated that providers value the immediate clinical decision support offered by the real-time exchange of data. We continue to be concerned with the embracing of DIRECT as a standard for public health because it does not support real-time bidirectional data exchange, a use case critical for IIS-EHR interoperability. We will continue to explore the use of DIRECT for other public health use cases, and ask that ONC partner with data integration stakeholders like Orion and Mirth to develop easy to implement platforms that can integrate with existing public health data exchange strategies (e.g., replacing sFTP, PHINMS integration).
90	**Table 12. L3.**	4) Health IT developers should widely implement national standards for query. 5) Health IT developers should widely implement national standards for publish/subscribe. 6) Health IT developers should implement national standards for	We agree with the recommendation to implement national standards for query, and encourage ONC request input from Public Health, particularly the IIS community, as well as the EHR vendor community on the inclusion of SOAP vs. REST. Ideally, only one preferred web service standard would be recommended and

Page	Section	Phrase/paragraph from Plan	Comment/Recommendation
		RESTful web services as they are available.	supported.
94	**Table 13**	1) ONC and SDOs should standardize the minimum recommended data elements to be consistently included in all queries for patient clinical health information, and to be used to link patient clinical health information from disparate systems. 5) Health IT developers should reliably include standardized data elements in exchange transactions. 9) Providers and health IT developers should use best practices for data quality and algorithms to enhance identity matching accuracy in a majority of identity matching services.	We support both the adoption of a minimum data set for both query and submission of patient level data. We agree with the proposed list of data elements, and encourage the ONC to consider adoption of a national health identifier. We encourage ONC to review an deduplication/patient matching report conducted by the IIS community: http://www.cdc.gov/vaccines/programs/iis/interop-proj/downloads/de-duplication.pdf We also encourage ONC to look outside the health system environment for innovative solutions for individual data matching.
98	**Reliable Resource Location**	Moving Forward - Reduce Duplicate Data Entry: Allowing for two-way sharing of data between NPPES and other CMS system such as PECOS, the provider enrollment system for Medicare.	Will there also be opportunities for state systems to leverage two-way sharing of data with NPPES?
100	**Table 14**	N1. Development of New Architecture and Standards - 4: Through coordinated governance, public and private stakeholders should prioritize the participants and services that are to be discoverable using resource location and identify a near-term goal for the first small set of resources to be included in an initial implementation.	Is this referring to a national implementation of a national directory? Perhaps a set of smaller scale pilots will help inform the implementation?
101	**Table 14**	N2. Refinement and Adoption of Standards and Best Practices – 1: As an interim step, ONC will work with others to encourage initial uptake of current provider directory activities	We encourage ONC to work with organizations and states on the initial uptake and governance of provider directories by providing technical assistance.

			We support ONCs commitment to the development and adoption of national standards for locating participants and resources. Public health agencies have long struggled with how best to manage provider directories within their various systems and have looked toward our state and federal partners to provide guidance on how to and who should maintain up to date and accurate information. We look forward to partnering with ONC as they lead this charge.
101	**Table 14**	N2. Refinement and Adoption of Standards and Best Practices – 3: CMS/HRSA/OIG should advance the proposed effort to consolidate/synchronize national credentialing support systems	Oregon is currently working on a statewide common credentialing project that is comprised of a program and database to provide credentialing organizations access to information necessary to credential or re-credential all health care practitioners in the state. Implementation is expected during the 2016-2017 timeframe. We expect the data to populate another state project, a statewide provider directory. We would like to suggest aligning the state program(s) with the national efforts.
106	**Figure 12**	"Information Flow and Usage" column	Many of these items are challenging to measure in a meaningful way (e.g., availability of information, easily)
106	**Figure 12**	"Impacts"	The items in this column do not seem to be measures.
107	**Measuring the Flow and Use of Interoperable Information**	Interoperability of Data and Systems: "downstream" uses	Please define. Unclear how the example provided fits the definition.
109	**Gaps in Measurement**	Measures should possess some key characteristics…	We appreciate ONC highlighting this list of important characteristics. It will likely be particularly challenging to ensure that the measures are "objectively measureable and quantifiable".
112	**Table 15**	4) Data holders, entities that	We appreciate ONC's inclusion of

		enable exchange and other key stakeholders will work with ONC to identify mechanism for reporting of key metrics, including potentially voluntarily publicly reporting at an aggregate level metrics related to exchange activity (e.g., volume and nature of exchange occurring).	metrics regarding interoperability. Many public health programs already provide this type of information to our funding agencies. We look forward to continuing to partner with our funders as well as the ONC to improve interoperability throughout our jurisdiction.
163-165	**Appendix H**	1) Public health agencies routinely use data derived from standards-based connections with HIEs and EHRs and uses it to plan investments in public health activities. 2) Clinical settings and public health are connected through bi-directional interfaces that enable seamless reporting to public health departments and seamless feedback and decision support from public health to clinical providers. 8) CEHRT should be required to provide standardized data export and import capabilities to enable providers to change software vendors. 15) Researchers are able to use de-identified clinical and claims data from multiple sources with robust identity integrity. 27) Data for disease surveillance, immunization tracking and other public health reporting are exchanged automatically. 29) Query-based exchange should support impromptu patient visits in all settings. 35) Individuals have electronic access to an aggregated view of their health information including their immunization history.	We support these public health and population health use cases and encourage ONC to continue collaboration with public health stakeholders to develop standards for testing each of these. We look forward to collaborating as these use cases are refined. We recommend the abbreviated list presented here be prioritized for public health, and while we understand prioritization of the full list will include other stakeholders, we'd like to see this list prioritize as follows: 2 27 29 8 35 44 50 15 1

		44) Providers have ability to access information in PDMP systems before prescribing narcotics to patients. 50) Population health measurement is supported at the community level and includes data from all relevant sources on each patient in the population (including information on births, deaths and occupational health hazards) and is accessible to providers and other population health stakeholders.	

Oregon Health Authority's comments on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3; 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Proposed Rules

General Comment Summary:

Overall, the Oregon Health Authority's Office of Health Information Technology finds the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3; 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Proposed Rules useful for outlining the expectations for meaningful use Stage 3 and setting the stage for a facilitated, more streamlined approach. Oregon relies on the meaningful use program to incentivize investments in health information technology. We have concerns about the balance between the added value in the adoption and utilization of this technology; and the resource burden and (at times significant) challenges to meeting the meaningful use requirements. If we do not strike the right balance between value and burden, providers will opt out of the meaningful use program. This could undo the progress made to date.

We support the overall approach to updating meaningful use in the NPRM. We agree with the change to 90-day EHR reporting period for 2015, and support CMS' approach to streamline the criteria for Stage 3 by creating a single stage of meaningful use that is optional in 2017, thereby allowing some providers to report at Stage 2 for an additional reporting period, and having Stage 3 required for all providers in 2018. The institution of intermediary steps to achievement of Stage 3 in 2018 will allow providers to use products certified to different years and allow for some choice in where they will participate for the program year. This could enable more effective program support and permit flexibility while raising the bar for achievement. We also support proposing certification programs that include expanded types of health IT, such as the provider directory.

We have heard from stakeholders, including specialists, health plans, and coordinated care organizations among others, their concerns regarding the increase in thresholds around patient engagement.[1] Larger practices and primary care providers may have greater flexibility and built-in patient motivation for this manner of engagement, but it is more challenging for specialists and small practices, particularly as reaching the previous 5% threshold was already a challenge. Smaller and specialty providers will face significant, specific challenges in meeting the thresholds and some fear that the information is not meaningful to their patients in that setting.

