Health Information Technology Oversight Council

June 5, 2019, 12:30 PM - 3:45 PM

In-Person Attendance	Remote Attendance
Location: Transformation Center Training Room (7th floor), Five Oak Building, 421 SW Oak Street, Suite 775, Portland, OR 97204	**Telephone:** (888) 808-6929, Access Code: 453773# **Webinar**: https://attendee.gotowebinar.com/register/7666381504337845507

Name	Organization	Title
Bill Bard	Consumer	Retired
Maili Boynay	Legacy Health System	Vice President of Information Systems Applications
Kacy Burgess	Deschutes County Health Services	Clinical Information Systems Administrator
Jennifer Clemens, DMD	Capitol Dental Care	Dental Director
Erick Doolen (chair)	PacificSource	Executive Vice President & Chief Operating Officer
Amy Fellows	We Can Do Better	Executive Director
Valerie Fong, RN	Providence St. Joseph Health	Executive Director and Chief Nursing Informatics Officer
Charles (Bud) Garrison	Oregon Health & Science University	Clinical Informatics Director
Janet Hamilton	Project Access NOW	Deputy Director
Amy Henninger, MD (vice-chair)	Multnomah County Health Dept.	Deputy Medical Director
Mark Hetz	Montclair Health Advisors	Principal Consultant
Anna Jimenez, MD	CareHere	Primary Care Physician
Bonnie Thompson	Greater Oregon Behavioral Health Inc.	Director of Health System Improvements
Greg Van Pelt	Oregon Health Leadership Council	President
Steven Vance	Lake Health District	Director of Information and Technology Services

Time	Topic and Lead	Action	Materials
12:30-12:45	**Welcome, Introductions & HITOC Business**—Erick Doolen (Chair) • Approval of Minutes	Information Discussion Action	• April Draft HITOC Minutes • HITOC 2019 Work Plan

	- Work Plan Check-In, Francie Nevill, OHA - OHPB Update, Kirsten Isaacson, OHPB		
12:45-1:00	**Health Equity Definition**—Francie Nevill, OHA	Information, Discussion	• Health Equity Committee Letter
1:00-1:20	**HIT Commons and HITOC Relationship**—Susan Otter, OHA	Information, Discussion	• HIT Role Table
1:20-2:05	**Patient Engagement and HIT: Introduction and Federal Roadmap**—Kristin Bork, OHA; Francie Nevill, OHA; Karen Hale, OHA	Information, Discussion	• Patient Engagement Matrix • HINTs Data Brief • Excerpts from Strategic Plan
2:05-2:15	**Break**		
2:15-2:40	**Patient Engagement and HIT: A Patient Perspective and HITOC Discussion**—Naomi Kaufman Price, Consumer Advocate; Susan Otter, OHA	Information, Discussion	
2:40-3:10	**Trusted Exchange Framework and Common Agreement (TEFCA) Update**—Rim Cothren, Health Tech Solutions	Information, Discussion	
3:10-3:25	**Behavioral Health Confidentiality Toolkit for Providers** —Jackie Fabrick, OHA; Kristin Bork, OHA	Information, Discussion	• Confidentiality Toolkit for Providers
3:25-3:35	**Updates** - HITOC Updates - Oregon State Public Health Laboratory RFP for HIE Planning Support	Information	• HITOC Updates
3:35-3:40	**Public Comment**	Information	
3:40-3:45	**Closing Remarks** – Chair		

Other Materials	
TEFCA Information https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement User's Guide to TEFCA Draft 2 https://www.healthit.gov/sites/default/files/page/2019-04/TEFCADraft2UsersGuide.pdf	Patient Engagement Resources OpenNotes Study: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5992450/

Vision

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

Three Goals of HIT-Optimized Health Care:

- Oregonians have their core health information available where needed so their care team can deliver person-centered, coordinated care.
- Clinical and administrative data are efficiently collected and used to support quality improvement, population health management, and incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.
- Individuals and their families access, use and contribute their clinical information to understand and improve their health and collaborate with their providers.

Next Meeting: **August 1, 2019, 12:30 PM – 3:45 PM**
Five-Oak Building (421 SW Oak St.,
Portland, OR 97214)

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help or have questions, please contact Brian Toups at 503-385-6542, or OHIT.Info@state.or.us at least 48 hours before the meeting. OHA will make every effort to provide services for requests made closer to the meeting.

Health Information Technology Oversight Council

June 5, 2019

Oregon Health Authority

Agenda

- Introduction (Minutes, Work Plan, OHPB Updates)
- Health Equity Definition
- HIT Commons and HITOC Relationship
- Patient Engagement and HIT
- Trusted Exchange Framework and Common Agreement (TEFCA) Update
- Behavioral Health Information Sharing Toolkit
- Updates
- Public Comment

Health Equity Definition Input

Francie Nevill, HITOC Lead Analyst

Request for input

- Health Equity Committee developing “health equity” definition to be adopted by the OHPB and its committees
- Will help provide clarity on where we are going and why
- Goal is to create a definition that is
  - clear and comprehensive
  - acknowledges the historical and structural underpinnings of inequities in health and the need for societal change

Health Equity Definition

- **Health equity** exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, language, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstances.
- Achieving **Health Equity** requires the ongoing collaboration of all sectors to address:
  - The equitable distribution or redistribution of resources and power; and
  - Recognizing and rectifying historical and contemporary injustices

Oregon Health Authority

HITOC Input

- How does this land for you?
- What works well for you?
- Anything that you feel is missing or concerns?
- Any other comments?

Think of something later? You can also contact the Health Equity Committee (maria.castro@state.or.us) directly by June 12th. Please copy Francie to keep OHIT in the loop!

HIT Commons and HITOC Relationship

Susan Otter, Director of Health IT, OHA

Context

- Health System Transformation for Oregon
  - Care delivery, payment, quality, access, cost containment
  - Supported by HIT and other components – e.g., data/quality, etc.
- Oregon Health Policy Board
  - 9-member board, appointed by the Governor, that is the policy-making and oversight body for the Oregon Health Authority
  - Committed to providing access to quality, affordable health care for **everyone** in Oregon (not just Medicaid) and to improving population health
  - Charters HITOC
- Oregon Health Leadership Council
  - Industry efficiencies, clinical leadership, HIT and administrative simplification

Oregon Health System Transformation

- Goal: better health, better care, and lower costs for all Oregonians
- Primary tool: Coordinated care model
  - Care coordination and population management throughout the system; integration of physical, behavioral, oral health; accountability, quality improvement and metrics; value-based payment; patient engagement
  - Social determinants of health and health equity
- The coordinated care model relies on HIT to share patient information and to analyze/report data
- The legislature created HITOC to ensure health system transformation efforts are supported by HIT

HITOC’s Responsibilities (ORS 413.301-08)

1. Explore HIT policy
2. Plan Oregon’s HIT strategy
3. Oversee OHA’s HIT efforts
4. Assess Oregon’s HIT landscape
5. Report on Oregon’s HIT progress
6. Monitor Federal HIT law and policy

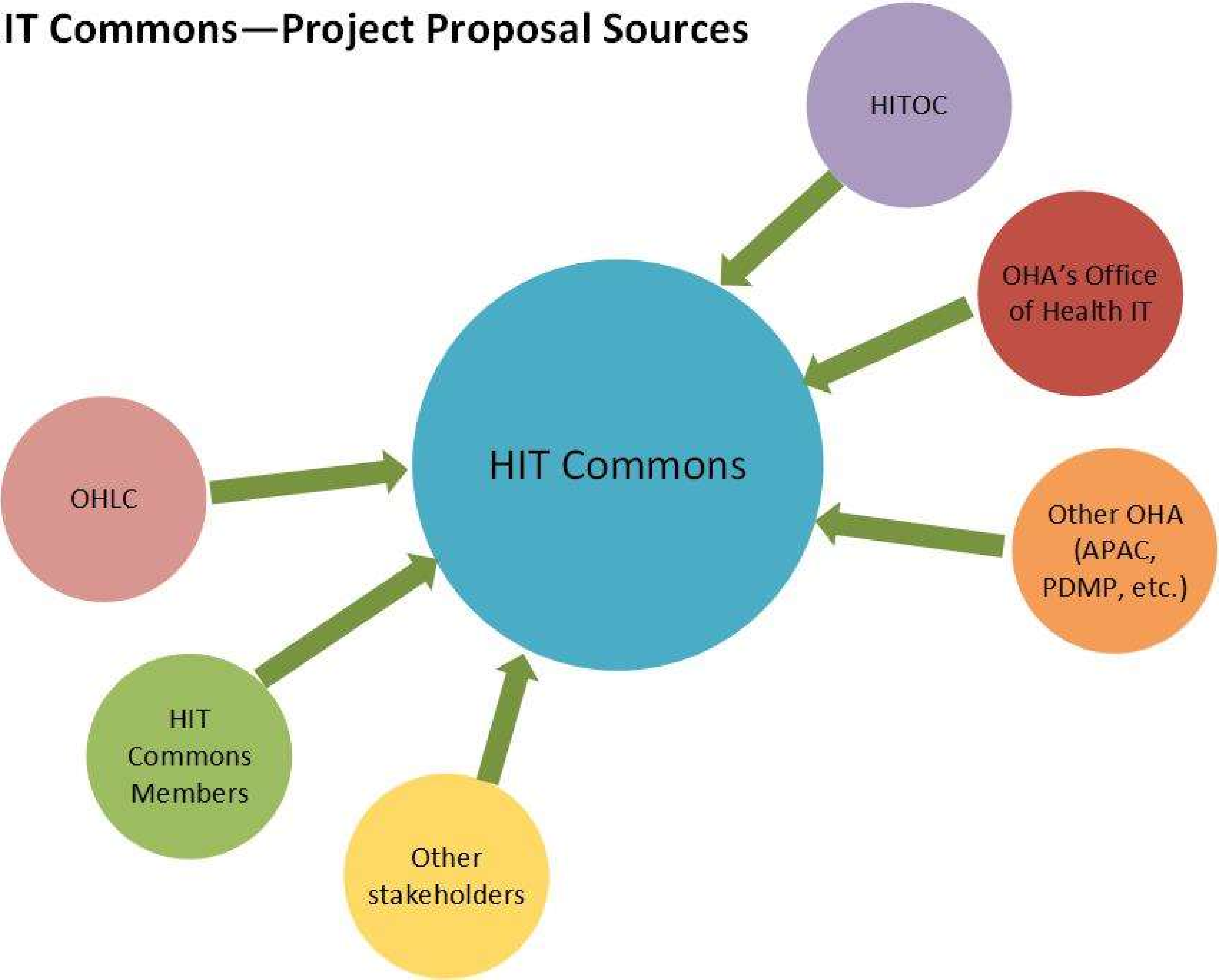
OHA, HITOC, and HIT Commons History

- Public/private HIT entity envisioned in 2010 HITOC strategic planning, 2013 HIT Business Plan
  - Needed to create sustainability for HIT efforts supported by time-limited federal funding, as well as accelerating other efforts
- HB 2294 (2015) authorized OHA's public-private partnership
  - OHA may be a voting member, provide funding, and transfer implementation/ management of one or more Oregon HIT Program efforts
- HIT Commons is one of HITOC's major strategies;
  - Extensive discussion of plans for HIT Commons in HITOC's 2017-2020 strategic plan
- EDIE Utility (2015-2017) laid the groundwork for HIT Commons in 2018
  - OHA and OHLC co-sponsored and provided seed funding

OHA, HITOC, and HIT Commons Today

- Independent bodies with complementary roles
  - Same broad reach (statewide, all markets); same guiding principles
- Important differences
  - HITOC: legislative mandate for public transparency/oversight; sets Oregon’s HIT strategy. HITOC must be inclusive of broad stakeholder needs for HIT to support Health System Transformation.
  - HIT Commons is closer to users and the business decisions they face; special expertise on value proposition for stakeholders. HIT Commons is selective; focused on implementing and accelerating specific projects.
- Collaboration:
  - HITOC strategic plan will update component on HIT Commons
  - HIT Commons, along with other stakeholders, provides input on HITOC’s strategic plan (update in 2020/2021)
  - HITOC, OHA and other stakeholders can ask HIT Commons to take on a project
  - HIT Commons can ask HITOC to explore policy issues

HIT Commons—Project Proposal Sources



Patient Engagement and HIT: Introduction and Federal Roadmap

Karen Hale, OHA
Francie Nevill, OHA

Oregon Health Authority

World Health Organization

"'Patient engagement' … refers to the process of building the capacity of patients, families, carers, as well as health care providers, to facilitate and support the active involvement of patients in their own care, in order to enhance safety, quality and people-centredness of health care service delivery."

Patient Engagement: Technical Series on Safer Primary Care, World Health Organization

Health Information Management Systems Society (HIMSS)

"A patient's greater engagement in healthcare contributes to improved health outcomes, and information technologies can support engagement. Patients want to be engaged in their healthcare decision-making process, and those who are engaged as decision-makers in their care tend to be healthier and have better outcomes."

https://www.himss.org/library/patient-engagement-toolkit

Patient Engagement: HITOC's Strategic Plan

- Where to find it
  - One of 3 overarching goals; included in the goals for statewide health information exchange
  - One of the 2017-2020 Focus areas
  - Full chapter in the strategic plan
  - Various other references

Strategic Plan: Goals and state role

- Goal 3, HIT-optimized health care
  - Individuals and their families access, use and contribute their clinical information to understand and improve their health and collaborate with their providers.
- Goal 3, Statewide Health Information Exchange:
  - HIE supports the coordinated care model, **patient engagement** and other alternative payment models.
- State will support community/organizational efforts by
  - Promoting EHR adoption and Meaningful Use
  - Leveraging national standards and federal EHR incentives
  - Providing guidance, information and technical assistance
  - Assessing changing environments and convening stakeholders

Patient engagement opportunities, levers, and progress highlights

Francie Nevill, Lead Policy Analyst, OHA
Karen Hale, Lead Policy Analyst, OHA

Overview

- Working toward better understanding of “lay of the land”
- New tool: Matrix based on federal roadmap
  - General categories of HIT for patient engagement
  - Specific actions and levers
  - In many cases, efforts are already underway
- Will start with brief background on major federal levers already in place
- Then review matrix, including a few progress highlights
  - Remember: fuller reports on patient engagement are being developed as part of data work

Federal Levers: Promoting Interoperability (PI) Programs

Medicare Quality Payment Program – Merit-Based Incentive Program

- Medicare Eligible Clinicians
- ~10,000 Oregon providers currently participating
- One of four PI measures is for Patient Engagement

Medicaid PI Program

- Medicaid Eligible Professionals
- 3445 Oregon providers currently participating
- Four of 19 PI measures are for Patient Engagement

Medicare PI Program

- Medicare Eligible Hospitals
- 58 Oregon Hospitals currently participating
- One of four PI measures is for Patient Engagement

Source: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html

Source: Oregon Medicaid Meaningful Use data through 5/30/2019

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Promoting Interoperability Participants

	Hospital	Physician	NPs	PAs	Dental	Other
Medicare Eligible Hospital	x					
Medicaid Eligible Professional (Oregon)		MD, DO, Naturopath	NPs	PAs in certain PA-led settings	Dentists	Pediatric optometrists
MIPs Eligible Clinician		MD, DO, podiatrist, optometrist	NPs	PAs	Dental surgery physician Dental medicine physician	Osteopathic practitioners, chiropractors, clinical nurse specialists, certified registered nurse anesthetists, PTs, OTs, clinical psychologists, qualified speech-language pathologists, qualified audiologists, registered dietitians, nutritional professionals

Hospitals: Subsection (d) hospitals paid under the Inpatient Prospective Payment System, Critical Access Hospitals, Medicare Advantage Hospitals

Certified EHR Technology for patient engagement capability

2011 CEHRT

- Required for Stage 1 Meaningful Use

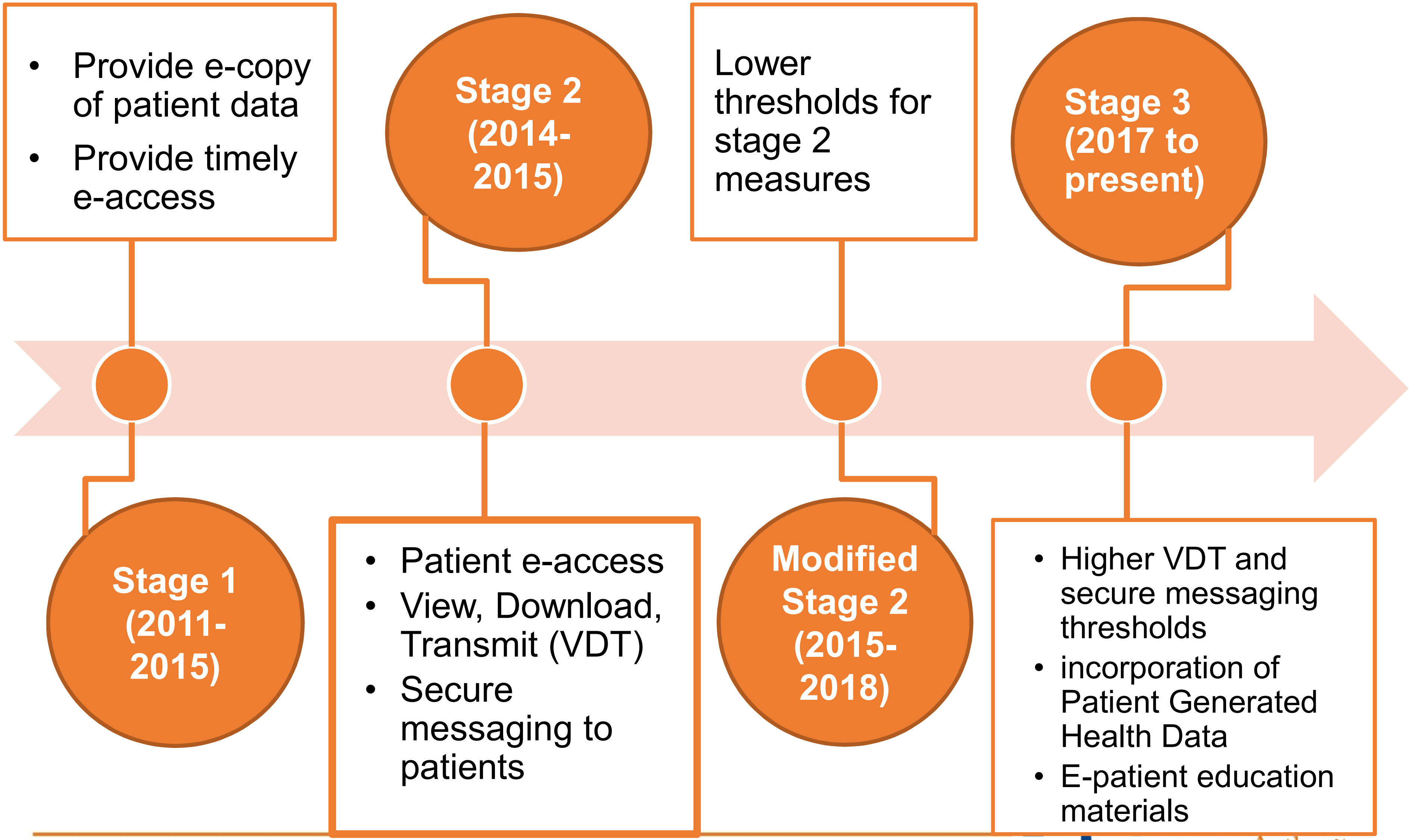
2014 CEHRT

- Required for all participants in the Promoting Interoperability (PI) starting in 2015;
- Required if reporting Stage 2 Meaningful Use
- Capabilities for view, download, and transmit/Direct secure messaging