We agree with CMS's approach to retire measures that are topped out, redundant, or duplicative. In Oregon for example, 92 % of the time smoking status was completed. This will allow providers to sharpen focus on those measures that are more challenging to reach, rather than dividing time between tracking measures that no longer hold meaning.

With Oregon's investments in a state Clinical Quality Measure Registry (CQMR), we are very interested to see the potential changes to the clinical quality metrics anticipated to be published in the Physicians

[1] See summary of Oregon's May X, 2015 HITOC ad hoc meeting with stakeholders on the CMS and ONC NPRMs: http://www.oregon.gov/OHA/OHPR/HITOC/Pages/Meeting_Materials.aspx

Fee Schedule (PFS) later this summer. We are pleased to see CMS' continued efforts to align quality reporting programs, timelines, and measures.

We strongly support the intent of the Health Information Exchange (HIE) Objective. However, we have some concerns that the Consolidated Clinical Document Architecture (C-CDA) has not been standardized. We do commend ONC for proposing a set of criteria for the summary of care document, the Common Clinical Data Set, and accompanying standards in the 2015 Edition proposed rule. We would like to emphasize that it is critical to address this area so as to not lose the purpose of this Objective.

Our goals are for coordination of care across the whole community of health care. We have on-going concerns that non-eligible professionals' (Non-EPs) exclusion from the incentive program creates a significant gap. It is challenging to coordinate across the entire continuum of care, particularly for behavioral health and long term care providers, as Non-EPs continue to lack access to incentives for investing in standards-based EHRs.

We believe that the intent of the HIE Objective, to ensure that information contained within a summary of care record from an outside source can be transmitted and then incorporated into a CEHRT, is appropriate and in sync with the current goals of interoperability and care coordination. Given significant interoperability challenges that we've seen with the interoperability of CCDs so far; the lack of meaningful, usable information in some cases; and significant questions around capability to accurately track and measure the ingestion/incorporation of CCDAs sent; the proposed thresholds seem quite high. To jump from the current threshold, which is already difficult to reach for many EPs and EHs, to a much higher threshold in the future, is incredibly challenging. Achieving this threshold at even the current level is a heavy lift that requires a solid provider directory, true interoperability, and a practical method to accurately determine if the measurement has been met. We would recommend that the threshold be reconsidered, and that CMS focus on refining the components that work together to reach this measure.

There is consternation over including clinical data registry (CDR) reporting as a measure for the public health objective. As written, providers must attest to three measures and can select up to three CDRs to meet this requirement. While CDRs are important, they are rarely used for public health surveillance and seldom accessible to public health agencies. We encourage CMS to consider the CDR measure as distinct from public health, or at a minimum, allow these as options only if actual public health measures cannot be met. Oregon's Public Health Department will submit detailed comments on this issue separately and we refer you to those comments.

CMS states that HIPAA Security Rule and 42 CFR part 2 fall outside of the scope of the rulemaking and recommends that interested parties consult with SAMHSA for answers. We are supportive of the clarification around the privacy and security measures made in the NPRM, however 42 CFR part 2 has been and remains a significant barrier to interoperability, information exchange, and care coordination, and needs to be addressed. While CMS states that the application of the rule is narrow, EPs and EHs cannot ignore the implications of privacy of data for behavioral health information. Oregon's health care community has found that existing guidance is insufficient. We encourage a coordinated effort across CMS, ONC, and SAMHSA to better support healthcare stakeholders across the country struggling with 42 CFR part 2 to deliver whole-person coordinated care.

We appreciate and commend the recent federal efforts to provide a clear and further streamlined approach for the implementation of meaningful use and the incentive program. We will continue to look to HHS and CMS for guidance to ensure continually aligned efforts in Oregon.

About the Oregon Health Authority's Office of Health Information Technology:

The Oregon Health Authority's Office of Health Information Technology (OHIT) was established in 2011 as a part of the state's health agency to support the adoption of electronic health records, the secure exchange of health information, and supporting meaningful use initiatives in the state. OHIT is a resource for both state programs and other public and private users of health information, providing planning, coordination, policy analysis and the development of public/private partnerships to further health IT in Oregon. Health IT is a key part of Oregon's efforts to create a system of better health, better care and lower cost for all Oregonians.

Specific Comments:

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
16739	**(i) Calendar Year Reporting**	We are proposing to change the definitions of "EHR reporting period" and "EHR reporting period for a payment adjustment year" under 495.4 for EPs, eligible hospitals, and CAHs such that the EHR reporting period would be one full calendar year…"	We agree that the program will be further simplified by transitioning hospitals from reporting on the federal fiscal year to the calendar year, beginning in 2017.
16740	**(ii) Eliminate 90-day EHR Reporting Period**	"...we propose to eliminate the EHR reporting period of any continuous 90 days for EPs, eligible hospitals, and CAHs that are demonstrating meaningful use for the first time".	We are concerned that Medicare and Medicare Advantage EPs and eligible hospitals that are attesting to meaningful use for the first time must meet measures based on a full calendar year rather than a 90-day EHR reporting period starting in 2017 and for Medicaid providers in 2018. This proposed change does not allow first time meaningful users any room for error or growth and further alienate providers that are not on board with meaningful use. While we support allowing Medicaid providers a 90-day reporting period in 2017, we believe this policy should extend to all new participants in their first year of the EHR incentive programs in the remaining program years.
16742	**(b) Electronic Versus Paper-Based Objectives and Measures**	"We are simply proposing that paper-based formats would not be required or allowed for the purposes of the objectives and measures for Stage 3 of meaningful use"	We agree that paper-based formats should not be required or allowed to meet Stage 3 meaningful use. Providers have told us that they have had to purchase an extraordinary amount of paper to meet various MU measures such as transitions of care (for receiving faxes) and patient summaries.
16743	**(d) Flexibility Within**	"We are proposing to incorporate flexibility within certain objectives	We support the proposal to require reporting and agree with