2015 CEHRT

- Required for *all* participants in PI programs starting in 2019;
- Required if reporting Stage 3 Meaningful Use
- Capabilities for:
  - Application Programming Interface (API) functionality for patient access
  - Patient generated health data integration
  - Electronic patient education materials

Medicaid Meaningful Use Patient Engagement Measure History



Stage 1 (2011-2015)

- Provide e-copy of patient data
- Provide timely e-access

Stage 2 (2014-2015)

- Patient e-access
- View, Download, Transmit (VDT)
- Secure messaging to patients

Modified Stage 2 (2015-2018)

Lower thresholds for stage 2 measures

Stage 3 (2017 to present)

- Higher VDT and secure messaging thresholds
- incorporation of Patient Generated Health Data
- E-patient education materials

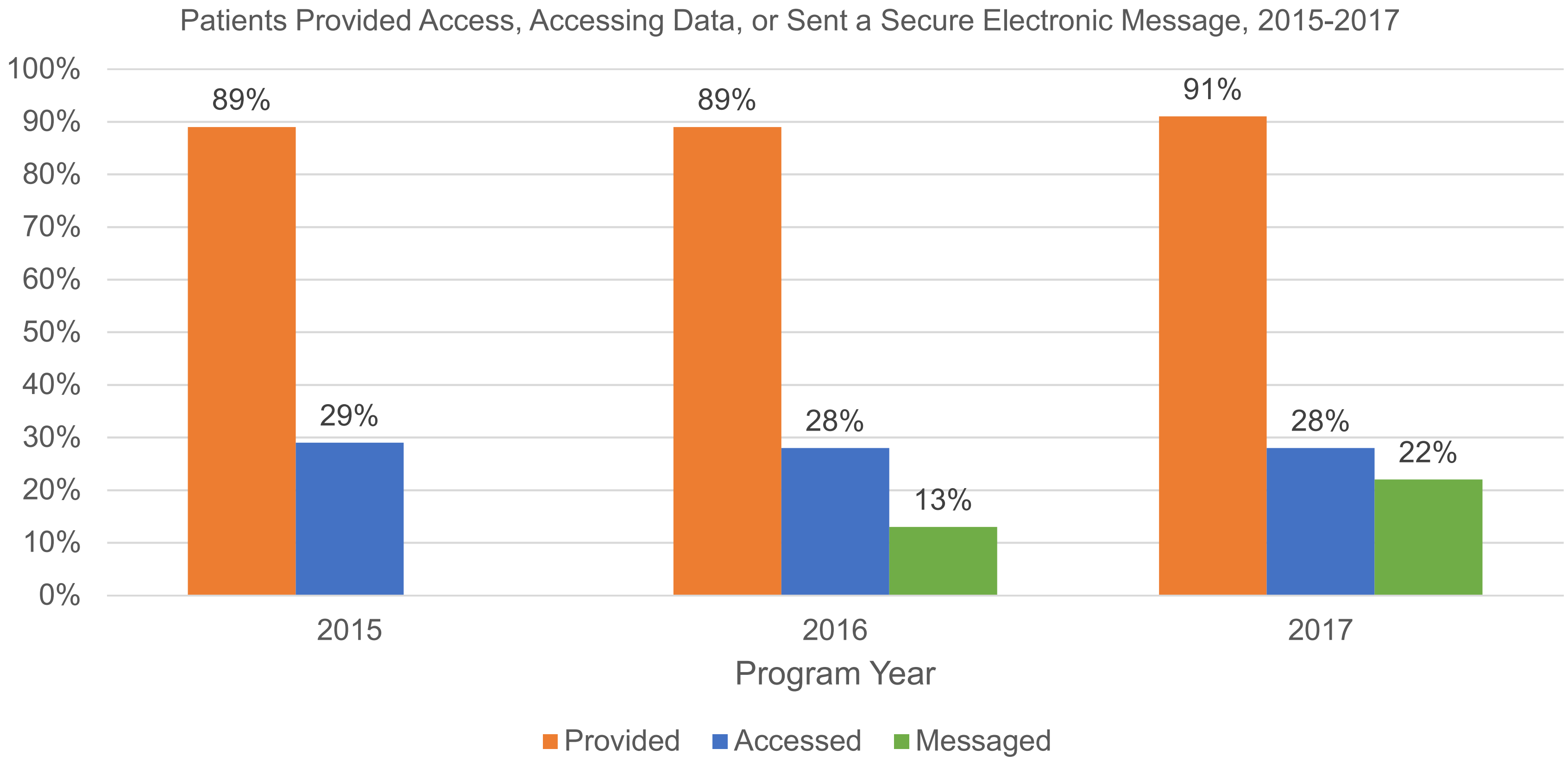
Promoting Interoperability program data challenges

- Medicaid Meaningful use data
  - Does not cover all providers
  - Many providers maxed out participation (6 years)
  - New first-timers no longer allowed
  - Final year of program = 2021
- Medicare MIPs data
  - Working to gain access
- Data only covers providers participating in the programs

Matrix overview

- Overarching issues: Health Equity and CCO 2.0
- Organizing principle: ONC's HIT Playbook (federal roadmap)
- Four main categories
  - Portal access to patient's own records
  - Patient-directed data
  - HIT for relationship management
  - Enhanced care access
- For each category
  - Action items with bullet points for more detail
  - Levers (what's already in place to move this forward)
  - Notes

Meaningful Use: Patient Access to Data and Messaging



- Rates of providing access and patients accessing data are flat
- Rates of sending patients messages increased from 2016-17 (first years tracking)

Source: Oregon Medicaid Meaningful Use data through 3/31/2019

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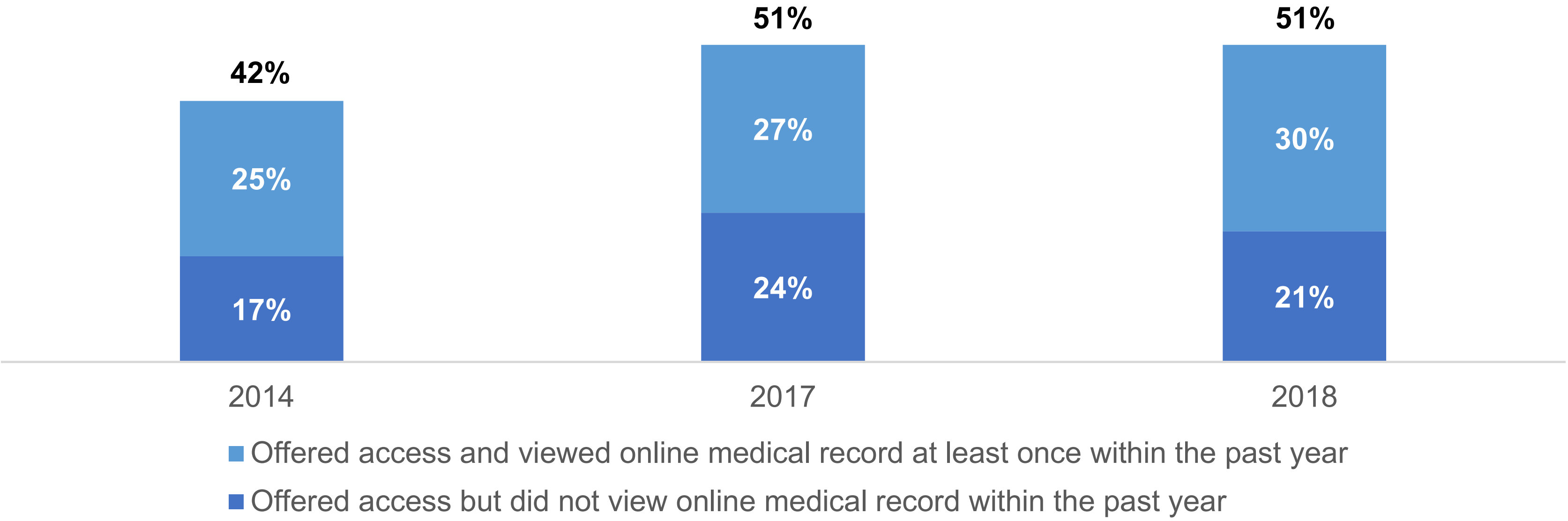
National HINTS Survey

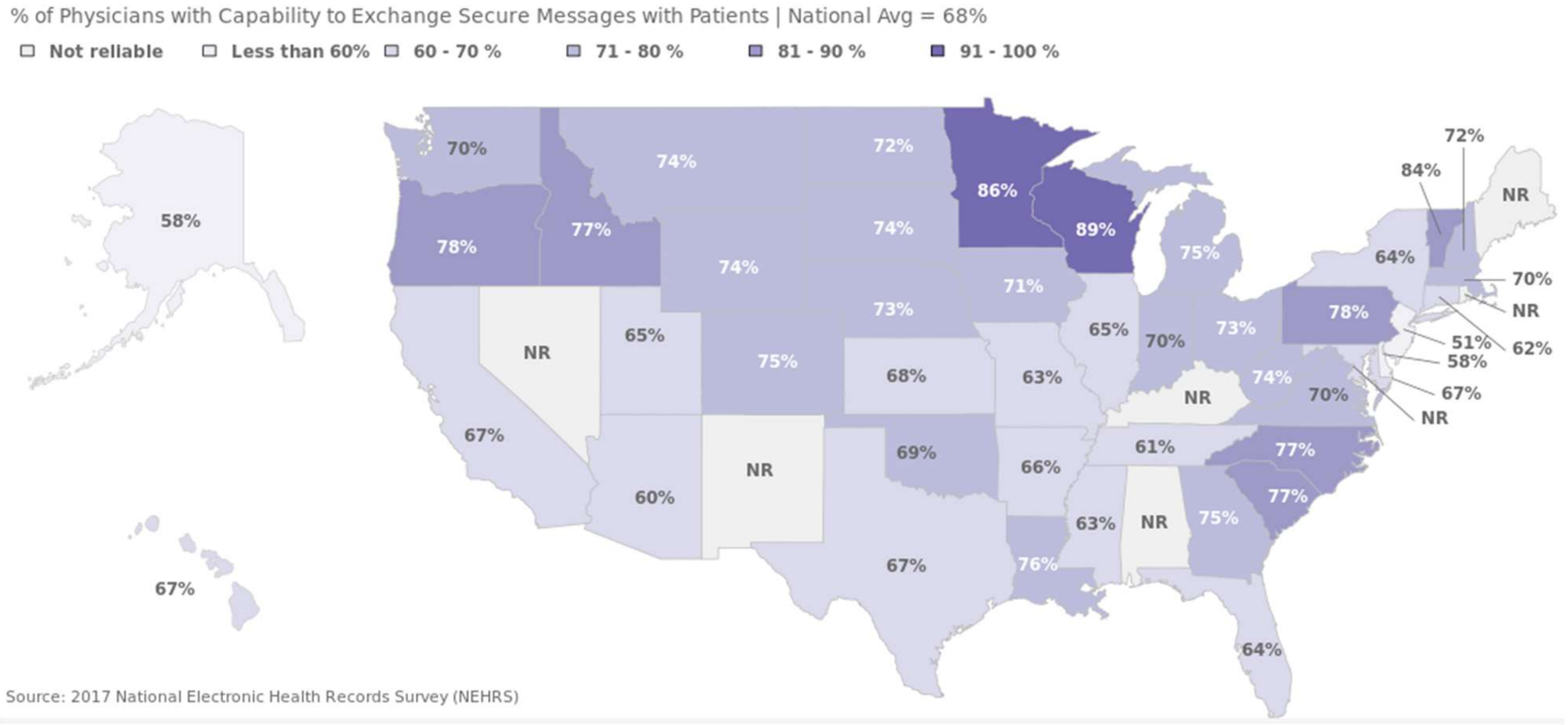
- ➢ Only half of patients report being offered access
- ➢ Significant differences by gender, income, education, internet access, urban/rural, insurance coverage, chronic condition

Figure 1: Percent of individuals ever offered access to their online medical record by a health care provider or insurer by whether they viewed their online medical record, 2014-2018



Source: Health Information National Trends Survey, ONC Data Brief No. 47, May 2019

Secure Messaging Capability by State

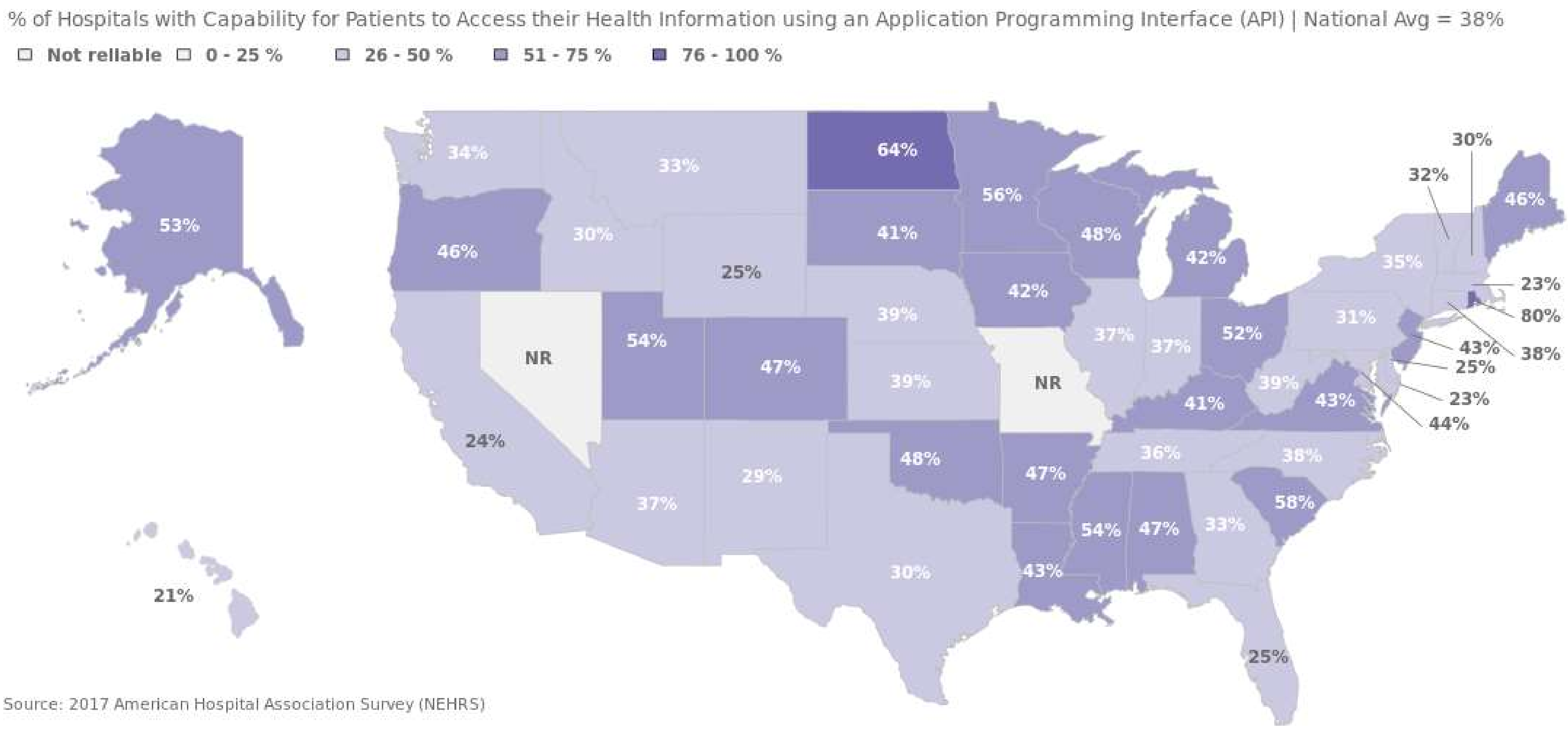


% of Physicians with Capability to Exchange Secure Messages with Patients | National Avg = 68%

Source: 2017 National Electronic Health Records Survey (NEHRS)

Source: ONC Health IT dashboard (https://dashboard.healthit.gov/apps/physician-health-it-adoption.php)

Hospitals with Patient Access Via API



% of Hospitals with Capability for Patients to Access their Health Information using an Application Programming Interface (API) | National Avg = 38%

Source: 2017 American Hospital Association Survey (NEHRS)

Source: ONC Health IT dashboard (https://dashboard.healthit.gov)

Matrix overview

- Overarching issues: Health Equity and CCO 2.0
- Organizing principle: ONC's HIT Playbook (federal roadmap)
- Four main categories
  - Portal access to patient's own records
  - Patient-directed data
  - HIT for relationship management
  - Enhanced care access
- For each category
  - Action items with bullet points for more detail
  - Levers (what's already in place to move this forward)
  - Notes

A Patient Perspective on OpenNotes

Naomi Kaufman Price, Consumer Advocate

Oregon Health Authority

Discussion

Susan Otter, OHA

HITOC Questions

- 2019 Work Plan
  - HITOC learns about the current “lay of the land” of HIT for patient engagement including emerging issues
  - HITOC makes decisions about its next steps
- What stood out for you in the presentation?
- What is encouraging/concerning for you?
- What are high-priority opportunities within HITOC’s role?
- What additional information would be most helpful?
- What, if anything, should HITOC consider pursuing at this time? In the next strategic plan?

Trusted Exchange Framework and Common Agreement (TEFCA) Update

Rim Cothren, Health Tech Solutions

TEFCA Draft 2

- Released on April 19, 2019
- Designed to
  - Scale electronic health information (EHI) exchange nationwide
  - Help ensure that health information networks (HINs), health care providers, health plans, individuals, and other stakeholders have secure access to their electronic health information when and where it is needed
- Accompanies by Notice of Funding Opportunity to select a Recognized Coordinating Entity (RCE)
- Open for public comment through June 17, 2019

Called for in Cures Act

"[T]he [Office of the] National Coordinator [for HIT (ONC] shall convene appropriate public and private stakeholders to develop or support a trusted exchange framework for trust policies and practices and for a common agreement for exchange between health information networks. The common agreement may include—

"(I) a common method for authenticating trusted health information network participants;

"(II) a common set of rules for trusted exchange;

"(III) organizational and operational policies to enable the exchange of health information among networks, including minimum conditions for such exchange to occur; and

"(IV) a process for filing and adjudicating noncompliance with the terms of the common agreement."

Components

1. Trusted Exchange Framework (TEF) outlines principals and an architecture for a nationwide network
2. Common Agreement (CA) that Qualified HINs (QHINs) voluntarily agree to follow
   - Minimum Required Terms and Conditions (MRTCs)
   - Additional Required Terms and Conditions (ARTCs)
3. QHIN Technical Framework (QTF) defines technical and functional components for exchange among QHINs
   - Included in the CA by reference

Responsibilities

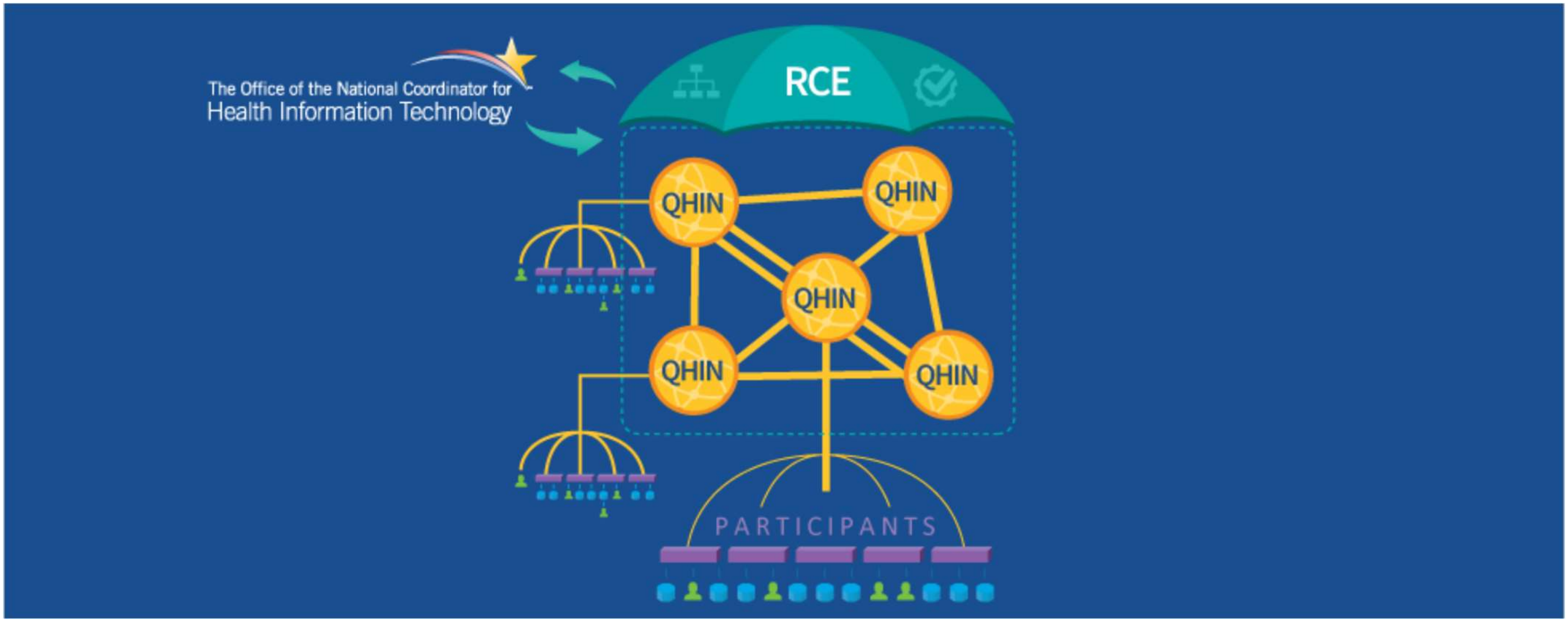
Office of the National Coordinator for HIT (ONC)

- Author Minimum Required Terms and Conditions
- Approve CA

RCE

- Author Additional Required Terms and Conditions
- Finalize CA
  - QHINs enter into the CA with the RCE
- Finalize QTF
- Socialize TEFCA

Participants



QHINs

- Form the "backbone" of the TEF
- HIN defined in ONC proposed rule
- No longer specifies technical components of QHINs
  - Draft 1 required Master Patient Indexes (MPIs) and Record Locator Services (RLSs)
  - Draft 2 focuses on functional requirements
  - Easier for some national networks such as eHealth Exchange or Carequality to become QHINs
- No longer prohibits an HIE from becoming a QHIN

Transactions

- QHIN Targeted Query: QHIN requests EHI from specific QHIN(s)
- QHIN Broadcast Query: QHIN request requests EHI from all other QHINs
- QHIN Message Delivery (new): QHIN delivers EHI to QHIN(s), perhaps for delivery to one or more Participants or Individuals

- No longer includes Population-Level Data Exchange

Exchange Purposes

- Treatment
- Payment and health care operations, limited to
  - Quality Assessment and Improvement
  - Business Planning and Development
  - Utilization Review
- Public Health
- Benefits Determination
- Individual Access Services

- No longer includes Payment or all Healthcare Operations as defined by HIPAA

Minimum Required Terms and Conditions (MRTCs)

- Definitions
- Onboarding and operation of QHINs
- Data quality and minimum necessary
- Transparency
- Cooperation and non-discrimination
- Privacy, security, and patient safety
- Participant minimum obligations
- Participant member minimum obligations
- Individual rights and obligations

QHIN Technical Framework (QTF)

- No longer specifies architecture for QHINs
  - No longer need to include an MPI or RLS
  - Instead, need to identify patients and locate EHI

- Largely based on SOAP web services and IHE profiles
  - Not based on FHIR
- Query is similar to eHealth Exchange specifications
  - Uses a different security model
- Message delivery is also a SOAP-based IHE profile
  - Does not use Direct messaging
  - Uses a different transaction than eHX

Considerations

- Will all HIEs and providers join TEFCA as participants?
- Will TEFCA impact HIE business models or sustainability?
- Will HIEs be pressured to become QHINs?
- Is Oregon’s Network of Networks considered a HIN?

Next Steps

- Public comment period ends June 17
- RCE proposals due June 17

- ONC selects RCE
- ONC publishes final TEFCA
- RCE develops, ONC approves, and RCE publishes draft of CA

Behavioral Health Confidentiality Toolkit

Kristin Bork, Lead Policy Analyst
Jackie Fabrick, Behavioral Health Policy Analyst

May 2019

Oregon Health Authority

Agenda

- Background and purpose of the toolkit
- Overview of the toolkit
- Questions and discussion

Background

- In 2015, OHA created an **internal Behavioral Health Information Sharing Advisory Group** to help improve coordination between physical health and behavioral health providers.
- This group **focused on**
    - **developing a strategy to support integrated care and services by enabling the electronic sharing of behavioral health information between providers**.
- One of the outcomes of the work of the Behavioral Health Information Sharing Advisory Group is the ***Confidentiality Toolkit for Providers***.

Why a Toolkit?

As Oregon works to integrate the delivery of behavioral and physical health:

- It is important to be able to **share health information** between providers to make sure that **care is coordinated** well for patients.
- **Understanding the legal barriers and common misconceptions** to sharing behavioral health information becomes increasingly important.
- Federal and state health information privacy laws create a **complex network of requirements** governing the use and disclosure of health information.

The Toolkit Does

- Support integrated care
- Provide overview of confidentiality issues/perceived obstacles
- Provide links to additional information

The Toolkit Does not

- Offer legal advice
- Take place of legal counsel

Confidentiality Toolkit

The toolkit includes:

- Consent Sample Templates
- Chart of relevant statutes
- FAQs – which are being developed from past webinars and questions that OHA staff receives
- Use Cases, which will include examples of sharing of behavioral health information relevant to 42 CFR Part 2 protected information

Toolkit Timeline

Activity	Date
Stakeholder input	May-June 2019
Revisions	July-August 2019
Published online	September 2019

Legal Action Center's Actionline

- OHA has purchased a subscription to the Legal Action Center's Actionline to provide phone-based consultation services regarding federal confidentiality laws and regulations protecting individuals with a substance use disorder.

- Available for any Oregon substance use disorder treatment provider.

- The Actionline is available anytime between 1pm-5pm (ET) Monday-Friday. Callers should ask to speak to the Attorney on Call.

- The service *does not include* advice about corporate legal issues for programs, general legal services for clients, or state law issues. Neither does it include representation on any issue or in-depth analysis of large documents, such as policies and procedures and training materials.

QUESTIONS?

Contacts

- Jackie Fabrick @ jackie.fabrick@state.or.us
- Kristin Bork @ kristin.m.bork@state.or.us

Updates

Oregon Health Authority

Oregon State Public Health Laboratory: RFP for HIE Planning Support

- The Oregon State Public Health Laboratory (OSPHL) provides testing that:
  - Helps state and local epidemiologists identify, monitor and control communicable disease outbreaks and foodborne illness,
  - Provides testing services to more than 120,000 newborn babies a year

- Spring 2019: RFP for technical consultation to aid in the development of a strategic plan for integration with health information exchanges
  - Align with OHA overall strategy for a “network of networks” HIE approach
  - Strategic plan will guide the development and implementation of a regional Electronic Test Ordering and Result (ETOR) system for OSPHL

Public Comment

Next Meeting

- August 1 (Thursday), Five Oak Building (421 SW Oak St., Portland, OR)

Health Information Technology Oversight Council
Meeting Minutes - Draft

Thursday, April 4, 2019; Portland, Oregon
9 am – 3:30 pm

Council Members Present: Bill Bard, Maili Boynay, Kacy Burgess, Jennifer Clemens, Erick Doolen (Chair), Amy Fellows, Valerie Fong, Bud Garrison, Janet Hamilton, Amy Henninger (Vice-Chair), Mark Hetz, Anna Jimenez, Bonnie Thompson, Steven Vance, Greg Van Pelt
Council Members by Phone: None
Council Members Absent: None
Oregon Health Policy Board Liaison: Kirsten Isaacson
Guests: Abby Dotson (Oregon Health and Science University), Nicole Friedman (Kaiser Permanente)
Staff Present: Kristin Bork, Marta Makarushka, Britteny Matero, Francie Nevill, Susan Otter
Consultants: Rim Cothren (HealthTech Solutions)

Welcome & HITOC Business – Erick Doolen (Chair)
Minutes – Erick Doolen (Chair)
The April 2019 minutes were unanimously approved by all present without abstention. Mark Hetz and Anna Jimenez were not yet present.

Work Plan Review – Francie Nevill (OHA)
[see Work Plan handout for context]
Francie presented the updates to the work plan: a cover sheet showing the status of each item, and "track changes" to show updates to the text of the work plan. HITOC members also requested an "emerging issues" section for the cover sheet and that the work plan items be numbered so they can be cross-referenced in the cover sheet.

Data Reporting ("Dashboards"): Draft Materials, Feedback Themes, Discussion, and Next Steps — Marta Makarushka *[see slides and Data Reporting Draft Materials and Feedback Themes handouts for context]*

Marta presented early drafts of data reporting materials, including a framework, one-page executive summaries filled with draft data, and the themes of the feedback received so far. HITOC will use this information to inform its strategic planning efforts. HITOC members provided the following feedback:

- It would be helpful to define acronyms and provide a glossary. Multiple terms need clearer definitions. Also need to keep in mind that different sectors define things differently.
- We need to connect data to health outcomes. Also need to be able to see how HIT is impacting health disparities and health equity—important to track demographics.
- Need to be able to crosswalk data with HITOC's strategies so HITOC can track progress towards goals.
- Need to be able to look at a snapshot and quickly identify areas that need attention.
- The data should tell a story. May want to interpret what the data means for various groups. Need to understand "why" and "so what." Maps would also be useful to more fully visualize impact.
- When asking about provider/patient experience, need to be strategic. Ask what is working and what could be improved, rather than just satisfied/not satisfied. Also be aware that administrators and providers, as well as provides in a large system vs a small system, may have different answers.
- Need clarity about where patient engagement information fits in; robust information on patient experience is needed.

HITOC members met in small groups to review the draft Executive Summary and then reported out:

- It is important to see trends and impacts of efforts (although that can be very difficult)—to see the "so what" implications. Helps us tell the story and show the value created by HIT investments.

- Re-iterated that it is important to tie data to strategies so HITOC can quickly see the opportunities.
- Need to keep in mind the broad spectrum of readers: on one end there's HITOC, and on the other end there's making this data available for transparency to Oregonians and the public. Avoid acronyms and insider terminology.
- Discussion of OHA staff role: All agreed it was useful for staff to draw out implications of data; some felt that it was helpful for staff to provide perspectives on potential strategic implications, others felt that went too far into HITOC's role.
- Need to be aware of the cost/benefit of collecting data. Look for opportunities to gather data in an ongoing way and partner with other data efforts (including the HIT Commons).

Working Lunch: Physician Orders for Life Sustaining Treatment (POLST)/ePOLST Update — Abby Dotson, OHSU *[see slides for context]*

Abby presented on the current status of the POLST registry and future plans. Oregon is a leader in POLST and ePOLST systems. The registry includes bidirectional data and the Emergency Department Information Exchange (EDie) now provides POLST information to hospitals across Oregon.

Oregon Health Policy Board Liaison – Kirsten Isaacson, OHPB

Erick introduced Kirsten Isaacson, Oregon Health Policy Board member and new OHPB liaison to HITOC. Kirsten discussed OHPB priorities and reported on the April OHPB meeting: health equity, children's health, and cost containment. Will likely be creating a new committee under OHPB re cost containment. Recent OHPB meeting occurred in Lake County, and included lessons learned from their collective approach to health care and services.

Social Determinants of Health (SDOH)/Health Equity and HIT —Kristin Bork, Nicole Friedman (Kaiser Permanente), Greg Van Pelt (HIT Commons), Susan Otter

Kristin Bork summarized the SDOH panel discussion from the February HITOC meeting *[see slides for context]*. There was a discussion of the definition of SDOH; the Medicaid Advisory Committee's definition will be sent out to HITOC members. A HITOC member also noted that limiting the SDOH work to Medicaid is too narrow.

Nicole Friedman presented on Kaiser's efforts to integrate SDOH into their health care work via a social service resource locator tool that would help connect patients to services in the community *[see slides for context]*. It will integrate with the Epic EHR and include bidirectional closed-loop referrals for SDOH. Kaiser's intensive care management program saw a 50% reduction in overall costs for their highest utilizers by connecting them to predominantly behavioral health care providers and care coordinators and connecting them to resources in the community. She also talked about the need to extract SDOH-related data more easily (as opposed to chart review) for cross-sector collaboration, policy change, and removing structural and logistical barriers. Kaiser wants to prepare for expected federal SDOH screening requirements in the future—already in northern California, hospitals must screen for homelessness and make a referral to a shelter if a patient is homeless or face a fine.

Greg Van Pelt shared information about the HIT Commons' process for evaluating potential projects, and then talked about HIT Commons' exploration of potential role supporting an Oregon Community Information Exchange *[see slides for context]*. OHA has provided funding for research into the opportunity. Later in the year, HIT Commons would like to share information about the results from HITOC and hear HITOC's insights. HITOC shared the following feedback:

- Aligning on coding of SDOH needs would be helpful
- Would be helpful to be able to integrate with HIEs and other tools, rather than EHRs only
- Need to think through how to keep directory updated
- Need to think about organizational capacity and how to distribute patients among organizations

- There are limited resources—efforts like his may help to highlight where there are insufficient resources and bring the community together to take action

Susan led a discussion with HITOC about their role in SDOH and health equity *[see slides for context]*. HITOC could support potential HIT Commons SDOH work, convene stakeholders to discuss critical HIT issues, consider developing guidance in coordination with other OHA work, continue HITOC's work on the Network of Networks, and monitor state/national efforts. HITOC provided the following feedback:

- Would be helpful to show the ways that OHA is incentivizing SDOH currently
- Need to understand where schools and federal privacy rules re: educational settings come in
- Need to ensure that HITOC stays inside its scope
- Some suggested that HITOC could help promote HIT Commons' social service resource locator efforts if the project goes forward. Consider need for operational framework; give roadmaps or examples.
- Need to know how this actually informs care. How do provides assess risk and then act? How do workflows change?

HITOC decided to take the following next steps:

- No additional panels right now
- Need to reflect on existing resources, e.g., San Diego CIE white paper
- Hear back from HIT Commons on Oregon CIE work

Network of Networks Update and Next Steps – Rim Cothren (HealthTech Solutions), Francie Nevill (OHA) *[see slides for context]*

Francie presented an update on the Network of Networks work to date, summarizing the strategic plan, the work with the Network of Networks Definitions Group, changes in the state landscape, and discussions with the HIT Commons. The HIT Commons reviewed OHA's proposal for the HIT Commons to take on the Network of Networks work; at this time, the HIT Commons only has capacity for one large project, and thus the HIT Commons likely cannot take on the Network of Networks efforts as a whole. Rim Cothren then presented on the new rules proposed by the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health IT.

Kirsten Isaacson asked if OHA is planning to make a public comment on the information blocking sections. Susan stated that OHA is analyzing the rule and is relying primarily on health care organizations and entities to make comments.

Susan shared that the proposed rules will have major impacts on the HIT landscape in Oregon: new requirements around patient access and information sharing and new penalties for information blocking. There is a concern about getting too far ahead of these changes in our efforts. Susan recommended that HITOC monitor the landscape for changes while we consider the best role for statewide efforts, consider use of surveys or listening sessions rather than a work group for now. She shared that OHA expects an increasing role for the state to play in convening and educating, based on feedback from the Definitions Group and in other states as 90/10 HITECH funding wanes, and that in a few CCO meetings, some have expressed that they want the state to take a more prescriptive role. HITOC members were supportive of that approach.

HIT Program Updates [*See HITOC and HIT Program Update document]*
Susan indicated updates were in the packets. Susan highlighted ONC's development of a new EHR Reporting Program and OHA helping to provide space for ONC/HTS listening sessions.

Public Comment
None

Closing Remarks – Erick Doolen (Chair)
Erick thanked members for participating in the HITOC meeting. The next meeting will be on Wednesday June 5, in the Five-Oak Building (formerly known as the Lincoln Building) in Portland, from 12:30 pm until 3:45 pm.