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
	Meaningful Use Objectives and Measures	proposed for Stage 3 for providers to choose the measures most relevant to their unique practice setting…"	only having to meet the thresholds for: • 2 of the 3 Coordination of Care through Patient engagement measures • 2 of the 3 HIE measures This will help certain providers who cannot meet the thresholds of measures due to patient population, settings, etc.
16747	**Objective 2: Electronic Prescribing**	"Proposed EP measure: More than 80 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT"	Based on current averages for Oregon providers for Stage 1, we believe increasing the threshold to 80% is appropriate for Stage 3.
16748	**Objective 2: Electronic Prescribing**	"We also propose to maintain for Stage 3 the exclusion from Stage 2 if no pharmacies within a 10-mile radius of an EP's practice location at the start of the EHR reporting period accept electronic prescriptions (77 FR 53990). This is 10 miles in any straight line…"	The exclusion clarification should be based on either a straight line or travel route. For rural providers who struggle with meeting MU for some measures, a more flexible interpretation should be allowed.
16750	**Objective 3: Clinical Support**	CMS and ONC are committed to harmonizing the quality improvement ecosystem, refining and developing outcome measures, and aligning standards for CDS and quality measurement. Work is underway in the ONC Standards and Interoperability Framework to align and develop a shared quality improvement data model and technical expression standards for both CDS and quality measurement. Upon successful completion, such standards may be considered for inclusion in future quality measurement and certification rulemaking.	OHA is appreciative of the strengthened connection of CQMs to CDS. We are looking forward to seeing the outcome of the discussion from the ONC's Standards and Interoperability Framework.
16750-1	**Objective 4: CPOE**	"In Stage 3, we propose to continue the policy from the Stage 2 final rule at 77 FR 53986 that orders	We support the ability for entries by qualified individuals, including scribes.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		entered by any licensed healthcare professional or credentialed medical assistant would count…"	
16752-3	**Objective 5: Patient Electronic Access to health information**	"We are also proposing to expand the options through which providers may engage with patients under the EHR Incentive Programs. Specifically, we are proposing an additional functionality, known as application-program interfaces (APIs), which would…."	We support the use of APIs to meet the patient access to health information objectives. Currently, patients have to sign up for multiple portals to have access to their health information from disparate providers. Having the ability to have all information collected and incorporated in a single access point will simplify and add an element of control from the patient's perspective. We have heard concerns from stakeholders regarding an increase in security risks as a result of greater API utilization—particularly for smaller practices or those without sufficient resources for continuous monitoring of the system to ensure that breaches have not occurred. So, while the greater flexibility that API could bring is valued, there are concerns as well.

16754	**Objective 5: Patient Electronic Access to Health Information**	We note that for this objective, the provider is only required to provide access to the information through these means; the patient is not required to take action in order for the provider to meet this objective. In the Patient Electronic Access to Health Information objective, we note that "provides access" means that the patient has all the tools they need to gain access to their health information including any necessary instructions, user identification information, or the steps required to access their information if they have previously elected to "opt-out" of electronic access. If this information is provided to the patient in a clear and actionable manner, the provider may count the patient for this objective.	We applaud the move to providers only being required to provide access to the information, and no longer being penalized if patients do not take action. However, we question the feasibility of measuring that patients were provided access through the definition provided. What is meant by access and what would be an auditable definition of 'clear and actionable'?

16754	**Objective 5: Patient Electronic Access to Health Information**	We are proposing a continuation of the exclusion in Stage 2 for both EPs and eligible hospitals/CAHs in that any EP, eligible hospital, or CAH would be excluded from the first measure it if is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period. We continue to recognize that in areas of the country where a significant section of the patient population does not have access to broadband internet, this measure may be significantly harder or impossible to achieve. Finally, we propose an additional exclusion for EPs for Stage 3, that any EP who has no office visits during the EHR reporting period may be excluded from the measures. We encourage comments on these exclusions and will evaluate them again in light of the public comments received.	We agree with an exclusion based on the availability of broadband at a sufficient speed. However, this does not take into account disparities that may exist between towns or areas within a county, particularly a county that is large in area but small in population. Depending on provider location and population of patients, even in counties where 50% have availability, this may still be challenging to meet. Oregon has providers who serve in very large rural areas with inadequate broadband access that struggle to meet the thresholds for meaningful use. However, in our experience so far, none of the counties meet the 3 Mbps exclusion. We cannot tell if the 4 Mbps exclusion would impact any providers because this information is not yet available from the FCC. We agree with the exclusion for EPs who do not see anyone during the subject period. We would recommend consideration for a higher number than zero. Should a provider see only a few patients, this greatly increases the pressure on the provider to ensure that these limited patients have access to and are comfortable using the electronic system.
16754	**Objective 5: Patient Electronic Access to health information**	"We propose to increase the threshold for measure 1 from the Stage 1 and Stage 2 threshold of 50 percent to a threshold of 80% for Stage 3." "…we further propose to decrease patient wait time for the availability	We are concerned that the higher threshold for this measure and the 24-hour wait time are too aggressive for Stage 3. Allowing one or a two-business day availability would provide a better approach.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		of information to within 24 hours of the office visit…"	
16755	**Objective 5: Patient Electronic Access to Health Information**	We believe the current view, download, and transmit functions are widely in use and represent the current standard for patient access to their health record. However, we believe that the use of APIs could potentially replace this function and move toward a more accessible means for patients to access their information. Therefore, we are seeking comment on alternatives which would present a different mix of CEHRT functionality for providers to use for patients seeking to access their records. … Specifically, we are seeking comment on whether the API option should be required rather than optional for providers, and if so, should providers also be required to offer the view, download, and transmit function.	Providing options can be very beneficial. We would recommend continuing to have the API as optional rather than required. Providers who see the benefit in adoption of API for themselves and their patients could choose to engage an API. It is easier to increase adoption when people see the value in the tool. There have also been concerns expressed by stakeholders regarding the level of security with API—and whether or not smaller practices have the resources available to ensure appropriate levels of security on a daily basis with the utilization of APIs.
16755	**Objective 5: Patient Electronic Access to Health Information Alternate proposals**	We are also proposing to expand the options through which providers may engage with patients under the EHR Incentive Programs. Specifically, we are proposing an additional functionality, known as application-program interfaces (APIs), which would allow providers to enable new functionalities to support data access and patient exchange(page 16755) These three alternate proposals would represent different use cases for the CEHRT function to support view, download, and transmit and/or API functionality. We note that under these proposed alternates the following mix of functions would be applicable: Alternate A would require both functions to be available instead of allowing the provider to choose	We believe Alternate A would be the best option but are concerned about the significant investments already made by providers for their portals. While we believe APIs are a solid approach for patient access to their information, providers have already made investments into their portals that are working successfully. Allowing disconnected portals to continue however, may not be optimal for a streamlined approach for patients in the long-run. While a need for "additional flexibility" (page 16753) is referenced, it isn't clear what benefits will be provided to patients and providers by an API beyond those currently provided by patient portal technology.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		between the two; Alternate B would require the provider to choose to have either both functions, or just an API function; and Alternate C would require the provider to only have the API function. For Alternate C, the use of a separate view, download, and transmit function would be entirely at the provider's discretion and not included as part of the definition of meaningful use. We welcome public comment on these proposals. (pg 16755)	If we need to select an option, we would choose A. However, we believe that due to the burden on providers, API should be optional, not required.
16756	**Objective 6: Proposed Objective—Use communications functions of CEHRT to engage with patients or their authorized representatives about the patient's care Proposed Measure 1**	"Proposed Measure 1: During the EHR reporting period, more than 25% of all unique patients seen by the EP or discharged from the eligible hospital or CAH …actively engage with the electronic health record made accessible by the provider."	We are concerned that the threshold is too high (raising from an already difficult 5% for some providers) for the variety of EP types under the EHR incentive program. Some specialists may run tests that patients will want to access, while others do not have information that patients are necessarily compelled to view. Requiring a provider in the latter group to meet a 25% threshold would be difficult if not impossible to meet leaving the provider forced to meet the thresholds for the two remaining measures.
16756	**Objective 6: Coordination of Care Through Patient Engagement, Proposed Objective**	Overall: Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patients care.	We agree with and thank CMS for this expansion of methods through which providers may engage with their patients, including the use of APIs. We have further, more specific comments and concerns in regards to APIs.
16756-7	**Objective 6: Proposed Objective—Use communications functions of**	"Patient generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15% of all unique patients seen by the EP or	We agree with including a broad range of information including social service data, data generated by a patient or a patient's authorized

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
	CEHRT to engage with patients or their authorized representatives about the patient's care Proposed Measure 3	discharged by the eligible hospital or CAH inpatient…"	representative, advance directives, medical device data, home health monitoring data, and fitness monitor data. We are concerned however, that as a new measure, 15% is too high of a number to meet and instead use a measure of 1 or recommend more.
16757	**Objective 6: Coordination of Care Through Patient Engagement**	…we seek comment on how this action could be counted in the numerator, and the extent to which that interaction could or should be counted for eligible providers engaged in the communication. For example, should only the initiating provider be allowed to include the communication as an action in the numerator? Or, should any provider who contributes to such a message during the EHR reporting period be allowed to count the communication?	It would seem that overall utilization of secure messaging is the goal, and so allowing all providers, regardless of whether they initiate or respond, to count their communications in the numerator would make sense.
16757	**Objective 6: Coordination of Care Through Patient Engagement**	…we seek comment on what should be considered a contribution to the patient-centered communication; for example, a contribution must be active participation or response, a contribution may be viewing the communication, or a contribution may be simple inclusion in the communications.	In looking at what should be considered a contribution to patient-centered communication, we feel that at a minimum, viewing the communication is a direct contribution to patient-centered communication. Inclusion is insufficient to meet the intention of patient-centered communication or moving secure messaging forward.
16758	**Objective 6: Use communications functions of CEHRT to engage with patients or their authorized representatives about the patient's care**	"any EP, eligible hospital, or CAH would be excluded from the first measure if it is located in a county that does not have 50% or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period."	See comment on Objective 5 Patient Access to Electronic Health Information, page 16754
16758	**Objective 7: Health**	"For more than 40% of transitions or referrals received and patient	We agree that the information received from others should be

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
	Information Exchange Proposed measure 2	encounter in which the provider has never before encountered the patient, the EP, eligible hospital, or CAH incorporates into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system."	incorporated and measured as a meaningful use measure. We support the provider being able to exclude patients in the denominator where an electronic summary of care record was requested but not received or at least one external source was queried using HIE functionality and did not locate a summary of care document for a patient (or the provider does not have access to the HIE functionality). However, especially in earlier years of reporting Stage 3, providers may have a very difficult time meeting the 40% threshold and we recommend lowering the threshold to 25%.
16758	**Objective 6: Coordination of Care Through Patient Engagement, Proposed Objective**	Question: Should there be structured data elements available for this data as fields in the EHR?	If it is determined that there should be structured data elements available for this data as fields in the EHR, please ensure that the standards and specifications align with the C-CDA structures being assessed by the 2015 Interoperability Standards Advisory and are able to be exchanged using Direct.
16759	**Objective 6: Coordination of Care Through Patient Engagement, Proposed Objective**	Proposed Objective: The EP, eligible hospital, or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of certified EHR technology. We note that for a transition or referral to be included in the numerator, if the receiving provider already has access to the CEHRT of	We are looking for a clearer definition of what constitutes a transition or referral.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		the initiating provider of the transition or referral, simply accessing the patient's health information does not count toward meeting this objective.	
16761	**Objective 7: Health Information Exchange**	Specifically we seek comment on whether providers who create a summary of care record using CEHRT for purposes of Measure 1 should be permitted to send the created summary of care record either—(1) through any electronic means; or (2) in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.	This is ambiguous as the governance mechanism has not yet been established for the nationwide health information network.
16761	**Objective 7: Health Information Exchange**	We additionally seek comment on whether providers who are receiving a summary of care record using CEHRT for the purposes of Measure 2 should have a similar requirement for the transport of summary of care documents requested from a transitioning provider.	Transport requirements and specifications should be standardized for all exchanges. This ensures interoperability between CEHRTs and health information service providers (HISPs).
16761	**Objective 7: Health Information Exchange**	We seek comment on whether electronic alerts received by EPs from hospitals when a patient is admitted, seen in the emergency room or discharged from the hospital—so called ''utilization alerts''—should be included in measure two, or as a separate measure. Use of this form of health information exchange is increasingly rapidly, driven by hospital and EP efforts to improve care transitions and reduce readmissions.	We support the use of utilization alerts in care coordination efforts, but want to ensure that existing investments at the state and regional levels are incorporated into the standard and objectives. The ability for users to configure alerts is critical to avoid "alert fatigue." We would like more detail about what a MU measure would include.
16761	**Objective 7: Health Information Exchange**	We also seek comment on which information from a utilization alert would typically be incorporated into a patient's record and how this is done today.	Utilization alerts in Oregon are pushed from a data system to hospitals. Hospitals are free to incorporate information into the patient's record as they choose, but many are just receiving alerts

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
			through secure fax or printer and not incorporating this information into the EHR. Users can manually add information into the system including care recommendations, care history, history of behavioral health or substance use issues, etc. Some hospitals are able to simply push the same information contained in their EHR into the system, while others are beginning to explore this option.
16762	**Objective 7: Health Information Exchange**	"any EP, eligible hospital, or CAH would be excluded from the first measure if it is located in a county that does not have 50% or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period."	Oregon has providers who serve in very large rural areas with inadequate broadband access that struggle to meet the thresholds for meaningful use. However, in our experience so far, none of the counties meet the 3 Mbps exclusion. We cannot tell if the 4 Mbps exclusion would impact any providers because this information is not yet available from the FCC.
16763	**Objective 8: Public Health and Clinical Data Registry Reporting**	Active Engagement Option 3—Production: The EP, eligible hospital, or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.	We would like clarification on what it means to be "electronically submitting" to the PHA or CDR. Does the PHA or CDR have discretion over "electronically submitting" when there are providers that have achieved e-submission at one point but later are unresponsive to PHA/CDR requests when there are issues with the data or do not submit on the agreed upon schedule?
16764	**Objective 8: Public Health and Clinical Data Registry Reporting**	For EPs, we propose that an exclusion for a measure does not count toward the total of three measures. Instead, in order to meet this objective, an EP would need to meet three of the total number of measures available to them. If the	This objective can be difficult for providers to meet when exclusions do not count towards meeting the measure. We are concerned that the provider may end up meeting an exclusion for a measure they were planning on

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than three, the EP can meet the objective by meeting all of the remaining measures available to them and claiming the applicable exclusions. Available measures include ones for which the EP does not qualify for an exclusion.	reporting (e.g., immunizations measure where they did not administer immunizations in a 90-day EHR reporting period), thus placing the provider in the position of needing to register and report to another PHA or CDR that they weren't planning on reporting. We support CMS work to develop a centralized registry of available CDRs and PHRs so that providers can plan for reporting to more registries.
16766	**Objective 8: Public Health and Clinical Data Registry Reporting**	"For the purposes of meaningful use, 'public health registries' are those administered by, or on behalf of, a local, state, territorial, or national public health agencies; and 'clinical data registries' are administered by or on behalf of, other non-public health agency entities."	We would like to have further clarification on the definition of a CDR. For example, Oregon is working on the development of a Clinical Quality Metrics Registry which will collect CQMs for our Coordinated Care Organizations as well as for the administration of the Medicaid EHR incentive program. Reporting to clinical data registries, which are outside of the state systems, will be difficult and burdensome for the state to count and verify attestations. We agree that clinical data registries are important and would be interested in solutions that minimize the administrative burden for the Medicaid EHRIP.
16768	**B. Reporting on Clinical Quality Measures Using Certified EHR Technology for EPs, Eligible hospitals, and Critical Access Hospitals**	"Therefore, it is our goal to align the reporting requirements for the CQM component of meaningful use under the Medicare EHR Incentive Program and for PQRS wherever possible…"	We support streamlining and reporting wherever possible. Our providers have told us about the burdens for reporting measures that are often times the same in all respects except for either a few small reporting distinctions or reporting time frames. We suggest CMS consider requiring all providers to report CQMs for