HITOC 2019 Work Plan Status

Projected Quarter for Work	Work to be Done (major bodies of work—see work plan below for details)	Item #	Status
First quarter (Jan-Mar) **February HITOC Meeting**	Begin SDOH/HE and HIT work	2	○
	Begin ~~dashboarding/milestone~~data reporting discussion	13	○
	Oversight at each meeting	9	○
Second quarter (April-June) **April HITOC Retreat** **June HITOC Meeting**	SDOH/HE and HIT next steps	2	○
	Intensive ~~dashboarding/milestone~~data reporting work	13	○
	Intensive network of networks work	7	○
	Behavioral Health HIT Workgroup priorities/roadmap discussion/decisions	8	◊
	Oversight at each meeting	9	○
Third quarter (July -Sept) **August HITOC Meeting**	Begin patient engagement and HIT work and set next steps	1	Ahead of schedule
	~~Dashboarding/milestone~~Data reporting work	13	
	Possible strategic plan update	6	
	HITOC recruitment discussion	15	
	Oversight at each meeting	9	
Fourth quarter (Oct-Dec) **October HITOC Meeting** **December HITOC Meeting**	~~Dashboarding/milestone~~Data reporting review	11, 13	
	Network of networks work	7	
	Possible HIT Commons and CCO 2.0 reports	3, 5, 10	
	HITOC's report to OHPB and 2020 HITOC workplan	12, 15	
	Oversight at each meeting	9	
Emerging issues that impact work plan	New release of Trusted Exchange Framework and Common Agreement (TEFCA) (will add item to June meeting and potentially other meetings)	14	
	Need additional support on health equity for data reporting and other work (will add item to a future meeting)	13	

Key

Green with circle: On track as originally planned

Yellow with diamond: Another priority has emerged, but work can be reshuffled to complete this item in 2019

Red with square: Another issue has taken precedence and HITOC needs to reprioritize remaining work or move this item to 2020

HITOC 2019 Work Plan

HITOC Responsibilities	Strategic Plan: 2017-2020 Focus Areas (or statute)	Strategic Plan: 2017-2020 "Topics"	2019 HITOC Work	Item #
Explore HIT Policy Explore high-priority HIT policy topics related to Oregon's goals of health system transformation and promoting health equity; when appropriate, convene workgroups to aid exploration	Spread patient access to health data (focus area)	Patient access, consent, and specially protected information	• HITOC learns about the current "lay of the land" of HIT for patient engagement including emerging issues (presentation and discussion) • HITOC makes decisions about its next steps (more deep dive panels, other options)	1
	Support high-value data sources, including the social determinants of health/health equity (focus area)	Data sharing needs related to social determinants of health ~~(SDoH)~~/health equity	• HITOC learns about the current "lay of the land" of HIT for social determinants of health/health equity including emerging issues (presentation and discussion) • HITOC makes decisions about its next steps (more deep dive panels, short-term workgroup, other options)	2
	Support value-based payment efforts (focus area)	Development or endorsement of strategies to support HIT for Value-Based Payment	• HITOC stays informed about OHA work on value-based payment (presentation and discussion)	3
	Stay aligned with other OHA efforts (foundational)	Coordination with related OHPB committee work	• HITOC is informed about high-value opportunities for collaboration/coordination and takes action if appropriate	4
	TBD	New priorities as determined by OHPB and HITOC	• Possible work: Updates on HIT implications within CCO 2.0	5

HITOC Responsibilities	Strategic Plan: 2017-2020 Focus Areas (or statute)	Strategic Plan: 2017-2020 "Topics"	2019 HITOC Work	Item #
Plan Oregon's HIT Strategy Make recommendations to the Oregon Health Policy Board ("the Board") about HIT policy, including HIT strategic planning, priority setting, policy direction, legislative opportunities, and other opportunities to improve the effectiveness of HIT efforts in Oregon	Fulfill HITOC's statutory obligation to make strategic planning recommendations to OHPB	Review and update sections of strategic plan annually as needed (will need to reissue in 2021)	• HITOC discusses strategic plan update opportunities and decides whether to update strategic plan in 2019 • If HITOC decides to update strategic plan, HITOC works with staff on strategic plan content; reviews and approves strategic plan update • HITOC chair/vice-chair or designee and OHA staff present strategic plan update to OHPB for approval	6
	Spread health information exchange and other HIT efforts to support the coordinated care model (including physical, behavioral, and oral health providers) (focus area)	Development or endorsement of strategies to support Network of Networks for HIE	• HITOC receives updates on progress and provides advice to OHA on Network of Networks planning as needed • HITOC chair/vice chair approves Network of Networks Advisory Group membership • HITOC reviews Network of Networks Advisory Group report and provides advice/feedback; approves final report • HITOC oversees resulting Network of Networks work, including o If HIT Commons chooses to take on Network of Networks initiatives, HITOC monitors following transition • *Possible: HITOC updates strategic plan with more detail of Network of Networks strategy*	7

HITOC Responsibilities	Strategic Plan: 2017-2020 Focus Areas (or statute)	Strategic Plan: 2017-2020 “Topics”	2019 HITOC Work	Item #
	Spread health information exchange and other HIT efforts to support the coordinated care model (including physical, behavioral, and oral health providers) (focus area)	Support for behavioral health information sharing	*Behavioral Health HIT Workgroup* • HITOC receives updates on progress and provides advice to OHA about the work of the BH HIT Workgroup • HITOC reviews BH HIT Workgroup recommended plan for carrying out the high-level recommendations from Dec 2018, and provides advice/feedback; approves final plan • HITOC oversees resulting BH HIT work, including o HITOC is informed about OHA’s work on the 42 CFR Part 2 Toolkit o If legislature approves funding, HITOC provides advice on the development of the BH HIT Incentive Program • *Possible: HITOC updates strategic plan with more detail of BH strategy*	8
Oversee OHA’s HIT Efforts Oversee and monitor OHA’s HIT efforts, including the Oregon HIT Program; promote transparency about those efforts	Fulfill HITOC’s statutory duty to oversee OHA’s HIT efforts	• Oregon HIT Program *(Note: Oregon HIT Program efforts support physical, behavioral, and oral health providers, and in some cases other provider types)*	• HITOC provides a forum for public transparency on HIT efforts, makes sure HIT efforts are aligned with HITOC’s Strategic Plan, makes sure HIT efforts are aligned with one another, and assesses effectiveness of HIT efforts, primarily by receiving reports and providing advice and guidance related to HITOC’s oversight role. • Oregon HIT Program includes: o Oregon Provider Directory (launch 2019) o Clinical Quality Metrics Registry (launch Jan. 2019)	9

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HITOC Responsibilities	Strategic Plan: 2017-2020 Focus Areas (or statute)	Strategic Plan: 2017-2020 "Topics"	2019 HITOC Work	Item #
			o HIE Onboarding Program (launch Jan. 2019) o Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) (ends May 2019) o Medicaid EHR Incentive Program (ends 2021) o HIT Commons: EDIE/PreManage and Oregon's Medicaid PreManage subscription o HIT Commons: PDMP Integration initiative o Oregon's Flat File Directory for Direct secure messaging • HITOC receives an update on POLST/ePOLST work	
	Develop shared governance for long-term HIT sustainability and alignment	Support HIT Commons and determine appropriate oversight and reporting roles	• HITOC is informed about the HIT Commons' development as Oregon's HIT public/private partnership and provides advice and input as appropriate, including: o Organizational changes (e.g., moving to an LLC) o New projects and process for selecting projects • *Possible: HITOC informs or endorses OHA proposals to HIT Commons for new work (e.g., Network of Networks initiative)* • *Possible: HITOC receives recommendations from the HIT Commons for strategic or policy work and takes action related to HIT Commons' work if appropriate.*	10

HITOC Responsibilities	Strategic Plan: 2017-2020 Focus Areas (or statute)	Strategic Plan: 2017-2020 "Topics"	2019 HITOC Work	Item #
Assess Oregon's HIT Landscape Assess the state of HIT in Oregon; identify gaps, barriers, areas where more information is needed, and other issues with HIT in Oregon	Fulfill HITOC's statutory duty to assess Oregon's HIT landscape, including physical, behavioral, and oral health providers and others	Develop additional capacity for ongoing environmental scanning, with focus on new priorities	- HITOC provides advice to OHA on what HIT scan work is needed to ensure that stakeholders are well informed about the HIT landscape, highlight HIT gaps or barriers, or otherwise inform HITOC's strategic planning work - HITOC reviews scan reports and makes decisions on appropriate next steps - HITOC engages the HIT/HIE Community and Organizational Panel where needed	11
Report on Oregon's HIT Progress Develop reports to inform the Board and other stakeholders about use of HIT in Oregon, including electronic health record (EHR) adoption and use, participation in HIT efforts, and other topics important to achieving Oregon's goals for HIT-optimized health care	Fulfill HITOC's statutory duty to report on Oregon's HIT Progress including physical, behavioral, and oral health providers and others	Annual reports to legislature and OHPB	- HITOC provides advice on OHPB report content; reviews and approves OHPB reports (or designates chair/vice-chair to work with staff to finalize reports) - HITOC chair/vice-chair or designee and OHA staff present reports to OHPB - HITOC reviews Oregon HIT Program annual report presented to legislature to fulfill reporting requirements	12
	Fulfill HITOC's statutory duty to report on Oregon's HIT Progress including physical, behavioral, and oral health providers and others	Explore opportunities to create dashboards to measure statewide progress; Data-driven measurement and milestones for HIT oversight	- HITOC works with OHA staff to develop priorities for dashboard to measure HIT progress, and provides advice and support on dashboarding content and format - HITOC works with OHA staff to develop priorities for milestones and targets, and provides advice and support on milestone development, data sources for baseline and targets, and other technical issues as needed - HITOC is informed about data sources currently available and data challenges; and provides advice and	13

HITOC Responsibilities	Strategic Plan: 2017-2020 Focus Areas (or statute)	Strategic Plan: 2017-2020 “Topics”	2019 HITOC Work	Item #
			support to OHA regarding overcoming data challenges *Detailed Data Goals for 2019 (added at February HITOC)* • Operational dashboard o Landscape o OHIT Programs Tracking o Oregon HIT Progress Monitoring • Data gaps identified • Priorities for landscape assessment work identified	
Monitor Federal HIT Law and Policy Monitor federal HIT laws and policies that impact Oregon; make recommendations to the Board or the Oregon Congressional Delegation or take other action when appropriate	Monitor Federal HIT Law and Policy	Federal Law/Policy Considerations	• HITOC is informed about new issues and proposed changes to federal law and policy, which may include o ONC implementation of a Trusted Exchange Framework and Common Agreement o ONC implementation of an EHR Reporting program o Federal changes to data sharing privacy laws or regulations such as HIPAA or 42 CFR Part 2 • HITOC takes action, if appropriate, such as responding to proposed changes, or providing reports to OHPB/Oregon Congressional Delegation about impacts to Oregon’s HIT efforts	14
Logistical Tasks	HITOC completes the logistical tasks that are necessary to keep HITOC running efficiently.	N/A	*Membership* • HITOC members are informed about OHPB priorities for HITOC’s 2020	15

HITOC Responsibilities	Strategic Plan: 2017-2020 Focus Areas (or statute)	Strategic Plan: 2017-2020 "Topics"	2019 HITOC Work	Item #
			recruitment and add any HITOC priorities • HITOC members assist OHA in identifying and recruiting HITOC candidates *2020 Work Plan* • HITOC provides input on HITOC's 2020 Workplan, reviews and approves 2020 workplan (or designates chair/vice-chair to work with staff to finalize) • HITOC chair/vice-chair or designee and OHA staff present workplan to OHPB for approval	

Oregon Health Authority | Office of Equity and Inclusion

Hi all,

We are reaching out to Health Equity Committee (HEC) friends and community partners and asking for your assistance in the development of health equity definition.

As you know, achieving health equity, including a healthcare workforce that reflects the demographics of the communities it serves, is a priority for the Oregon Health Policy Board (OHPB), the Oregon Health Authority (OHA) and the Governor. In 2017, OHPB formed the Health Equity Committee and its purpose is to coordinate and develop a policy that proactively promotes the elimination of health disparities and the achievement of health equity for all people in Oregon.

The HEC is acutely aware that in the case of health equity, definitions matter. As stated in a 2017 RWJF report, "Clarity is particularly important in the case of health equity because pursuing equity often involves a long uphill struggle that must strategically engage diverse stakeholders, each with their own agenda. Under those circumstances, if we are unclear about where we are going and why, we can more easily be detoured from a path toward greater equity; our efforts and resources can be co-opted, and we can become lost along the way".

Under that premise, the HEC felt it was essential to develop a definition, to be adopted by the OHPB and its committees. The hope is to find a definition of health equity that is clear and comprehensive, and that acknowledges the historical and structural underpinnings of inequities in health and the need for societal change.

In its April 2019 meeting, the HEC develop a draft definition, and we are reaching out to you for feedback:

Health equity exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, language, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstances.
Achieving **Health Equity** requires the ongoing collaboration of all sectors to address:
- The equitable distribution or redistribution of resources and power; and
- Recognizing and rectifying historical and contemporary injustices

Please take a moment, review this draft definition and let us know by Friday, May 5th, if you have any comments or questions via email to Maria Castro, HEC staff at maria.castro@state.or.us

All the responses to this request will be reviewed and discussed at our May meeting. Our meetings are public and have an opportunity for public comments. Agenda for the May meeting with conference call/GoToMeeting information will be posted by Thursday, May 2nd. You can find all HEC meeting information here: https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

HEC values your time and would like to ensure all voices are heard, please let us know how we can contact you by email or phone to keep you up to date with the development of the health equity definition.

We thank you for your time.

OHPB Health Equity Committee

Oregon Health Authority
Office of Equity and Inclusion

Queridos Amigos del Health Equity Committee (Comité de Equidad en Salud).

Nos acercamos a ustedes, amigos del Comité de Equidad en la Salud (HEC) y miembros de la comunidad para pedirles su ayuda en el desarrollo de la definición del término “equidad en la salud”.

Como saben, lograr equidad en la salud, incluyendo una fuerza laboral de salud que refleje la demografía de las comunidades a las que sirve, es una prioridad para la Junta de Políticas de Salud de Oregón (OHPB), la Autoridad de Salud de Oregón (OHA) y el Gobernador de nuestro Estado. En 2017, OHPB formó el Comité de Equidad en la Salud cuyo propósito es coordinar y desarrollar una política que promueva proactivamente la eliminación de disparidades y el logro de la equidad en la salud para todas las personas en Oregón.

La HEC está consciente de que, en el caso de la equidad en salud, las definiciones son importantes. Como se indicó en un informe de RWJF del año 2017, “La claridad es particularmente importante en el caso de la equidad en la salud porque la búsqueda de la equidad a menudo implica una larga y ardua lucha que debe involucrar estratégicamente a diversas partes interesadas, cada una con su propia agenda. En esas circunstancias, si no tenemos claro hacia dónde vamos y por qué, podemos desviarnos del camino hacia una mayor equidad; nuestros esfuerzos y recursos pueden ser cooptados, y podemos perdernos en el camino ".

Bajo esa premisa, el HEC sintió que es esencial desarrollar una definición, para ser adoptada por el OHPB y sus comités. La esperanza es encontrar una definición de equidad en la salud que sea clara y completa, y que reconozca los fundamentos históricos y estructurales de las inequidades en la salud y la necesidad de un cambio social.

En su reunión de abril de 2019, la HEC desarrollo un borrador de definición y queremos su opinión. Esta es nuestra definición:

La equidad en la salud existe cuando todas las personas pueden alcanzar su máximo potencial de salud y no tienen la desventaja de lograrla debido a su raza, etnia, idioma, condición social y económica, clase social, religión, edad, discapacidad, género, identidad de género, orientación sexual u otras circunstancias socialmente determinadas.
Lograr la equidad en salud requiere la colaboración continua de todos los sectores para abordar:
- La distribución equitativa o redistribución de recursos y poder; y
- Reconocimiento y rectificación de injusticias históricas y contemporáneas.

Tómese un momento, revise este borrador de definición y háganos saber antes del viernes 5 de mayo, si tiene algún comentario o pregunta a Maria Elena Castro, su correo electrónico es maria.castro@state.or.us

Todas las respuestas a esta solicitud serán revisadas y discutidas en nuestra reunión del mes de mayo. Nuestras reuniones son públicas y aceptamos comentarios públicos. La agenda de la reunión de mayo e información sobre el número de conferencia telefónica / GoToMeeting se publicará el jueves 2 de mayo. Puede encontrar toda la información de la reunión de HEC aquí: https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

HEC valora su tiempo y escuchar todas las voces; háganos saber cómo podemos comunicarnos con usted por correo electrónico o por teléfono para mantenerlo informado sobre el desarrollo de la definición de equidad en salud.

Le agradecemos por su tiempo.

Miembros del Comité de Equidad en Salud (Health Equity Committee)

HIT Role Table (May 2019)

	Oregon Health Policy Board (OHPB)	Oregon Health Authority (OHA)	HITOC (HIT Oversight Council)	HIT Commons
Geographic reach	Statewide	Statewide	Statewide	Statewide
Stakeholders: Payers, providers, systems	All markets and sectors	All markets and sectors – primary on Medicaid	All markets and sectors	All markets and sectors
Health system transformation (HST)	Determine goals, action plan, priorities, provide oversight	Implement plan, priorities – primary on Medicaid, State budget	Support all HIT components (broad accountability for health reform HIT support)	Support selected HIT components (e.g. PreManage)
Stakeholder engagement*	All HST stakeholders	All HST stakeholders – primary on Medicaid	All HST stakeholders that touch HIT	HIT Commons members (current and potential)
Oregon's HIT strategy*	Sets policy priorities Approves HITOC's Strategic Plan	Align efforts with HITOC's Strategic Plan	Sets Oregon's HIT Strategic Plan Engage stakeholders in strategic plan updates	Aligns HIT Commons efforts with HITOC strategic plan Key stakeholder input on HITOC strategic plan updates
HIT policy*	Refer HIT policy issues to HITOC, review HITOC recommendations	Office of HIT analysis of state, federal policy	Monitor and explore policy issues, make policy recommendations to OHPB	Can raise policy issues to OHA/HITOC
HIT programs, services		Operate Oregon HIT Program Co-Sponsor HIT Commons Can recommend HIT projects to HIT Commons	Oversee and provide public transparency (re: Oregon HIT Program, OHA's Partnership with HIT Commons) Can recommend HIT projects to HIT Commons	Select HIT Projects Operate HIT Commons programs, initiatives Accelerate HIT efforts (e.g. Oregon Provider Directory)
Oregon's HIT landscape and HIT progress*	Receive HITOC reports	Assess landscape and report on HIT progress	Review and report to OHPB on landscape and HIT progress	Assess and monitor landscape related to HIT Commons efforts Report on HIT Commons project progress

*Opportunity to coordinate OHA, HITOC and HIT Commons work

Oregon HIT Program: Oregon Provider Directory (OPD), Clinical Quality Metrics Registry, Medicaid EHR Incentive Program, Medicaid PreManage subscription, Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP), HIE Onboarding Program

HIT Commons initiatives: EDie/PreManage, PDMP Integration initiative, Accelerating Oregon Provider Directory (exploratory), Oregon Community Information Exchange (exploratory)

Overview Matrix: HIT for Patient Engagement (Draft)

Overarching equity considerations: Need to consider disabilities, literacy, health literacy, access to computer/smartphone, differences in needs across demographics like race/ethnicity, gender, age, written/spoken language, rural/urban/frontier location, education, income, etc.