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
			the entire calendar year, even Medicaid providers that are reporting MU in their first year. We also feel all providers reporting MU in their first year should be able to retain the 90-day EHR reporting period for the MU objectives and measures that carry thresholds to meet. CQMs do not have thresholds and requiring a full-calendar year of data will promote a "report once" objective. Further, we also believe CQMs should be readily shared amongst affiliated programs. For example, for Oregon's Coordinated Care Organizations, providers have to report their CQMs to PQRS and again to the state. This is essentially duplicate reporting, as Oregon turns around and reports the same information collected by both PQRS and the state back to CMS. Having the ability to leverage the already reported data would further relieve burden to providers and remove duplicative reporting.
16769	**2. CQM Reporting Period**	We are proposing to require the same length for the CQM reporting period for EPs, eligible hospitals, and CAHs beginning in 2017. As noted, we are proposing a limited exception for Medicaid providers demonstrating meaningful use for the first time who would have a CQM reporting period of any continuous 90 days that is the same 90-day period as their EHR Reporting Period. We believe full year reporting would allow for the collection of more comparable data across	We are enthusiastic about program requirements that maximize opportunities for providers and hospitals to participate in the Medicaid EHR Incentive Program. However, we are also very interested in creating opportunities to collect comparable data.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		CMS quality programs and increase alignment across those programs. The more robust data set provided by a full year reporting period offers more opportunity for alignment than the data set provided by a shorter reporting period, especially compared across years. We further believe this full calendar year reporting period for CQMs would reduce the complexity of reporting requirements for the Medicare EHR Incentive Program by streamlining the reporting timeline for providers for CQMs and meaningful use objectives and measures. We welcome comment on the following proposals.	
16770	**3. Reporting Methods for CQMs**	"…we propose that states would continue in Stage 3 to be responsible for determining whether and how electronic reporting of CQMs would occur, or whether they wish to continue to allow reporting through attestation."	Oregon is in the process of developing a clinical quality metrics registry (CQMR) which will collect eCQMs for providers attesting under the Medicaid EHR Incentive Program. We anticipate the CQMR will be ready to accept eCQMs in 2018, subject to CMS approval.
16771	**5. EHR technology Certification requirements for Reporting of CQMs**	"We believe EHRs should be certified to more than the minimum number of CQMs required by one or more CQMs quality reporting programs…"	We agree with CMS that EHRs should be certified to a full set of CQMs and are looking forward to future rulemaking on this subject. Providers do not often know which CQMs they need for certification and are at the mercy of which CQMs their vendor decided to have certified and then charged to make modifications.
16771	**5. EHR Technology Certification Requirements for Reporting of CQMs**	We realize that requiring EHRs to be certified to more than the minimum number of CQMs required by the Medicare and Medicaid EHR Incentive Programs may increase the burden on EHR	OHA appreciates that CMS is considering a requirement that EHRs are certified to more than the number of minimum number of CQMs required by the EHR Incentive Program. While

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		vendors. However, in the interest of EPs, eligible hospitals, and CAHs being able to choose to report eCQMs that represent their patient populations, we would like to see EP vendors certify to all eCQMs that are in the EP selection list, or eligible hospital/CAH vendors certify to all eCQMs in the selection list for those stakeholders. We are also considering a phased approach such that the number of CQMs required for the vendors to have certified would increase each year until EHR products are required to certify all CQMs required for reporting by EPs, eligible hospitals, and CAHs.	requiring additional CQMs may place an additional burden on EHR vendors, it seems critical in order best serve the interest of EPs, eligible hospitals, and CAHs. This would increase the likelihood that providers are able to utilize CQMs and the associated Health IT functionality to successfully meet the disparate requirements of multiple quality reporting programs as well as the ability to select measures that best represent their patient populations. Additionally, an increase in CQM requirements could assist with quality program development (specifically measure selection) as there would be less variance of measure availability across EHR products. If it is too ambitious to require that EHR vendors certify to all measures, requiring a certain core set plus an additional number could go a long way in alleviating the current issues around vendor variance related to CQM availability.
16773-4	**(2) CEHRT and Stage Flexibility in 2017**	"We are seeking comment on whether those providers with fully implemented EHR technology certified to the 2015 Edition in 2017 should be required to attest to Stage 3 only in 2017."	We believe these providers should have maximum flexibility and have the option to report at stage 2 or 3 in 2017.
16773-16774	**(c) EHR Reporting Period in 2017 and Subsequent Years**	For CQM reporting in 2018 and subsequent years, as outlined in section II.B.3 of this proposed rule, we are proposing that providers participating in the Medicare program must electronically report,	We are encouraged by the fact that beginning in 2018 the on-going expectation is that CQMs will be reported electronically and that attestation to CQMs will no longer be an option except in

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		where feasible, and that attestation to CQMs would no longer be an option except in circumstances where electronic reporting is not feasible. This would include providers facing circumstances which render them unable to electronically report (such as a data submission system failure, natural disaster, or certification issue outside the control of the provider) who may attest to CQMs if they also attest that electronically reporting was not feasible for their demonstration of meaningful use for a given year.	circumstances where electronic reporting is not feasible for the Medicare EHR incentive program. We would appreciate additional detail as to the circumstances that would appropriately satisfy the "not feasible" clause, especially around the provided example of "certification issue outside the control of the provider" (page 16774). We are concerned that the current language is broad and may allow opportunities beyond those that CMS would like to reasonably extend for participating providers to report via attestation.
16779-80	**2. Reporting Requirements**	"We propose to require states to submit annual reports to CMS within 45 days of the end of the second quarter of each federal fiscal year"	Oregon supports this requirement and appreciates establishing regular timing for annual and quarterly reporting deadlines. We also support removing the information about practice locations for providers that qualify for incentive payments as this information has been difficult to obtain.

Oregon Health Authority's comments on the 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications

General Comment Summary:

Overall, the Oregon Health Authority's Office of Health Information Technology finds the 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications useful for ensuring the broad interoperability and usability of health IT, and taking major steps toward ensuring that health IT is interoperable in the real world environment. Oregon's health IT strategies rely on the use of standards-based technology and true interoperability to support new expectations for care coordination, accountability, and payment in the healthcare delivery system. Until now the promise of interoperability has not been realized, and Oregon stakeholders have made significant investments in technology tools that fall short of what they could achieve. Much progress is needed, and the ONC Notice of Proposed Rule Making (NPRM) makes steps in the right direction.

We are pleased to see the following in the ONC NPRM:

- Expansion of the Health IT Certification Program to include electronic health record (EHR) products for providers that are not eligible for the EHR incentive programs.
    - This expansion directly serves the Oregon goal of providers having access to information to coordinate and deliver whole person care;
- Inclusion of provider directories in the certification program.
    - Oregon is investing in a statewide provider directory and is anticipating leveraging the HPD standard to federate to resident provider directories in EHRs and other HIT;
- Increased surveillance and disclosure requirements
    - There is a significant need for accountability to ensure real world interoperability, and the lack of these requirements has been sorely felt;
- Increased emphasis on privacy and security capabilities
    - Ensuring that all health IT presented for certification possesses the relevant privacy and security capabilities;
- Efforts to increase product transparency that will support more informed HIT policies and decisions including:
    - Conversion of the Certified Health IT Product List (CHPL) to an open data file to make the reported product data (e.g., test results) more accessible for product analysis;
    - Proposal to require that ONC-Authorized Certification Bodies (ONC-ACBs) report an expanded set of information in the open data file for increased product transparency; and
- The increasing movement toward a holistic approach to patient engagement, with broader representation of gender, patient preferred language, etc.

We are encouraged to see greater clarity around the Consolidated-Clinical Document Architecture (C-CDA), as the interoperable exchange of Continuity of Care Documents (CCD) has been a great challenge to those using Direct exchange to meet the "transitions of care" Stage 2 meaningful use measure. In the final rule, we would like greater specificity from ONC on standards and requirements for the C-CDA to address the inconsistencies in implementation by the various vendors. These inconsistencies lead to receivers being unable to consume C-CDAs generated by multiple vendors. This has stymied

interoperability and the ability to meet MU objectives. Interoperability, specifically the successful exchange of C-CDAs, is critical to create comprehensive care plans that address whole person care.

We appreciate and commend the recent federal efforts to provide clear and timely plans to advance HIT across the care spectrum. We will continue to look to HHS and ONC for HIT plans and guidance to ensure continually aligned efforts in Oregon.

About the Oregon Health Authority's Office of Health Information Technology:

The Oregon Health Authority's Office of Health Information Technology (OHIT) was established in 2011 as a part of the state's health agency to support the adoption of electronic health records, the secure exchange of health information, and supporting meaningful use initiatives in the state. OHIT is a resource for both state programs and other public and private users of health information, providing planning, coordination, policy analysis and the development of public/private partnerships to further health IT in Oregon. Health IT is a key part of Oregon's efforts to create a system of better health, better care and lower cost for all Oregonians.

Specific Comments:

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
16806	**B. Summary of Major Provisions**	Proposed 2015 Edition Base EHR definition	We support the new privacy and security approach to certification criteria to hold health IT developers responsible.
16806	**B. Summary of Major Provisions**	Proposed 2015 Edition Base EHR definition	We support inclusion of transport certification criteria and the inclusion of the Direct Project criterion and Direct Project, Edge Protocol and XDR/XDM criterion. We encourage ONC to further revise and update the certification criteria and to take into considerations the recommendations and solutions put forward by DirectTrust in the white paper *A Report on Direct Trust Interoperability Testing and Recommendations to Improve Direct Exchange*, found at http://static1.1.sqspcdn.com/static/f/1340919/26054983/1426686689687/Report+on+DirectTrust+Interoperability+Testing.pdf?token=A0DNBiAqjJ2YzuhUTn4vnBMrtVI%3D
16806	**3. The ONC Health IT Certification Program and Health IT Module**	We propose to require that ONC-ACBs report to the National Coordinator complaints received on certified health IT	We agree that ACBs should be required to report complaints to ONC. Currently there is uncertainty on who to report challenges to regarding certified health IT. In order to improve issues related to HIT, we support reporting to one governing body, and see ONC as the most appropriate agency to serve in this role. We hear confusion from the healthcare community as to how and where they can report concerns. Requiring ONC-ABCs to report complaints to ONC would streamline and facilitate the process for members of the healthcare community, and ensure

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
			that there is a structured process in place with a definitive responsible body.
16807	**3. The ONC Health IT Certification Program and Health IT Module**	We propose to adopt new requirements for "in-the-field" surveillance under the ONC Health IT Certification Program that would build on ONC-ACBs' existing surveillance responsibilities by specifying requirements and procedures for in-the-field surveillance.	What is the responsibility of the ONC-ACB to report out on surveillance findings so that states know what issues or challenges are being discovered and brought forward? Once reporting has taken place, the end resolution or steps towards resolution needs to be reported back to those experiencing the challenges.
16807	**The ONC Health IT Certification Program and Health IT Module**	"…we propose not to require ONC-Authorized Certification Bodies (ACBs) to certify all Health IT Modules to the 2015 Edition "meaningful use measurement" certification criteria (§ 170.315(g)(1) "automated numerator recording" and § 170.315(g)(2) "automated measure calculation"). We note that CMS has proposed to include the 2015 Edition "meaningful use measurement" certification criteria in the CEHRT definition as a unique program requirement for the EHR Incentive Programs.	We support the approach to make the ONC IT Certification Program more open and accessible to other types of health IT that serves beyond those practices that are meeting meaningful use and include certification for HIT in practice settings such as behavioral health and long-term care.
16807	**The ONC Health IT Certification Program and Health IT Module**	We propose new and revised principles of proper conduct (PoPC) for ONC-ACBs. We propose to require ONC-ACBs to report an expanded set of information to ONC for inclusion in the open data file that would make up the Certified Health IT Product List (CHPL). We propose to revise the PoPC in order to provide for more meaningful disclosure of certain types of costs and limitations that could interfere with the ability of users to implement certified health IT in a manner consistent with its certification. We propose that ONC-ACBs retain records longer and consistent with industry	We believe greater enforcement and oversight of health IT vendor practices, as well as improved transparency, will increase confidence in the Health IT certified products and program.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		standards. We propose to require that ONC-ACBs obtain a record of all adaptations and updates, including changes to user-facing aspects, made to certified health IT, on a monthly basis each calendar year. We propose to require that ONC-ACBs report to the National Coordinator complaints received on certified health IT. We propose to adopt new requirements for "in-the-field" surveillance under the ONC Health IT Certification Program that would build on ONC-ACBs' existing surveillance responsibilities by specifying requirements and procedures for in-the-field surveillance.	
16812	**Applicability**		We support the replacement of "EHR technology" with "health IT." Broader certification types are beneficial to health care organizations with varying abilities to implement specific types of "EHR technology"
16828	**Social Connection and Isolation**	In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?	We recognize that this comes from a standard question on the National Health and Nutrition Examination Survey (NHANES). However, given the rapid change in engagement, particularly among younger people, it seems more appropriate to add to the question or add additional questions regarding other communication means such as text along with speaking on the phone.
16831	**Updated C-CDA Standard**	Entire section	We support a single source for implementers to find CDA templates that encourages the reduction of technology versioning, and fosters standardization and interoperability. We encourage the ONC to take into consideration the challenges