CCO 2.0: CCO 2.0 requirements include using HIT for patient engagement, so CCO contracts are an additional lever for the state. CCOs may choose how best to use HIT for patient engagement given needs and resources.

Sources

📖 Office of the National Coordinator for HIT, Patient Engagement Playbook (last updated 1/2019), https://www.healthit.gov/playbook/pe/introduction/ Health IT Playbook (last updated 2/2018), https://www.healthit.gov/playbook/introduction/

👓 OHA research/analysis

Portal access to patients' own records

Actions	Overview of Levers	Notes
📖 Facilitate easy enrollment (in EHR portal) • Provide simple, secure portal signup • Develop an automatic enrollment policy • Register patients in the office • Market and educate effectively	☑ Medicaid Meaningful Use Program Measures (stronger/narrower) ☑ Medicare Quality Payment Program (Merit-based Incentive Program (MIPs)) Measures (weaker/broader)	
📖 Activate portal features that meet patient needs • Allow online booking and prescription refills • Set up secure messaging • Share notes • Connect patients to educational and community resources • Support electronic records requests	☑ Medicaid Meaningful Use Program Measures re secure messaging (weaker/narrower) ☑ SIM grant for OpenNotes (past) ☑ Medicaid Meaningful Use Program Measures re connecting patients to educational and community resources (stronger/narrower) ☑ New CMS rules re electronic health records requests	See OpenNotes study finding that people with less education have higher interest in seeing notes compared with HINTS results showing that people with less education are offered portal access less often. OpenNotes study also found that people of color had significantly higher interest in seeing notes than white people did.

🕮 Ensure all patients can access and understand information • Ensure portal access for all patients (disabilities, literacy cited specifically) • Address adolescent health and privacy concerns • Engage non-English-speaking patients	☑ CCO 2.0 year 2 requirement to request culturally/linguistically appropriate tools from vendors ☑ Medicare Quality Payment Program (Merit-based Incentive Program (MIPs)) measure notes that providers subject to civil rights laws re: access for people with disabilities must comply with law	
🕮 Allow portal access for caregivers • Set up varying levels of portal access • Integrate advance care planning documents	☑ Medicaid Meaningful Use Program Measures apply to patient's authorized representative (stronger/narrower)	
👓 Patient record access via HIE		
👓 Pharmacy portals		

Patient-directed data

Actions	Overview of Levers	Notes
🕮 Integrate patient-generated health data and EHRs • Track patient-generated health data • Collect family histories	☑ Medicaid Meaningful Use Program Measures re patient-generated health data (stronger/narrower)	
🕮 Leverage APIs and other HIT • Use APIs to help patients control their data • Use apps to support patient engagement	☑ Medicaid Meaningful Use Program Measures re API use (stronger/narrower) ☑ ONC's proposed rule re API standards	

HIT and relationship management

Actions	Overview of Levers	Notes
🕮 Improve appointments with HIT • Build trust with patients through sharing notes • Offer video appointments	☑ SIM grant for OpenNotes (past)	

• Balance technology with interpersonal communication		
👓 Improve patient experience of clinic administration (see also "Activate portal features that meet patient needs" above) • Text appointment reminders • Text/online quality surveys • Online bill payment		

Enhanced care access

Actions	Overview of Levers	Notes
📖 Telehealth Definition: The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Telehealth includes (but is not limited to) direct, electronic patient-to-clinician interactions. There are four basic methods: • Live video (synchronous) • Store-and-forward (asynchronous) • Remote patient monitoring • Mobile health (mHealth) (smartphone apps and text-based programs)	Telehealth is a separate, complete body of work that includes reimbursement/ payment, credentialing, and other concerns in addition to the technology utilized for the service. Telehealth is undergoing many changes right now at the federal level, particularly around rules governing its use for Medicare and for treatment of substance use disorders and prescriptions. Many of the changes focus on what can be reimbursed and what is considered 'telehealth' for purposes of reimbursement. OHA continues to monitor telehealth at the federal and state level to understand how the definition is evolving and how that may impact HIT strategies going forward.	
👓 Kiosks		
👓 Online health coaching, peer support, wellness programs, etc.		

Medicaid EHR Incentive Program and Medicare Quality Payment Program (Merit-based Incentive Program (MIPs)) details:

- Eligible Professional means a physician (MD, DO, and naturopath), nurse practitioner (including certified nurse-midwife), dentist, physician assistant in certain practice settings, and pediatric optometrist. There are also Medicaid patient volume requirements.
- Eligible Hospital means an acute care hospital with at least 10% Medicaid patient volume or a children's hospital.
- Eligible Clinician means physician (including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry), osteopathic practitioner, chiropractor, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, physical therapists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists, registered dietitians or nutrition professionals. There are other criteria these practitioners must meet to participate.

Measures

- Medicaid Eligible Professionals: Patient E-Access, Measure 1 (>80% patients seen are provided timely access to portal)
  - Access must be available using an API
- Medicare Eligible Hospitals: Provider to Patient Exchange (>1 patient is provided timely access to portal)
- Quality Payment Program Eligible Clinicians: (>1 patient is provided timely access to portal).
  - Note on specifications sheet: "MIPS eligible clinicians should also be aware that while the measure is limited to the capabilities of CEHRT to provide online access, there may be patients who cannot access their EHRs electronically because of a disability. MIPS eligible clinicians who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations."
- Medicaid Eligible Professionals: Coordination of Care through Patient Engagement, Measure 3 (>5% patients are sent a secure message/or provider sends response to patient)
  - Access must be available through an API
- Medicaid Eligible Professionals: Patient E-Access, Measure 2 (>35% patients are provided e-access to patient-specific educational resources)
- Medicaid Eligible Professionals: Coordination of Care through Patient Engagement M3 (>5% patients have patient-generated health data incorporated into certified electronic health record)

The Office of the National Coordinator for
Health Information Technology

ONC Data Brief ■ No. 47 ■ May 2019

Trends in Individuals’ Access, Viewing and Use of Online Medical Records and Other Technology for Health Needs: 2017-2018

Vaishali Patel PhD MPH & Christian Johnson MPH

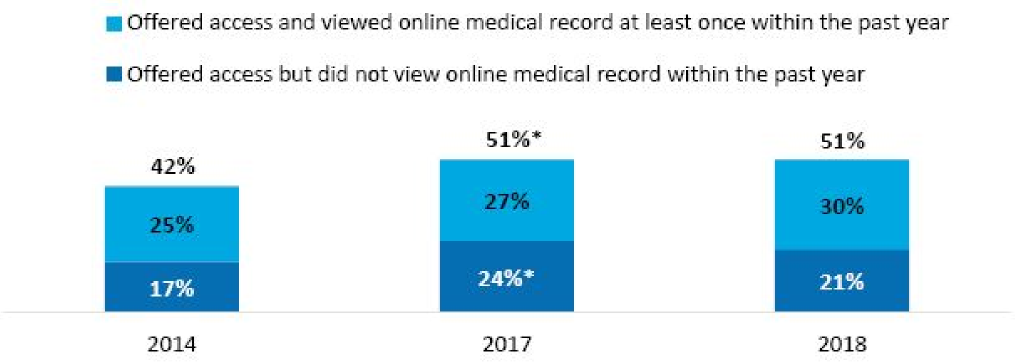
The access, exchange, and use of electronic health information is essential for individuals to better manage their health care needs and share information with their providers and caregivers. Many hospitals and physicians possess capabilities that enable patients to view and download their health information. However, additional steps are needed to make health information more accessible and useful to individuals (1, 2).   A majority of individuals have smartphones and use applications (apps) to help them manage various tasks. The 21st Century Cures Act emphasizes the importance of making patient health information more easily accessible and the need for greater education regarding patients’ rights to access their health information (3). This data brief uses the Health Information Trends Survey (HINTS), a nationally representative survey, to assess individuals’ access, viewing and use of their online medical records, and the use of smartphone health apps and other electronic devices in 2017 and 2018.

HIGHLIGHTS

- The percentage of individuals who were offered access to their online medical record did not change between 2017 (52%) and 2018 (51%).
- In 2018, about 3 in 10 individuals were offered access to their online medical record and viewed their record at least once within the past year.
- Individuals’ rates of being offered access and viewing their online medical records at least once in the past year varied by their health care use, socio-demographic characteristics, Internet access and use, and health.
- Among individuals who viewed their online medical record at least once in the past year, the percentage that downloaded their health information increased by about one-third between 2017 and 2018.
- In 2018, half of smartphone or tablet owners had health or wellness apps which were commonly used to track progress towards a health-related goal (75%).

The percentage of individuals offered access to their online medical record did not change between 2017 and 2018.

Figure 1: Percent of individuals ever offered access to their online medical record by a health care provider or insurer by whether they viewed their online medical record, 2014-2018.

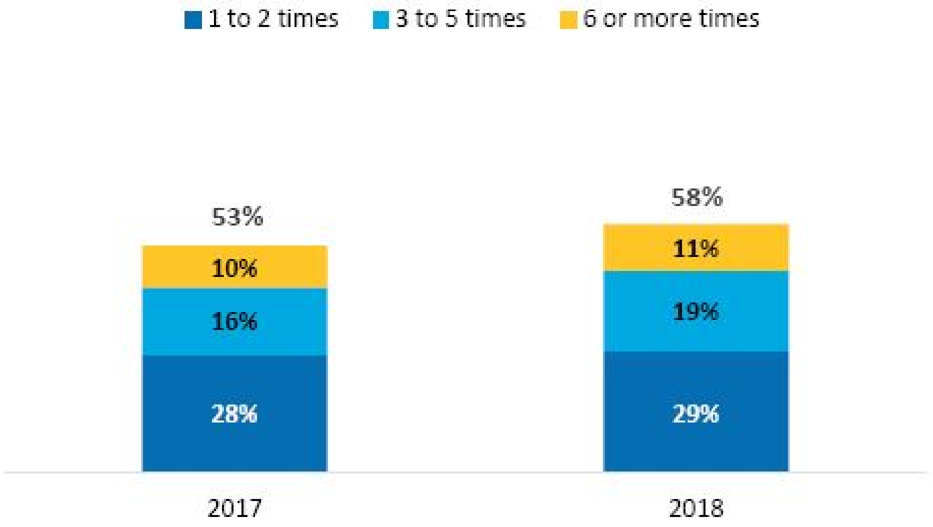


SOURCE: HINTS 4 Cycle 4, 2014; HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTES: *Significantly different from previous year (p<0.05). Denominator represents all individuals. Percentage reflects weighted national estimate.

★ In 2018, three in 10 individuals were offered access to their online medical record and viewed their record at least once within the past year.

Among individuals who had been offered access to an online medical record, nearly six in 10 viewed their record at least once in 2018.

Figure 2: Frequency of viewing an online medical record within the past year among those who had been offered an online medical record by a health care provider or insurer, 2017-2018.



SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTE: Numbers do not add up to 58% due to rounding. Denominator represents individuals who were offered access to their online medical record (52% of individuals nationwide in 2017; 51% of individuals nationwide in 2018).

- ★ Between 2017 and 2018, there were no differences in frequency of viewing online medical records.
- ★ In 2018, among individuals who were offered access to their online medical record, about three in 10 individuals viewed their data one to two times per year.
- ★ In 2018, among individuals offered access to their online medical record, only about one in 10 viewed their data six or more times within the past year.

Individuals' viewing of online medical records varied by their health care usage, rural/urban location, socio-demographic characteristics, Internet access and use, and overall health.

Table 1: Variation in individuals being offered and accessing their online medical records by selected characteristics, 2017-2018 (combined sample)

Characteristic		% Individuals who were offered access to online medical records by characteristic (2017-2018)	Among individuals offered an online medical record, % who viewed their record by characteristic (2017-2018)
Gender	Male (reference)	45%	54%
	Female	57%*^	58%
Annual Household Income	$0 to $34,999	36%*^	41%*^
	$35,000 to $74,999	49%*^	53%*^
	$75,000 or more (reference)	65%	66%
Education	College Degree or more	63%*^	68%*^
	Less than College (reference)	46%	48%
Internet access and use	Yes	57%*^	59%*^
	No (reference)	26%	24%
Geography	Urban	52%*	57%*^
	Rural (reference)	45%	45%
Doctor Visit in Past Year	Yes	57%*^	58%*^
	No (reference)	27%	38%
Health Insurance Coverage	Yes	54%*^	57%*
	No (reference)	25%	34%
Have a Chronic Condition	Yes	55%*^	57%^
	No (reference)	46%	54%

SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTES: Unadjusted weighted national estimate shown. *Unadjusted estimate significantly different from reference category (p<0.05). ^Adjusted estimate (not shown) significantly different from reference category (p<0.05). The adjusted estimates controlled for survey year (2017/2018), gender, age, race/ethnicity, income, education, geography, having seen a doctor in the past year, internet access, chronic condition, and health insurance. Chronic condition was defined as having at least one of the following conditions: diabetes, hypertension, chronic heart disease, chronic lung disease, arthritis, or a mental health condition.

- ★ Access to online medical records varied by individuals' health care use, socio-demographic characteristics, Internet access and use, and by whether they had a chronic health condition.
- ★ Individuals with an annual household income of $75,000 were more likely to be offered access as well as view their online medical record compared to those with less income.
- ★ Individuals who went to the doctor at least once within the past year were twice as likely to be offered access to their online medical record, and were over 50 percent more likely to view their online medical record at least once compared to those who did not visit their doctor within the past year.
- ★ Individuals with at least a college degree had higher rates of being offered access and subsequently viewing their online medical records compared to those with less than a college degree.
- ★ Individuals with chronic health conditions were more likely to be offered access and view their online medical records compared to individuals without chronic health conditions.

Most individuals cited their preference to speak to a provider directly and perceived lack of need as reasons for not viewing their online medical records in 2017 and 2018.

Table 2: Reasons for not accessing online medical record as reported by individuals who did not view their online medical record within the past year, 2017-2018.

Reason for Not Using Online Record	2017	2018
Prefer to speak to health care provider directly	76%	73%
Did not have a need to use your online medical record	59%	65%
Concerned about the privacy/security of online medical record	25%	14%*
No longer have an online medical record	19%	13%
Do not have a way to access the website	20%	10%*

SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTE: *Significantly different from previous year ($p<0.05$). Denominator represents individuals who were offered an online medical record but did not view their record within the past year.

- ★ About three-quarters of individuals cited their preference to speak with their health care provider directly as a reason for not using their online medical record within the past year.
- ★ The percent of individuals who did not view their online medical record within the past year due to privacy and security concerns decreased by 11 percentage points between 2017 and 2018.
- ★ Fewer individuals reported not having a way to access their online medical record’s website as a reason for not viewing their record in 2018 compared to 2017.

Nearly eight in 10 individuals who viewed their online medical record reported that it included summaries of their office visits in 2018.

Table 3: Types of information reported in individuals' medical record amongst those who were offered and viewed their record within the past year, 2017-2018.

Type of Information	2017	2018
Clinical notes	51%	51%
Immunization or vaccination history	55%	58%
Allergy list	62%	61%
List of health/medical problems	70%	72%
Summaries of your office visit	76%	78%
Current list of medications	79%	-
Laboratory test results	92%	-

SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTE: Denominator represents individuals who were offered access to the online medical record and viewed their online medical records at least once within the last year. Data for Current List of Medications and Laboratory Test Results were not collected in 2018.

- ★ There were no changes in the availability of specific types of information in individuals' online medical records between 2017 and 2018.
- ★ In 2018, about six in 10 individuals who viewed their online medical record reported having access to their vaccination history and allergy list.
- ★ A majority of individuals who had viewed their online medical record indicated that it included a list of their health/medical problems and summaries of their office visits.
- ★ Among individuals who had viewed their online medical record within the past year (representing 30% nationally), about half indicated clinical notes were included in their online medical record.

In 2018, the percent of individuals who viewed their online medical record and downloaded their record data increased by over 30 percent.

Table 4: Among those viewed their record at least once within the past year, the percentage that used view, download, or transmit functionalities 2017-2018.

View, Download or Transmit	2017	2018
View test results	84%	-
Download online medical record data	17%	26%*
Transmitted data to at least one outside party listed below	14%	17%
Transmit to another healthcare provider	10%	14%
Transmit to caregiver	4%	4%
Transmit to service or app	3%	3%

SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTE: *Significantly different from previous year ($p<0.05$). Denominator represents individuals who viewed their online medical records at least once within the last year (30% of respondents). Data for View Test Results was not collected in 2018.

- ★ One quarter of individuals who viewed their online medical record also downloaded their data in 2018.
- ★ In 2018, nearly one in five individuals who viewed their online medical record also transmitted their data to an outside party (another healthcare provider, caregiver, or app/service).
- ★ In 2017 and 2018, only three percent of individuals who viewed their record within the past year transmitted their record data to a service or app.

Half of individuals that viewed their online medical record used it to communicate with their health care providers via secure messaging in 2018.

Table 5: Reported online medical record functionalities used by individuals amongst those who were offered and viewed their record, 2017-2018.

Uses of Online Medical Record	2017	2018
Convenience Functions		
Request refill of medications	38%	39%
Fill out forms or paperwork related to your health care	38%	44%*
Updating Medical Record		
Request correction of inaccurate information	8%	7%
Add health information	19%	24%
Communicating with Health Care Provider		
Securely message health care provider and staff (e.g., e-mail)	48%	53%
Decision Making		
Help you make a decision about how to treat an illness or condition	19%	24%
Perceptions regarding Usefulness of Online Medical Record		
Consider online medical record useful for monitoring health	84%	83%

SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
Note: Denominator represents individuals who were offered access to the online medical record and viewed their online medical records at least once within the last year.

- ★ Among those who viewed their online medical record, about four in 10 used it to request medical refills and fill out forms related to their health care in 2018.
- ★ The percent of individuals who reported using their online medical record to fill out forms related to their health care increased by six percentage points between 2017 and 2018.
- ★ Among individuals who viewed their online medical record, about 10 percent requested corrections to their online medical record in 2018.
- ★ More than eight in 10 individuals who viewed their record reported that their online medical record was useful for monitoring their health in 2018.