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
			and solutions recommended by the DirectTrust in Chapter 2, Chapter 7 and Chapter 8 of the white paper, "A Report on Direct Trust Interoperability Testing and Recommendations to Improve Direct Exchange," found at http://static1.1.sqspcdn.com/static/f/1340919/26054983/1426686689687/Report+on+DirectTrust+Interoperability+Testing.pdf?token=A0DNBiAqjJ2YzuhUTn4vnBMrtVI%3D The Oregon Health Authority's CareAccord program (EHNAC/DTAAP accredited health information service provider (HISP)) has seen many challenges with Direct secure messaging exchange of CDAs. Instead of a fluid exchange (export of a CDA from one EHR to the ingestion of a CDA by a different EHR), there are numerous issues due to different versioning, header issues, and document formatting. Some CDAs are ingested but when printed they are 50 pages long; others are rejected when the EHR tries to ingest them. This results in HISPs, EHR vendors and providers problem solving each new partner exchange to solve interoperability issues for a successful exchange.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
16831-2	**Transitions of Care**	Addition of new structural elements: new document sections and data entry templates: • New Document Templates for: Care Plan; Referral Note; Transfer Summary. • New Sections for: Goals; Health Concerns; Health Status Evaluation/Outcomes; Mental Status; Nutrition; Physical Findings of Skin. • New organizers and many new entries (e.g. Wound Observation).	We support the inclusion of new document templates in the C-CDA Release 2.0 that will support the use case for referrals.
16833	**XDM Package Processing**	However industry feedback has indicated that the use of XDM packages has grown within the stakeholder community using Direct, which most often happens when Edge System A using XDR sends content and metadata to its HISP-A, who in turn packages that content and metadata into an XDM ZIP and sends it within a Direct message to HISP-B, which then ultimately sends the message containing the XDM package to Edge System B using an SMTP-based edge. Therefore, if Edge System B does not support XDM package processing, interoperability could be impacted when HISP-B forwards XDM packages to Edge System B via the SMTP protocol. To mitigate this potential incompatibility, we propose to include a specific capability in this certification criterion that would require a Health IT Module presented for certification that is also being certified to the SMTP-based edge to demonstrate its ability to accept and process an XDM package it	We support the approach to strengthen certification on interoperability related to XDM package processing. This has been a challenge experienced by providers sending messages between HISPs. In some cases, messages that contain a care summary will be delivered but if the receiving system does not support the .zip format, it will not be successful – error messages may or may not be displayed.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		receives, which would include extracting relevant metadata and document(s).	
16834	**Direct Best Practices**	Entire section	We agree that all stakeholders should be following the same best practices and criteria. We appreciate the time and commitment of those who have contributed to the guidance put forth by the Direct Project. We encourage the ONC to continue to revise and update specification documents related to Direct transport. We need ONC to be more explicit and require testing around types of messages that can be exchanged via Direct. In Oregon, the following has happened: - Many providers receiving a Direct message can only receive the message if it contains a care summary (CCDA). - Providers sending a Direct message will not know what the receiving provider can receive. - Messages that do NOT contain a care summary will be dropped and the message not delivered. - Providers will not know if a message was dropped and the provider that sent the message will think it was delivered.
16835	**2015 Edition Health IT Certification Criterion**	Entire section	The Direct Project has already laid the foundation for certification criterion. As an EHNAC/DTAAP accredited DirectTrust member (CareAccord), we support the recommendations from the DirectTrust, as cited in their *A Report on Direct Trust Interoperability Testing and*

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
			Recommendations to Improve Direct Exchange including, 1) revising and making improvements to the Applicability Statement for Secure Health Transport. Currently, there are real-world interoperability challenges due to criterion ambiguity and developer interpretation of standards and requirements. We support a tightening of certification criterion. We support Message Disposition Notification (MDN) becoming a requirement for message delivery by HISPs. We believe this necessary level of assurance is critical for the exchange of PHI.
16839	**Data Portability**	From health IT developers, we have received requests for clarification about this certification criterion's scope. For example, requests for clarifications about the data that must be produced and from how far back in time the data must be produced. Whereas from providers (and the implementation professionals and third party developers with which they work), we have generally received more substantive critiques about the overall usefulness of the capability and the ways in which health IT developers met the certification criterion's requirements but did not necessarily deliver on its intent. Such "user" comments conveyed that some health IT developers provided a capability that was difficult or non-intuitive to use, difficult to find to even use (e.g., "hidden"), and in some cases either required developer personnel to assist the provider in executing the capability or limited its execution to only being done by the	We support that the capability would need to be more user focused/driven and have supporting certification on the functionality.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		developer at the provider's request. We have also received feedback that the scope of testing has not rigorously assessed the ability of health IT to create large quantities of export summaries. As a result, some providers have reported challenges and poor performance associated with this capability.	
16842	**Clinical quality Measures—Record and Export**	We propose to require that a system user be able to export CQM data at any time the user chooses and without subsequent developer assistance to operate. We also propose to require that this certification criterion be part of the set of criteria necessary to satisfy the ''2015 Edition Base EHR'' definition (see also section of this preamble for a discussion of the proposed 2015 Edition Base EHR definition).	OHA is glad to hear that this certification criterion will be part of the "2015 Edition Base EHR." Anecdotally, our stakeholders have indicated that QRDA export functionality is not widely available among implemented EHRs and does require developer assistance to operate.
16843	**Standards for Clinical Quality Measures**	Given the timing of this proposed rule and the expected deliverables for harmonized CQM and CDS standards as described above, we solicit comment on the version of QRDA or the QRDA-like standards we should adopt for this certification criterion. Specifically, we solicit comment on the following three options: • HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture (QRDA), DSTU Release 2 (July 2012); • HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture (QRDA), DSTU Release 2 (July 2012) and the September 2014 Errata; or • A QRDA-like standard based on the anticipated QUICK	OHA does not have a preference among the first two options, however we are concerned about adopting the third option for this certification criterion. While it is promising to hear about additional efforts to fully harmonize CQM and CDS standards, due to the fact that an output from the Clinical Quality Framework Standards and Interoperability (CQF S & I) Initiative is not expected until mid-2015 it may not be realistic that vendors are able to respond to a new standard in time for it to be utilized in program year 2017. Many entities seem to still be experiencing a learning curve when it comes to QRDA and moving to a new standard may not allow quality programs, users,

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		FHIR-based DSTU.CQM standards we should adopt for this certification criterion.	and health IT vendors to appropriately grasp a new standard prior to program implementation in 2017.
16843	**User Ability to Import CQM Data**	We have received stakeholder feedback that some systems certified to the 2014 Edition ''CQM—import and calculate'' certification criterion do not provide users the ability to import data ''on demand,'' and rather users must request this functionality from the system developer or vendor. Our intent is that users should be able to import CQM data formatted to the QRDA standard for one or multiple patients at any time the user chooses and without additional assistance. Thus, when a Health IT Module is presented for certification to this criterion, we would expect that testing of the Health IT Module would include demonstration of a user's ability to import CQM data without subsequent health IT developer assistance beyond normal orientation/ training.	OHA is very encouraged to hear about additional testing in order to demonstrate a Health IT Modules' ability to support QRDA in-the-field without subsequent developer assistance.
16843	**User Ability to Export CQM Data**	We have received stakeholder feedback that some systems certified to the 2014 Edition "CQM – capture and export" certification criteria do not provide users with the ability to export data "on demand" nor to export batches of multiple patients simultaneously.	We have heard from several providers that they cannot export their CQMs and have to work directly with their vendors. We support certification that allows a user to export CQM data without the assistance of a health IT developer.
16845	**Clinical Quality Measures – Filter**	We, therefore, propose a new certification criterion for CQM filtering that would require health IT to be able to record data (according to specified standards, where applicable) and filter CQM results at both patient and aggregate levels by each one and any combination of the following data:	We support adding certification criteria that allows for filtering of data at both patient and aggregate levels and feel the data elements are appropriate. This will be very helpful for our CCOs. However, because it is not a required element to meet meaningful use, we are unclear as to how many vendors will choose