In 2018, half of smartphone or tablet owners used a health or wellness app.

Table 6: Percent of individuals who reported having a smartphone, tablet, electronic monitoring device, or health and wellness app, 2017-2018.

Type of Device	2017	2018
Electronic Monitoring Device *(e.g., Fitbit, blood glucose meter, blood pressure device)*	34%	35%
Tablet	62%	58%
Smartphone	79%	80%
Tablet or Smartphone	84%	84%
Health and Wellness App (among those with a tablet or smartphone)	44%	49%

SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTE: Examples of an electronic monitoring device include Fitbit, blood glucose meter, and/or blood pressure monitor.

- ★ The proportion of individuals who reported owning a tablet, smartphone, or other electronic monitoring device did not change between 2017 and 2018.
- ★ Over eight in 10 individuals reported owning a tablet or smartphone in 2018.
- ★ One-third of individuals owned an electronic monitoring device such as a Fitbit, blood glucose meter, or blood pressure monitor in 2018.

Three-quarters of individuals with a health and wellness app used it to track progress on a health-related goal in 2018.

Table 7: Percent of individuals who reported using their health and wellness app or other electronic monitoring device to help discuss, track, and/or make decisions regarding their health, 2017-2018.

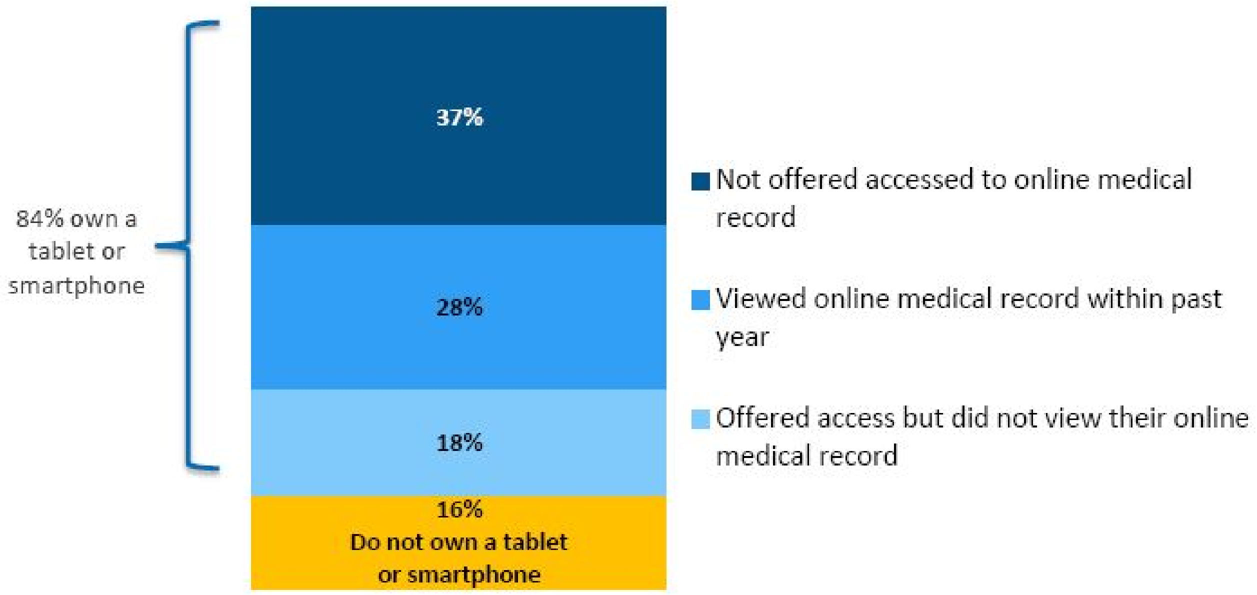
Use of Electronic Device	2017	2018
Individuals with a health & wellness app[1]		
Track progress on a health-related goal	69%	75%*
Make a decision about how to treat an illness or condition	45%	48%
Discuss your health with your health care provider	43%	45%
Individuals with a health & wellness app or other electronic monitoring device[2]		
Shared information from a smartphone, tablet, or other electronic monitoring device with a health professional	26%	28%

SOURCE: HINTS 5, Cycle 1, 2017; HINTS 5, Cycle 2, 2018.
NOTE: *Significantly different from previous year ($p<0.05$). Examples of an electronic monitoring device include Fitbit, blood glucose meter, and/or blood pressure monitor. [1]Denominator represents the sample of individuals that report having a health and wellness app; [2]Denominator represents the sample of individuals that report having a health and wellness app or electronic monitoring device.

- ★ The percentage of individuals who had a health and wellness app and used it to track progress on a health-related goal increased by six percentage points between 2017 and 2018.
- ★ In 2018, about half of individuals with a health and wellness app used it to make a decision about how to treat an illness or condition; a similar number used it to facilitate discussions with their health care provider.
- ★ More than a quarter of health and wellness app or other electronic monitoring device users shared information from their device with a health professional in 2018.

In 2018, one in five individuals owned a tablet or smartphone and were offered access to their online medical record but had not viewed their record within the past year.

Figure 3: Percent of individuals who were offered access and subsequently viewed their online medical record by whether they owned a smartphone/tablet, 2018.



SOURCE: HINTS 5, Cycle 2, 2018.
NOTES: Denominator represents all individuals. Percentage reflects weighted national estimate. Percentages do not add up to 84% due to rounding.

- ★ Almost three in 10 individuals owned a smartphone or tablet and viewed their online medical record at least once within the past year.
- ★ Over one-third of individuals owned a smartphone or tablet and were not offered access to an online medical record.

Summary

Individuals' rates of access and frequency of viewing their online medical records did not change between 2017 and 2018. In 2018, about half of individuals were offered online access to their medical record by a health care provider or insurer. Among these individuals, 58 percent viewed their online medical record at least once within the past year. Nationally, this represents about three in 10 individuals. With the exception of using online medical records to download health information and fill out paperwork, individuals' use of other functionalities remained similar to 2017. The availability of specific types of information in individuals' online medical records also did not change.

Individuals who did not view their online medical record most commonly cited their preference to communicate directly with health care providers (rather than using the online medical record) and a perceived lack of need. The percent of individuals citing privacy and security concerns as reasons for not viewing their online medical record dropped considerably in 2018. This might reflect an increase in the percentage of individuals nationally who express confidence that safeguards are in place to protect medical records from unauthorized viewing (4).

Individuals' rates of being offered and viewing their online medical record varied by factors related to health care access and use, socio-demographic characteristics, Internet use, and health. For example, individuals who had a doctor visit within the past year were twice as likely to be offered access to their online medical record compared to those who did not see their doctor. After adjusting for a variety of factors, including health care access and use, individuals with higher income and greater education were more likely to be offered access and subsequently view their online medical record. This suggests greater efforts are needed to offer access and encourage usage of online medical records across all individuals. Both ONC's *Patient Engagement Playbook* and *Guide to Getting and Using your Health Record* offer tips to providers and patients, respectively, that can make this process easier.

About eight in 10 individuals in 2018 had a tablet or smartphone. Among these individuals, about half had a health or wellness app. Encouragingly, three-quarters of health or wellness app users tracked progress on health-related goals and about half used their apps to make treatment-related decisions. Moreover, almost three in 10 individuals who owned a health and wellness app or an electronic monitoring device shared information from these devices with health care providers. However, few individuals reported transmitting their online medical record data to a health app. This may be related to providers' limited capabilities in offering this function (1, 2).

Making it easier for individuals to use apps to access, view, and subsequently share their online medical record data may enable individuals to better manage their health and address gaps in interoperability. ONC's proposed rule seeks to make patient health information from electronic health records accessible through application programming interfaces (APIs) (3). APIs are technology that allow a software developer to create programs and mobile apps that interact with another software without needing to know the "internal" workings of that software. The rule, as proposed, promotes the creation of apps that would enable individuals to more easily access and use their personal health information (5). One in five individuals had a smartphone or tablet and were offered access to an online medical record but did not view their record within the past year. Usage of online records by smartphone and tablet users, could increase if apps that provided access to view medical record data were widely available; such apps are being piloted by some health systems (6, 7). ONC's recent proposed rule would make it easier for health IT developers to make such products widely available, allowing individuals to more easily access, exchange, and use their health information (5).

Definitions

Definitions for variables derived by ONC during this analysis are described below:

Offered access to an online medical record: Individuals were considered to be offered access to an online medical record if they responded "yes" to either health care provider or insurer for the question, "Have you ever been offered online access to your medical records by: a) health care provider? b) health insurer?"

Ease of Understanding the Health Information in Your Online Medical Record: Health information was considered "Easy to Understand" if an individual responded "Very easy" or "Somewhat easy" to the question, "How easy was it to understand the health information in your online medical record?" Health information was considered "Difficult to Understand" if an individual responded "Very difficult" or "Somewhat difficult" to the same question.

Data Source and Methods

Data are from the National Cancer Institute's (NCI) Health Information National Trends Survey (HINTS). Since 2003, NCI has sponsored HINTS to assess the impacts of health communication, specifically measuring: how people access and use health information, how people use information technology to manage their health and health information, and the degree to which people are engaged in health behaviors.

ONC staff, working with the National Partnership of Women and Families and NCI, developed the survey content related to health IT use for HINTS 5. HINTS 5, Cycle 2 (2018) data were collected from January through May 2018. The sample design for HINTS 5, Cycle 2 (2018) consisted of a single-mode mail survey, using the Next Birthday Method for respondent selection.

The sample design for the HINTS 5, Cycle 2 (2018) survey consisted of two-stages. In the first stage, a stratified sample of addresses was selected from a file of residential addresses. In the second-stage, one adult was selected within each sampled household. The sampling frame consisted of a database of addresses used by Marketing Systems Group (MSG) to provide random samples addresses. Complete data were collected from 3,527 respondents. The response rate was in 33%, and results were weighted to account for non-response and generate national estimates.

The analyses conducted in this data brief primarily focused on questions from sections B and D. The questions asked in the HINTS 5, Cycle 2 (2018) survey can be found at https://hints.cancer.gov/docs/Instruments/HINTS5_Cycle2_Annotated_Instrument_English.pdf.

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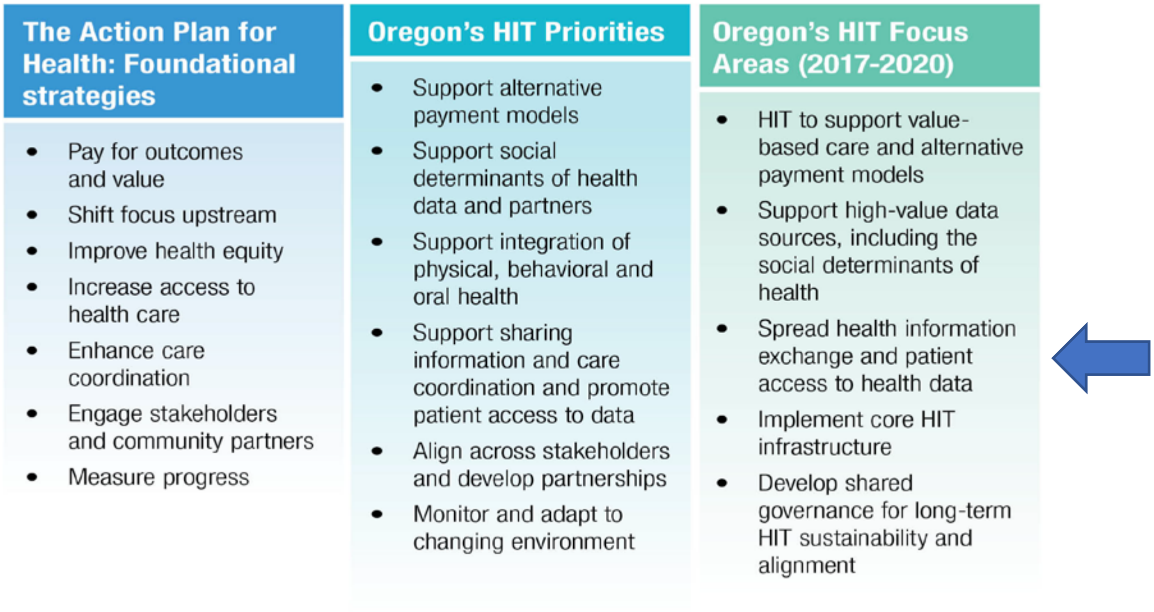
HIT and Patient Engagement references: Oregon's Strategic Plan for HIT/HIE 2017-2020

Patient engagement and HIT is reflected in several ways in the Strategic plan – it is one of 3 overarching goals and has its own chapter in the strategic plan, it is one of the 2017-2020 Focus areas, and it is included in the goals related to statewide health information exchange.

Goal 3: Aims and objectives (pg 9)
Individuals and their families access, use and contribute their clinical information to understand and improve their health and collaborate with their providers.

1. Increased patient access to/use of their complete health records
2. Improved ability for individuals to provide relevant information to their health records
3. Increased use of HIT by patients to engage providers (e.g., patient portals, e-visits, messaging, remote monitoring)

Priorities/Focus areas (pg 12)



The Action Plan for Health: Foundational strategies

- Pay for outcomes and value
- Shift focus upstream
- Improve health equity
- Increase access to health care
- Enhance care coordination
- Engage stakeholders and community partners
- Measure progress

Oregon's HIT Priorities

- Support alternative payment models
- Support social determinants of health data and partners
- Support integration of physical, behavioral and oral health
- Support sharing information and care coordination and promote patient access to data
- Align across stakeholders and develop partnerships
- Monitor and adapt to changing environment

Oregon's HIT Focus Areas (2017-2020)

- HIT to support value-based care and alternative payment models
- Support high-value data sources, including the social determinants of health
- Spread health information exchange and patient access to health data
- Implement core HIT infrastructure
- Develop shared governance for long-term HIT sustainability and alignment

Goals for Statewide Health Information Exchange (pg. 29)
To achieve the goals of HIT-optimized care, the state will work to ensure statewide coverage of HIE. To that end, three goals specific to HIE have been developed:

1. Oregonians have their core health information available wherever they receive care statewide.
2. HIE is meaningful to providers, takes into account usability and workflow and prioritizes high-value use cases.
3. HIE supports the coordinated care model, patient engagement and other alternative payment models.

Patient Access to Health Information – Strategic plan section (pgs.45-46)

Individuals and their families or caregivers can partner with their providers when they are educated and engaged. Increasingly, patients have access to some of their health care information through patient portals and other means. Individuals can also be empowered to provide some of their own clinical data using remote monitoring devices and new applications that allow them to remotely engage with their health care teams.

With support from OHA and several health care organizations, Oregon has become a leader in the OpenNotes initiative, which encourages and supports providers in offering electronic access to full clinical notes to their patients. OHA has also supported efforts to improve electronic access and exchange of POLST forms between providers and the statewide POLST registry.

To reduce gaps in patient access to their health information:

- Individuals should have access to their complete health record, including provider notes, treatments and goals in order to improve their understanding and engagement in their health care and outcomes.
- Individuals should have ways to provide important information into their health records, including clinical data and their preferences related to their care, such as end-of-life care and POLST forms.
- Individuals should have the capacity to facilitate care management by sharing data with their providers.
- Sufficient safeguards should be in place and be clearly communicated to patients so individuals have confidence in the privacy and security of their electronic health information.

Efforts to support improved patient engagement through HIT

The state will support community and organizational efforts by:

Promoting EHR adoption and Meaningful Use

The state will use levers, such as promoting the Medicaid EHR Incentive Program, to encourage providers to make protected health information available to patients. Meaningful Use Stage 3 and MIPS require eligible clinicians to give patients secure, electronic access to their health information.

Leveraging national standards and federal EHR incentives

To inform and support stakeholders, the state will monitor national efforts and standards, the evolving personal health record market and direct-to-consumer health care.

Providing guidance, information and technical assistance

The state will support efforts to make patient information available electronically by informing stakeholders, supporting initiatives and seeking to advance Meaningful Use requirements for making information available to patients.

Assessing changing environments and convening stakeholders

The state will identify and disseminate best practices and seek opportunities to explore promising approaches. As part of that effort, the state will engage individuals to identify opportunities, preferences and barriers around engaging in their health care via electronic interaction with their health information.

Other references in the Strategic Plan:

Executive Summary - Patient access and engagement (pg. 5):

Promoting patient access to their health information and patient engagement through HIT is one of HITOC's three goals of HIT-optimized care. Previous work has focused on promoting efforts to open access to clinician notes through OpenNotes and improving access and exchange of specially protected health information. Going forward, HITOC will explore the topic of patient access and engagement further to identify additional policy and strategic opportunities to leverage HIT to advance efforts. There are many potential opportunities to consider, from expanding access to records to engagement through telehealth and digital health to better understanding health conditions and treatment options. HITOC also remains committed to ensuring patient and consumer representation on stakeholder committees and initiatives, where appropriate, and will work to identify additional ways to engage patients in the work ahead.

Focus areas: Spread health information exchange, patient access to data and other HIT efforts (pg 12):

HIT can also help patients access their health information and better engage with their health care providers. This allows patients to participate more fully with their care team and can improve the effectiveness of health care interventions. Key HIT efforts include supporting initiatives such as OpenNotes that support patient access to clinician notes, engaging providers to increase the value of patient access and engagement, and helping spread best practices.

Landscape Challenges (pg 24):

Patient access and control remains challenging:

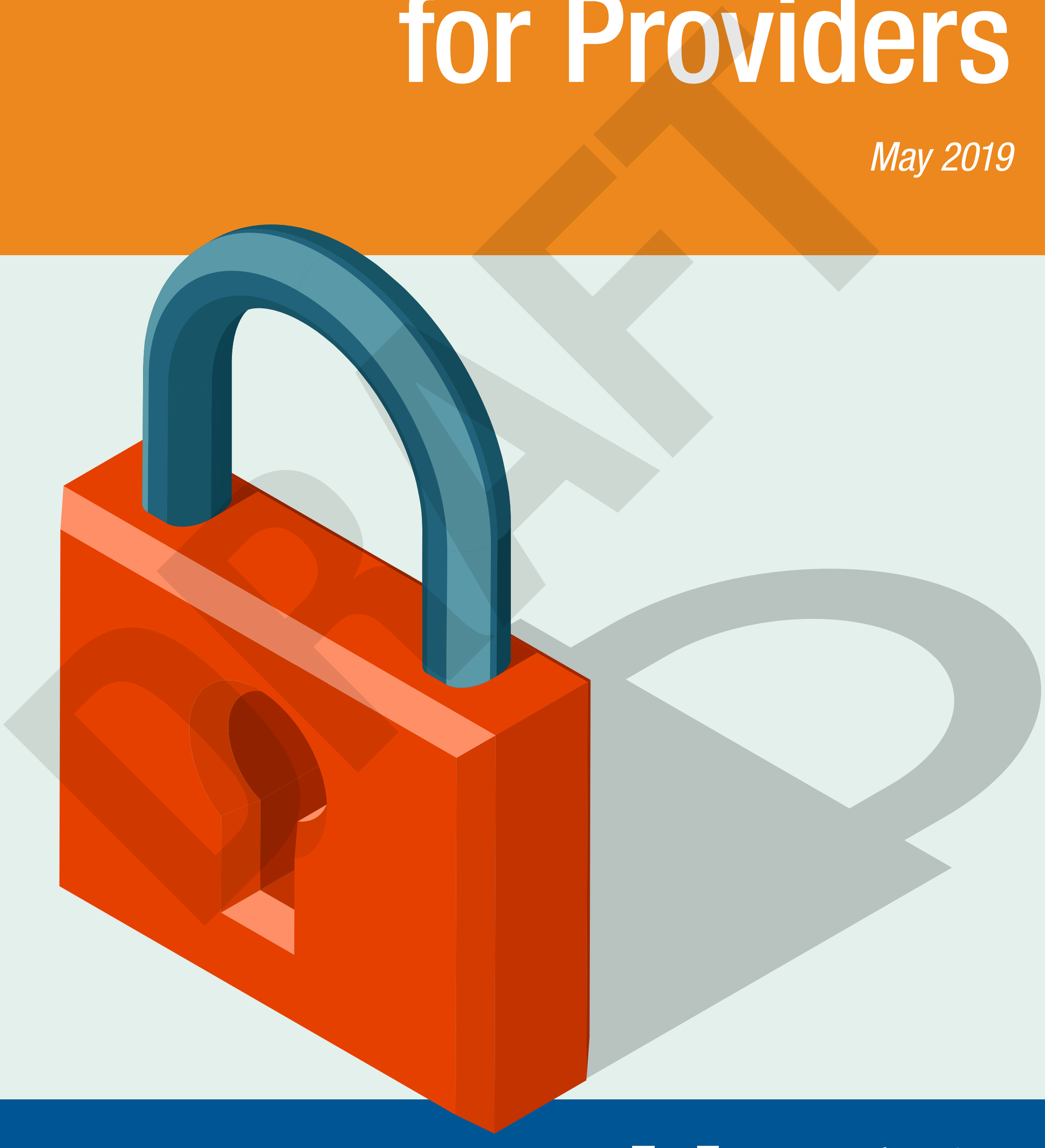
- Many patients still do not have access to their electronic health information. Those that do often have to access it through multiple unconnected portals. This is a particular challenge for patients with complex or chronic illnesses as well as for family members and others who support patients.
- The spread of HIE has particular implications for sensitive information, such as mental health, substance abuse and health data that may be connected with a particular setting (for instance, a county jail). HIE efforts should include considerations of patient choice and ability to control access to information.
- Incorporation of additional sources of data, such as those connected with the social determinants of health and those from HIPAA non-covered entities, raises additional concerns around privacy, stigma and rules surrounding sharing between organizations.

Stakeholder Roles (pg 28):

Individuals: Expect that providers have electronic access to their patient information, inform their providers where to access patient-generated information (such as personal health records), and seek to engage in their care and outcomes.

Confidentiality Toolkit for Providers

May 2019



Oregon Health Authority
ADDICTIONS AND MENTAL HEALTH
HSD Behavioral Health Policy

Contents

This toolkit is not legal advice. It is not a substitute for reviewing the law or consulting an attorney.

Introduction

In 2015, the Oregon Health Authority (OHA) created an internal Behavioral Health Information Sharing Advisory Group to help improve care coordination between physical health and behavioral health providers. This group focused on developing a strategy to support integrated care and services by enabling the electronic sharing of behavioral health information among providers. This is a critical step in supporting the coordinated care model, and realizing the goal of better health, better care and lower costs for everyone. This Confidentiality Toolkit for Providers is one outcome of the Behavioral Health Information Sharing Advisory Group's work.

The following resources and examples will help navigate some of the applicable confidentiality laws that may protect a patient's behavioral health information.

Summary of selected federal and state laws and regulations addressing confidentiality

Law	Citation	General description	Applicability	Information covered
Confidentiality of Alcohol and Drug Abuse Patient Records	42 CFR part 2 (42 U.S.C. § 290dd-2)	Confidentiality of alcohol and drug abuse patient records	Federally assisted substance use disorder treatment programs that provide diagnosis, treatment or referral to treatment	Covers patient records, and reference to publicly available information that identifies a person as currently or previously having an alcohol or drug use disorder.
Health Insurance Portability and Accountability Act	HIPAA Privacy and Security Rules 45 CFR Parts 160 & 164	Federal legislation enacted in 1996 that provides data privacy and security provisions to safeguard medical information	• Applies to covered entities and business associates of covered entities. • Covered entities include health care providers who conduct financial and administrative transactions electronically, health plans, and health care clearing houses. • A business associate is an entity that creates, receives, maintains or transmits public health information (PHI) on behalf of a covered entity.	Covers protected health information that identifies an individual or could be used to identify an individual and relates to physical or mental health of an individual, provision of health care and payment for health care.
Oregon Revised Statute	ORS 192.566	State law regarding form of release of information that supersedes *former* ORS 192.522	Disclosure of protected health information in accordance with ORS 192.558	Authorization form
Oregon Revised Statute	ORS 414.679	State law regarding sharing of information within CCO network and disclosure of mental health diagnoses	Governs sharing of patient information between CCOs and network providers	Covers member information, HIV, other health and mental health diagnoses

Law	Citation	General description	Applicability	Information covered
Oregon Revised Statute	ORS 179.505	State law regarding disclosure of written accounts by health services providers, including psychotherapy notes	Applies to health care service providers who are employed or under contract with a "public provider," as defined in the statute	• Law covers individually identifiable health information (written accounts) created or received by a health care services provider. • Statute also covers disclosure of psychotherapy notes, as defined in the statute.
Oregon Revised Statute	ORS 109.675	• State law regarding age of majority for patients 14 years and older who seek to obtain outpatient treatment for mental or emotional disorder or chemical dependency without parental consent • Establishes requirements and exceptions regarding parental involvement.	Applies to minors 14 years of age or older and providers listed in the statute	Covers the right to treatment for patients that are 14 years of age or older
Oregon Revised Statute	ORS 109.680	State law regarding the disclosure of a minor's diagnosis or treatment information to parents without the minor's consent	Applies to minors 14 years of age or older and their parents, as well as the providers listed in the statute	Covers information related to diagnosis or treatment of minors 14 years of age or older
Oregon Revised Statute	ORS 430.399(6)	Statute concerning records of a person at a treatment or sobering facility and the records' release with or without patient consent	Applies to providers or staff at a treatment or sobering facility	Covers any records of a person at a treatment facility or sobering facility
Oregon Revised Statutes	ORS 192.398(1)	Provides disclosure exemptions for records of physical or mental health or psychiatric care or treatment of a living individual who is less than 75 years old	Applies to any holder of public records described in the statute	Covers any public records relating to physical or mental health or psychiatric care or treatment of a living individual who is less than 75 years old

Law	Citation	General description	Applicability	Information covered
Oregon Revised Statutes	ORS 192.553 to ORS 192.581	Set of state laws regarding Oregon's policy on protected health information.	Applies to health care providers and state health plan	Covers protected health information held by a covered entity, as defined in ORS 192.556
H.R. 6	Support for Patients and Communities Act	• This recent federal legislation provides for opioid use disorder prevention, recovery and treatment. • Subtitle F (Jessie's Law sections 7051–53) address inclusion of opioid addiction history in medical records and developing best practices related to patient records of substance use disorder.	Applicable to health care providers and state agencies.	May cover records related to a patient's substance use disorder, in particular opioid use disorder

Frequently asked questions on behavioral health state and federal privacy laws

The questions included below are modeled, in part, after questions submitted to the Oregon Health Authority during a webinar. To access the online webinars please visit https://www.oregon.gov/oha/HSD/BHP/Pages/Behavioral-Health-Info.aspx.

For more frequently asked questions about applying 42 CFR part 2 to health information exchange (HIE), please see the U.S. Department of Health and Human Services. It is available at https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf.

SAMHSA is updating guidance on the new and updated regulations. See https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs.

General privacy law questions

Q. Is there any recourse for a health care entity when another entity has a more conservative interpretation of privacy laws that could affect patient care? Does an OHA program offer mediation in this situation?

A. There are often differences in how health entities interpret regulations. No OHA program handles appeals or mediation requests related to such differences. However, where there is a difference in interpretation or application of state and federal laws between different entities, you could follow up with the other covered entity about your interpretation of the regulations. Seek to understand why it differs in its interpretation.

Q. How do I know when information included in a medical record falls under 42 CFR part 2?

A. Whether information included in a medical record falls under 42 CFR part 2 generally depends on three factors:

- The type of information
- Who holds the information, and
- The purpose of the information.

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42 CFR § 2.12(a). Part 2 restricts disclosure of any information that would "identify a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person." 42 CFR § 2.12(a)(1)(i). Further, the information must be "obtained by a federally assisted drug abuse program . . . for the purpose of treating a substance use disorder, making a diagnosis for that treatment, or making a referral for that treatment." 42 CFR § 2.12(a)(1)(ii). Information might also be subject to protections in 42 CFR part 2 by agreement (e.g. Qualified Services Organization Agreement under 42 CFR 2.11 or audit/ evaluation under 42 CFR 2.53).

For additional information on the applicability of part 2 protections, see the following fact sheets issued by SAMHSA:

> "Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me?": https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf.
>
> and
>
> "Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?": https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf.

Q. What is a federally assisted drug use program?

A. Under part 2, a program is defined as:

- An individual or entity other than a general medical facility that holds itself out as providing and does provide drug/alcohol diagnosis, treatment or referral for treatment (e.g., freestanding drug and alcohol treatment program, PCPs who provide drug and alcohol services as their principal practice)
- An identified unit within a general medical facility that holds itself out as providing and does provide drug and alcohol diagnosis, treatment or referral for treatment (e.g., detox unit, inpatient or outpatient drug and alcohol program within a general medical facility), and
- Medical personnel or other staff in a general medical care facility whose primary function is providing drug and alcohol diagnosis, treatment or referral for treatment, and who are identified as such (e.g., addiction specialist working in a primary care practice). See 42 CFR § 2.11.

A program is federally assisted if:

- Any department or agency of the United States conducts it in whole or in part, directly or by contract
- It is carried out under a license, registration, certification or other authorization granted by any department of agency of the United States (i.e. Medicare)
- It is at all supported by funds from any department or agency of the United States
- It receives assistance from the IRS through tax deductions or exemptions. See 42 CFR § 2.12(b).

For additional information, see Question/Answer 2 in SAMHSA's "Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)," at https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf.

Q. How do federal privacy laws address the release of a child's behavioral health record from one provider to another provider without parental signature?

A. HIPAA regulations generally allow sharing patient behavioral health information, excluding psychotherapy notes, between providers when medically appropriate, regardless of the patient's age. See 45 CFR §§ 164.506, 164.508. For more information regarding exchange of information between providers, see Health and Human Service's fact sheet, "Permitted Uses and Disclosures: Exchange for Treatment," at https://www.hhs.gov/sites/default/files/exchange_treatment.pdf.

Part 2, however, sets out more restrictive consent requirements for sharing a minor's substance use disorder records; applicability will vary depending on the circumstances. For more information regarding part 2 consent requirements for minors, please see 42 CFR §§ 2.14; 2.31.

42 CFR part 2 questions

Q. Under part 2, what disclosures are permitted with a patient's written consent?

A. The current version of 42 CFR § 2.33 (Jan. 3, 2018), states:

(a) If a patient consents to a disclosure of their records under § 2.31, a part 2 program may disclose those records in accordance with that consent to any person or category of persons identified or generally designated in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§ 2.34 and 2.35, respectively.

(b) If a patient consents to a disclosure of their records under § 2.31 for payment and/or health care operations activities, a lawful holder who receives such records under the terms of the written consent may further disclose those records as may be necessary for its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder. Disclosures to contractors, subcontractors, and legal representatives to carry out other purposes such as substance use disorder patient diagnosis, treatment, or referral for treatment are not permitted under this section. In accordance with § 2.13(a), disclosures under this section must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

(c) Lawful holders who wish to disclose patient identifying information pursuant to paragraph (b) of this section must have in place a written contract or comparable legal instrument with the contractor or voluntary legal representative, which provides that the contractor, subcontractor, or voluntary legal representative is fully bound by the provisions of part 2 upon receipt of the patient identifying information. In making any such disclosures, the lawful holder must furnish such recipients with the notice required under § 2.32; require such recipients to implement appropriate safeguards to prevent unauthorized uses and disclosures; and require such recipients to report any unauthorized uses, disclosures, or breaches of patient identifying information to the lawful holder. The lawful holder may only disclose information to the contractor or subcontractor or voluntary legal representative that is necessary for the contractor or subcontractor or voluntary legal representative to perform its duties under the contract or comparable legal instrument. Contracts may not permit a contractor or subcontractor or voluntary legal representative to re-disclose information to a third party unless that third party is a contract agent of the contractor or subcontractor, helping them provide services described in the contract, and only as long as the agent only further discloses the information back to the contractor or lawful holder from which the information originated.

Q. Does part 2 require written consent from a patient for a provider to verify insurance benefits for a patient's treatment (i.e., allow disclosure to a third-party payer)?

A. Part 2 states that any information disclosed that identifies an individual, directly or indirectly, as having a current or past alcohol or drug problem is subject to part 2 protections and requires written consent (on paper or electronic). 42 CFR §§ 2.12(a); 2.31; 2.33.

Q. When a disclosure does not seem to violate HIPAA, but does violate the stricter requirement of 42 CFR part 2, what are the disclosure requirements for the covered entity?

A. Federal guidance states that:

> A health provider that provides treatment for substance use disorders, including opioid abuse, needs to determine whether it is subject to 42 CFR part 2 (i.e., a "part 2 program") and whether it is a covered entity under HIPAA. Generally, the part 2 rules provide more stringent privacy protections than HIPAA, including in emergency situations. If an entity is subject to both part 2 and HIPAA, it is responsible for complying with the more protective part 2 rules, as well as with HIPAA. HIPAA is intended to be a set of minimum federal privacy standards, so it generally is possible to comply with HIPAA and other laws, such as 42 CFR part 2, that are more protective of individuals' privacy.

For more information, please see "How does HIPAA interact with the federal confidentiality rules for substance use disorder treatment information in an emergency situation—which rules should be followed?" at https://www.hhs.gov/hipaa/for-professionals/faq/3005/how-does-hipaa-interact-federal-confidentiality-rules-substance-use-disorder-treatment-information-in-emergency/index.html (last reviewed Jan. 3, 2018).

Q. What part 2 notice requirements prohibit redisclosure of information?

A. 42 CFR § 2.32(a) states that any disclosure made with a patient's consent must be accompanied by one of two regulatory notices:

> (1) This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65; or
>
> (2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

SAMHSA has indicated that the second (abbreviated) notice was designed to fit in standard health care electronic systems, which often have an 80-character limit. However, SAMHSA states the abbreviated notice can be used in any instance requiring a notice. For more information, see 83 Fed. Reg. 240 (Jan. 3, 2018), at https://www.govinfo.gov/content/pkg/FR-2018-01-03/pdf/2017-28400.pdf.

Q. Are part 2 providers only those that treat substance use disorders, or do they include behavioral health providers?

A. Generally, a part 2 provider is any provider that meets the definition of "program" and is federally assisted (see A.3). As SAMHSA states:

Today, many patients receive treatment for a SUD in a primary care or integrated care setting. These settings may provide both behavioral and physical health services, and individual providers may address all of a patient's behavioral or physical health needs. Depending on its particular characteristics, an integrated care setting may not have a part 2 Program even if it provides some services for the diagnosis, treatment, or referral for treatment of a SUD.

See "Disclosure of Substance Use Disorder Patient Records: Does part 2 Apply to Me?" available at https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf.

Q. Under part 2, is a minor's consent needed for a parent's request for records?

A. The answer to this question can vary depending on several factors. To determine whether consent is needed, see 42 CFR § 2.14, which outlines part 2 consent requirements for minor patients.

For further guidance, see OHA's "Minor Rights: Access and Consent to Health Care," available at https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/Documents/minor-rights.pdf (Aug. 2016).

HIPAA questions

Q. What public interest and benefit activities are covered under HIPAA?

A. HIPAA's privacy rule permits use or disclosure of protected health information without an individual's authorization or permission under certain circumstances, including for public interest and benefit activities. See 45 CFR §§ 164.508, 164.512. Public interest and benefit activities include disclosures for the following: (1) as required by law; (2) for public health activities; (3) to assist victims of abuse, neglect, and domestic violence; (4) for health oversight activities; (5) for judicial and administrative proceedings; (6) for law enforcement purposes; (7) to make necessary disclosures to coroners, medical examiners, and funeral directors regarding decedents (8) to facilitate cadaveric organ, eye and tissue donation; (9) for research purposes; (10) to avert a serious threat to health or safety; (11) for specialized government functions (military, national security, etc.); and (12) for workers' compensation or similar programs. See 45 CFR § 164.512.

For more information, please see HHS's "Summary of the HIPAA Privacy Rule," available at https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (last reviewed on July 26, 2013).

Q. How do psychotherapy notes differ from service/progress notes (that document the content of the service provided)?

A. The HIPAA Privacy Rule defines psychotherapy notes specifically as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record." The definition of psychotherapy notes expressly excludes specific types of information that might otherwise be included in service/progress notes, including "medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." See 45 CFR § 164.501. Note that ORS 179.505 also defines psychotherapy notes for purposes of ORS 179.505.

Q. Why are psychotherapy notes treated differently from other mental health information?

A. According to HHS, "Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes."

See "Does HIPAA provide extra protections for mental health information compared with other health information?" available at https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html (last reviewed on September 12, 2017).

Q. If the patient's family is present, does the patient need to provide written consent, or would verbal consent suffice?

A. 45 CFR § 164.510 states, in part:

"A covered entity may use or disclose protected health information, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure, in accordance with the applicable requirements of this section. *The covered entity may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this section."* (Emphasis added.)

For more information, see "Does the HIPAA Privacy Rule permit a doctor to discuss a patient's health status, treatment, or payment arrangements with the patient's family and friends?" available at https://www.hhs.gov/hipaa/for-professionals/faq/488/does-hipaa-permit-a-doctor-to-discuss-a-patients-health-status-with-the-patients-family-and-friends/index.html (last reviewed on July 26, 2013).

Oregon law questions

Q. How are providers applying the "shall disclose" language in the Oregon Revised Statutes (e.g., ORS 192.561 and ORS 414.679) when the general rule for dealing with conflict between privacy laws is to accept the more restrictive law?