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		• TIN; • NPI; • Provider type; • Patient insurance; • Patient age; • Patient sex in accordance with the standard specified in § 170.207(n)(1) (HL7 Version 3); • Patient race and ethnicity in accordance with the standards specified in § 170.207(f)(1) (OMB standard) and, at a minimum, (f)(2) ("Race & Ethnicity – CDC" code system in the PHIN VADS); • Patient problem list data in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(4) (September 2014 Release of the U.S. Edition of SNOMED CT®); and • Practice site address	to certify this criterion.
16846	**Clinical Quality Measures—Filter**	We solicit comment on the appropriateness of the proposed data elements for CQM filtering, including whether they are being captured in standardized vocabularies. We also solicit comment on additional data elements that we should consider for inclusion and standardized vocabularies that might be leveraged for recording this information in health IT.	OHA is very encouraged to see the data elements for CQM filtering included in this NPRM. The State of Oregon is pursuing a technical solution to ingest clinical quality measure data and our program will be greatly assisted by these additional capabilities.
16857	**NISTIR 7742 Submission Requirements**	For the 2015 Edition SED criterion, we propose to include the information below in the regulation text of the 2015 Edition SED criterion to provide more clarity and specificity for the information requested to be provided to demonstrate compliance with this certification criterion. The findings that would be required to be submitted for each and every one	We agree adding additional information for NISTIR 7742 in the CHPL. In addition, while we could not find another section in the rule that references CHPL fields, we also wanted to comment on the use of the CHPL. We are often asked for additional information about EHR use for environmental scans in our state. The CHPL has been used to answer some of

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		of the criteria specified in the 2015 Edition SED criterion (and become part of the test results publicly available on the Certified Health IT Product List (CHPL)) are: • Name and version of the product • Date and location of the test • Test environment • Description of the intended users • Total number of participants • Description of participants as follows: ▪ Sex ▪ Age ▪ Education ▪ Occupation/role ▪ Professional experience ▪ Computer experience ▪ Product experience • Description of the user tasks that were tested and association of each task to corresponding certification criteria • List of the specific metrics captured during the testing ▪ Task Success (%) ▪ Task Failures (%) ▪ Task Standard Deviations (%) ▪ Task Performance Time ▪ User Satisfaction Rating (Scale with 1 as very difficult and 5 as very easy) • Test results for each task using metrics listed above • Results and data analysis narrative: ▪ Major test finding ▪ Effectiveness ▪ Efficiency ▪ Satisfaction ▪ Areas for improvement	those questions such as: how many complete or modular systems are certified for certain measures, which commonly used EHRs are certified for future stages (e.g., which commonly used 2011 certified systems had been certified for 2014), and which EHRs were certified for all CQMs vs. the minimum number. We would like to continue to use the CHPL to do these searches but found the current interface does not allow for exporting results, printing results, or viewing more than 20 records at a time. We would encourage ONC to make information available that is non-proprietary to a certified system available, whether it is through the CHPL or other reporting mechanism.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
16863	**Direct Project, Edge Protocol, and XDR/XDM**	Entire section	*See comments from page 16831 & 16835*
16863	**SOAP Transport and Security**	Entire section	*See comments from page 16831 & 16835*
16863	**Healthcare Provider Directory – Query Request/ Response**	General comment	We agree with ONC that the IHE HPD profile is needed to support the transitions of care measure for meaningful use and improves interoperability across trust communities. We also are aware that the new federated version standard is in trial implementation and we do not have a good sense of its adoption. Oregon is working on the development of a statewide provider directory that will facilitate HIE by making Direct addresses available. It will leverage data from existing data sources including data from provider directories that comply with new standards for IHE-HPD federated. We remain unclear as to whether an EHR will be able to meet the Stage 3 ToC measures without having the ability to query other provider directories and discover Direct addresses. For stage 2, Oregon's CareAccord program helped providers by implementing a flat-file directory whereby participants submit an extract of their directory and the CareAccord program would compile and create a master file for participants. The process is time-consuming and manual. The standards for provider directories should be required for the EHR Incentive Program rather than an optional certification.
16867	**Gap Certification**	Direct Project pieces	We support use of the guidance

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
	Eligibility Table for 2015 Edition Health IT Certification Criterion		and requirements put forth by the DirectProject. We recommend revision to the DirectProject documents related to transport, to take away ambiguity and continue to improve Direct exchange. We point the ONC to the DirectTrusts' white paper, cited elsewhere in our comments, for specific identification of challenges and proposed solutions.
16870	**Definitions**	Direct Project pieces	*See comments from page 16867*
16872	**III.B.3**	These stakeholders have expressed safety concerns that the volume of data in a comprehensive care plan can be so extensive that it may be difficult for a provider to quickly determine the information of value for the patient for the given situation. In consideration of this feedback, we clarify that we intend "care plan field(s), including goals and instructions" to be a single provider's documentation of their assessment, plan of treatment, goals, and health concerns for the patient (this clarification applies for 2014 Edition certification). We also make this clarification to better align with the terms used in the C-CDA Release 2.0, which includes the "Assessment and Plan Section (V2)," "Assessment Section (V2)," "Plan of Treatment Section (V2)," "Goals Section," and "Health Concerns Section." In previous iterations of the C-CDA, the "Plan of Treatment Section" was called the "Plan of Care Section," which resulted in the same level of confusion on whether the information was intended to represent a single encounter or the synthesis of multiple encounters.	We concur with the concern that messages often contain too much information to be relevant to providers at the point of care.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		For that reason, the "Plan of Care Section" is now called the "Plan of Treatment Section" to indicate that it is intended to represent a single encounter and not to be confused with the "Care Plan document template."	
16876	**D. Principles of Proper Conduct for ONC-ACBs**	We propose to adopt new requirements for ''in-the-field'' surveillance under the ONC Health IT Certification Program. Our proposal would build on ONC–ACBs' existing surveillance responsibilities by requiring ONC–ACBs to initiate in-the- field surveillance of certified Complete EHRs and certified Health IT Modules in certain circumstances and in accordance with certain standards and procedures described below.	OHA is appreciative of the ONC's additional specifications around the ONC-ACBs' responsibilities to initiative in-the-field surveillance of certified Health IT.
16877	**D. In the field surveillance and maintenance of Certification**	General	We agree that having better accountability and oversight after certification is needed. This provides a mechanism for identifying and responding to bad actors which has been frustrating. OHA seeks clarity on if the surveillance results will be made public.
16880	**2. Transparency and disclosure requirements**	Health IT developers would therefore be required to provide, in plain language, a detailed description of any material information about limitations that a purchaser may encounter and additional types of costs that a user may be required to pay in the course of implementing or using capabilities to achieve any use within the scope of the its certification. Such information would be "material" (and its disclosure therefore required) if the failure to disclose it could substantially interfere with the ability of a user or prospective user	We support improving transparency of costs, use limitations, and other technical or practical limitations by Health IT developers. We have heard that providers cannot enable certain functions unless they pay additional costs not disclosed to them.

Page	Section	Phrase/paragraph from NPRM	Comment/Recommendation
		to implement certified health IT in a manner consistent with its certification.	
16888	**ONC Implementation Guide for Delivery Notification in Direct**	Entire section	*See comments from page 16835*
16911	**View**	Patients (and their authorized representatives) must be able to use health IT to view in accordance with the standard adopted at 170.204(a)(1), at a minimum, the following data: (1) The Common Clinical Data Set (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set).	Using the word "English" could come across as exclusionary toward patients and their representatives who do not use English as a primary language.