A. In general, the use of the word "shall" implies an obligation or requirement to disclose if certain applicable conditions noted in the rule or statute are met. However, use of the word "shall" does not necessarily determine a provider's obligations. Ultimately, when determining whether disclosure is permitted or required under the Oregon Revised Statutes, a covered entity must consider all applicable state and federal laws.

Q. Can a substance use treatment facility share admit and discharge date information with the CCO for billing purposes? In the past, some facilities have not disclosed that information.

A. Part 2 rules state that any disclosed information that directly or indirectly identifies an individual , as having a current or past substance use disorder is subject to part 2 protections. See "Under part 2, what disclosures are permitted with a patient's written consent" question and answer on page 10.

Health information technology questions

Q. What is Consent2Share?

A. Consent2Share (C2S) is an open source software application sponsored by SAMHSA. C2S is designed to support consent management, data segmentation and health information integration with existing health information exchange (HIE) systems and electronic health records (EHR). The application manages patient consent and segments data that is subject to privacy protections, such as part 2 information. Consent2Share is an option available to entities interested in managing consent and segmenting data within their electronic health records and health information exchange systems. The application is designed to give patients a meaningful choice about what behavioral health information to share with providers.

For more information about C2S, please visit https://bhits.github.io/consent2share/. You can also listen to an informative webinar sponsored by SAMHSA, available at https://www.youtube.com/watch?v=WxM3CwAQdXo.

Q. Is C2S provided in multiple languages, and are there options for visually impaired patients?

A. As of January 2019, C2S is supported in English and Spanish. There is no information on whether C2S will be available in other languages or if there are options for visually impaired patients.

Q. Can C2S be accessed at home from a PC, or would portals be accessible in clinics?

A. To use C2S, patients will need access to any computer or tablet and an email address to create a C2S account. Providers will likely need staff to teach patients how to initially set up and use their C2S account.

See Consent2Share V3.4.0 Patient User Guide, available at https://bhits.github.io/consent2share/downloads/3.4.0/C2S_Patient_User_Guide_3.4.0.pdf.

Q. Is there guidance on how to use C2S?

A.20. Yes. C2S has four different types of user interfaces: master, provider, staff and patient. SAMHSA has produced user interface guides for the four different types of users. For the most recent versions of those guides, please visit https://bhits.github.io/consent2share/documentation/userGuides.html.

Q. How can providers begin to implement Consent2Share?

A. Consent2Share is available for free in its current form online at GitHub (version 3.5.0). For technical guidance on C2S and access to the software application, please visit https://bhits.github.io/consent2share/.

SAMHSA has also created an instructional video on how to download, install and run Consent2Share, which is available online at https://www.youtube.com/watch?v=fqLJlxt0MSo.

Q. Where has the SAMHSA Consent2Share application been implemented?

A. Several programs have successfully implemented the Consent2Share platform. SAMHSA funded some of these programs. For example, SAMHSA sponsored pilot projects with the Prince George's County Health Department and Arizona's Health-e Connection. Seattle, Washington has also begun implementing the program.

For more information about programs that have adopted C2S, please visit http://www.feisystems.com/what-we-do/health-it-application-development/consent2share-early-adopters/.

Exemptions and exceptions to part 2 regulations

Q. When can a part 2 provider disclose medical records without patient consent?

A. Part 2 permits the disclosure of patient information without written patient consent under certain circumstances; i.e., exempts in certain circumstances from the part 2 written consent requirement. This includes the following circumstances:

- Medical emergencies, see 42 CFR § 2.51.
- Research purposes, see 42 CFR § 2.51
- Audits and evaluations, see 42 CFR § 2.53.

Please note that under some circumstances, such as court-ordered disclosures, 42 CFR part 2 may not apply at all. See "What are the requirements for court-ordered disclosures?" question and answer on page 19.

Q. Are there circumstances where the restrictions of 42 CFR part 2 do not apply even though a part 2 provider has the information identifies a patient as having or having had a substance use disorder?

A. Yes. 42 CFR § 2.12 expressly provides the following exceptions to the applicability of part 2 regulations:

(1) **Department of Veterans Affairs.** These regulations do not apply to information on substance use disorder patients maintained in connection with the Department of Veterans Affairs' provision of hospital care, nursing home care, domiciliary care, and medical services under Title 38, U.S.C. Those records are governed by 38 U.S.C. 7332 and regulations issued under that authority by the Secretary of Veterans Affairs.

(2) **Armed Forces.** The regulations in this part apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Department of Veterans Affairs furnishing health care to veterans.

(3) **Communication within a part 2 program or between a part 2 program and an entity having direct administrative control over that part 2 program.** The restrictions on disclosure in the regulations in this part do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of patients with substance use disorders if the communications are:

(i) Within a part 2 program; or

(ii) Between a part 2 program and an entity that has direct administrative control over the program.

(4) **Qualified service organizations.** The restrictions on disclosure in the regulations in this part do not apply to communications between a part 2 program and a qualified service organization of information needed by the qualified service organization to provide services to the program.

(5) **Crimes on part 2 program premises or against part 2 program personnel.** The restrictions on disclosure and use in the regulations in this part do not apply to communications from part 2 program personnel to law enforcement agencies or officials which:

(i) Are directly related to a patient's commission of a crime on the premises of the part 2 program or against part 2 program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) **Reports of suspected child abuse and neglect.** The restrictions on disclosure and use in the regulations in this part do not apply to the reporting under state law of incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, the restrictions continue to apply to the original substance use disorder patient records maintained by the part 2 program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

Q. What are the requirements for court-ordered disclosures?

A. The requirements for court-ordered disclosures differ depending on the purpose and use of the records. Those requirements are outlined in 42 CFR subpart E: **§ 2.64** (noncriminal purposes), **§ 2.65** (criminal investigation or prosecution), **§ 2.66** (investigation or prosecution of a part 2 program or record holder), and **§ 2.67** (investigation of part 2 program employees or agents in connection with criminal matter).

Part 2 summarizes the legal effect of a court order entered under subpart E as follows:

42 CFR § 2.61

(a) Effect. An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290dd–2 and the regulations in this part. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under the regulations in this part.

(b) Examples.

(1) A person holding records subject to the regulations in this part receives a subpoena for those records. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under the regulations in this part.

(2) An authorizing court order is entered under the regulations in this part, but the person holding the records does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person holding the records must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of the regulations in this part.

Consents and qualified service organization agreements (QSOAs)

Q. What is a qualified service organization (QSO)?

A. Under 42 CFR § 2.11, a qualified service organization means an individual or entity that:

(1) Provides services to a part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(2) Has entered into a written agreement with a part 2 program under which that individual or entity:

(i) Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the part 2 program, it is fully bound by the regulations in this part; and

(ii) If necessary, will resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by the regulations in this part.

Note that, "The restrictions on disclosure in the [part 2 regulations] do not apply to communications between a part 2 program and a qualified service organization of information needed by the qualified service organization to provide services to the program." 42 CFR § 2.12.

Q. Can a behavioral health provider (specifically a substance use treatment provider) communicate with CCOs?

A. The answer to this question would depend on the circumstances presented. Possible factors might include whether the CCO qualifies as a QSO, whether the patient has or is willing to provide written consent, or whether the circumstances presented fall under one of the recognized exemptions or exceptions under part 2.

Q. Why is a qualified service organization agreement (QSOA) needed between providers if HIPAA allows the sharing of treatment information?

A. Although HIPAA regulations might allow the sharing of some patient behavioral health information among providers for care coordination, treatment, payment or health care operations, 42 CFR part 2 is more restrictive and prohibits provider-to-provider sharing of any substance use disorder records without specific authorization, such as written consent or a QSOA.

Q. When a consent references a specific recipient's name (i.e., their PCP), does this cover release to that PCP's office?

A. It depends. In general, "[i]f a patient consents to a disclosure of their records under § 2.31, a part 2 program may disclose those records in accordance with that consent to any person or category of persons identified or generally designated in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§ 2.34 and 2.35, respectively." 42 CFR § 2.33(a) (emphasis added). Therefore, whether a consent form covers the specific recipient's office may depend on how the consent form designates the recipient(s).

Note, however, that 42 CFR § 2.12(3) provides the following exception:

> Communication within a part 2 program or between a part 2 program and an entity having direct administrative control over that part 2 program. The restrictions on disclosure in the regulations in this part do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of patients with substance use disorders if the communications are:

(i) Within a part 2 program; or

(ii) Between a part 2 program and an entity that has direct administrative control over the program.

Q. When completing a consent form, is it enough for a patient to check the box for disclosure of substance abuse records and have the client sign the form?

A. No. 42 CFR § 2.31(a) details information that a valid written consent form must include. For instance, "[h]ow much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed." 42 CFR § 2.31(a)(3).

Q. Can a blank consent form be emailed to a client and then faxed back to the provider once completed?

A. The part 2 regulations do not specifically address faxed consent forms. However, 42 CFR § 2.31(a) states that "written consent to a disclosure under the regulations in this part may be paper or electronic." Part 2 also allows for electronic signatures "to the extent that they are not prohibited by any applicable law." 42 CFR § 2.31(a)(8).

Q. Who is responsible for setting up qualified service organization agreements (QSOAs)?

A. A part 2 program is responsible for assuring its compliance with law and using qualified service organization agreements when needed. A part 2 program and an individual or entity that qualifies as a QSO under 42 CFR § 2.11 can directly set up a qualified service organization agreement with each other. The state is generally not responsible for setting up such agreements when it is not a party to the agreement.

A sample QSOA that can be used by part 2 programs is in the "Sample common consent form and instructions" section.

Q. What is the difference between a business associate agreement (BAA) and a QSOA?

A. QSOAs under part 2 and business associate agreement under §§ 164.314(a) and 164.504(e) of the HIPAA Security and Privacy Rules have some similarities in that they can facilitate information disclosure between a part 2 program and an organization that provides services to the program, including health information exchanges (HIEs). However, there are important differences. BAAs apply to third party organizations serving covered entities under HIPAA; QSOAs apply to third party organizations that serve substance use programs covered under 42 CFR part 2. If a program is both a

HIPAA-covered entity and a 42 CFR part 2 program, agreements with third party organization may need to meet the requirements of both a BAA and a QSOA. The BAA and QSOA vary in their required provisions.

A "business associate" under HIPAA "is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. A member of the covered entity's workforce is not a business associate. A covered health care provider, health plan, or health care clearinghouse can be a business associate of another covered entity." See "Business Associates," available at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html. For a complete definition, see 45 CFR § 160.103.

HIPAA set outs a comprehensive list of requirements for BA agreements under 45 CFR §164.504(e). Those requirements, include, for example, that the business associate (BA) report to the covered entity whenever it is aware of any unauthorized use or disclosure of protected information. The BA must return or destroy all protected health information when the agreement terminates.

For more information regarding business associate agreements and sample agreement provisions, please see "Business Associate Contracts," available at https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html.

The terms of a QSOA are set out in part 2. For instance, under part 2, the QSOA must require that the entity acknowledge it is bound by part 2 regulations when receiving patient records from a part 2 program. The receiving entity must resist judicial proceedings to obtain access to patient records except as permitted by part 2. See 42 CFR § 2.11.

Q. Who retains information in QSOAs?

A. Under a QSOA, the part 2 provider/entity would share the necessary information as defined in the QSOA with the qualified service organization (QSO). The terms of the agreement may describe more specifically which entity could receive, store, process or deal with patient records. Both parties to the QSOA are bound by all part 2 regulations. See 42 CFR § 2.11.

Q. Under part 2, can a client really revoke authorization to communicate with a PCP if that communication is part of treatment?

A. As indicated under the written consent requirements, “the consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.” 42 CFR § 2.31(a)(6) (emphasis added).

Section 2.31(b) expressly states that a “disclosure may not be made on the basis of a consent” that is “known to have been revoked.”

Q. Why isn’t the QSOA exception, with its reference to medical services, used to address most information-sharing obstacles?

A. The QSOA exemption would not resolve most challenges related to information sharing because it is contingent on a particular relationship between the part 2 program and the QSO. The exemption can only be used if a person or organization is providing a service to a part 2 program (e.g., data processing; bill collecting; dosage preparation; lab analyses; or legal, medical, accounting or other professional services). In many instances, the recipient entity and the part 2 program will not have that specific relationship.

Q. Can a part 2 program contract with a QSO for a service whereby the QSO discloses specific information to other providers (PCP, hospital) or CCOs for care coordination purposes (i.e., the service provided is not only sharing information to/from the substance use disorder (SUD) program itself, but to share information on behalf of the SUD to other providers/CCOs)?

A. As SAMHSA explains:

> **A QSOA is a two-way agreement between a Part 2 program and the entity providing the service . . . The QSOA authorizes communication between those two parties, however the Part 2 program should only disclose information to the QSO that is necessary for the QSO to perform its duties under the QSOA. Also, the QSOA does not permit a QSO to redisclose information to a third party unless that third party is a contract agent of the QSO, helping them provide services described in the QSOA, and only as long as the agent only further discloses the information back to the QSO or to the Part 2 program from which the information originated.**

For more information, see “Applying the Substance Abuse Confidentiality Regulations,” at https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs (last updated 05/01/2018).

Examples of allowable sharing

Below are examples of allowable sharing of protected information. The examples consider elements of the analysis such as the information type to be disclosed; disclosing party; recipient of information; purpose for information sharing; if disclosure and re-disclosure are permitted.

When reviewing these use cases, bear in mind the exceptions to 42 CFR part 2. Exceptions can include, for instance:

- Veterans' Affairs/armed forces
- Program or administrative entity personnel
- Qualified service organizations
- Child abuse
- Medical emergencies
- Personal representatives
- Audit and evaluation
- Direct administrative control

Please note that these examples may encompass some of the common uses and types of disclosures, but they are not comprehensive and not a substitute for a case-by-case application of law to each disclosure.

Links to Oregon Revised Statutes and Code of Federal Regulation (CFR) 42 part 2, referenced in the charts:

ORS 179.505	https://www.oregonlegislature.gov/bills_laws/ors/ors179.html
ORS 192.556	https://www.oregonlegislature.gov/bills_laws/ors/ors192.html
ORS 192.558	https://www.oregonlegislature.gov/bills_laws/ors/ors192.html
ORS 192.561	https://www.oregonlegislature.gov/bills_laws/ors/ors192.html
42 CFR part 2	http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

Reliance eHealth Collaborative developed a legal use case matrix. It is available at http://reliancehie.org/wp-content/uploads/2017/08/Reliance-Legal-Use-Case-Matrix-1-6-15-FINAL.xlsx. It is not intended to serve as legal advice to other organizations or agencies. A grant from the Office of the National Coordinator for Health IT (ONC) (#90IX0007/01-00) funded this work

Sample common consent form and instructions

https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/me3010.pdf?CFGRIDKEY=MSC%203010,,Authorization%20for%20Disclosure,%20Sharing%20and%20Use%20of%20Individual%20Information%20(Statewide%20use),,me3010.pdf,,,,,,/es_xweb../FORMS/-,,/es_xweb../FORMS/-,

STATE OF OREGON 1859

Authorization for Disclosure, Sharing and Use of Individual Information

The purpose of this form includes referring, coordinating and monitoring your services with providers, as described below.

Legal last name of individual:	**First name:**	**MI:**	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification type: Choose one			
Legal last name of representative (*if any*):	**First name:**		**MI:**
Relationship to individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		

By signing this form, I authorize the named record holder(s) to disclose the following specific confidential information about me. Whenever "mutual exchange" is checked, those named agencies will be able to share information back and forth to better provide services to me.

REQUESTING AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL	
Purpose of the requested disclosure, sharing and use:	
Entity name: Choose one	
Date of records: Choose one	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Expiration date or event†:	Mutual exchange: ○ Yes ○ No
Are you requesting special health information to be released? ○ Yes ○ No	
Is there any specific information **not** to release? ○ Yes ○ No	

RELEASING AGENCY(IES), BUSINESS(ES), ORGANIZATION(S) OR INDIVIDUAL(S)	
Purpose of the requested disclosure, sharing and use:	
Entity name: Choose one	
Date of records: Choose one	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Expiration date or event†:	Mutual exchange: ○ Yes ○ No
Is there any specific information **not** to release? ○ Yes ○ No	

Not valid without signature page.

Page 1 of 2 MSC 3010 (Pilot, 12.21.2018)

CLIENT ACKNOWLEDGMENT	
• I was given the chance to ask questions about this form and what it does. • I understand what this form means and I approve of the disclosures or releases listed. • I understand that state and federal law protect information about services I receive from the listed agency(ies), business(es), organization(s) and individual(s). • This authorization is valid for one year from the date of signing unless otherwise specified.[†] • I understand that I can revoke (*cancel*) this authorization at any time and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, either I or a person legally authorized to act on my behalf must submit the cancellation request in writing. Oral or written notification of the cancellation of authorization for drug and alcohol information shall be accepted. Any request for cancellation must be provided to the requesting agency, business, organization or individual. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information or vocational rehabilitation records without authorization by me or a person legally authorized to act on my behalf. • I understand that information that is not subject to restrictions on re-disclosure as noted immediately above may be subject to re-disclosure and the information that is re-disclosed may no longer be protected under federal or state law. • I understand someone may need to contact me about this form to confirm my identity or to collect additional information. • **I am signing this authorization of my own free will.**	
Signature of individual or a person legally authorized to act on behalf of the individual:	
Printed name:	Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual must be provided.	

FOR **RELEASING** AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL USE ONLY		
Name and location of releasing individual, agency, business or organization:		
Name of staff person (*print*):	Signature of staff person:	Date:

Required information for the individual — Please read

Deciding not to sign this form may:

- *Prevent agencies from deciding if you are eligible for certain programs.*
- *Prevent you from getting referrals and make coordinating services with providers more difficult.*
- *Affect your ability to get services if this form's purpose is to share information necessary to your health services.*
- *Keep the Oregon Health Plan or Medicaid from paying for a service because they do not have authorization.*

Security statement

This form may contain your personal information. If you return the form by email there is some risk it could be intercepted by someone you did not send it to. If you are not sure how to send a secure email, consider using regular mail or fax.

[†] *This authorization is valid for one year from the date of signing unless otherwise specified.*

[‡] *For questions or help completing this form, please contact the agency(ies) with which you are working:*

Oregon Health Authority:	*503-947-2340*
Oregon Department of Human Services:	*503-945-5600*
Oregon Department of Employment:	*800-237-3710*
Oregon Department of Education:	*503-947-5600*
Oregon Housing and Community Services:	*503-986-2000*
Oregon Department of Justice:	*503-378-4400*
Oregon Department of Corrections:	*503-945-9090*
Oregon Youth Authority:	*503-373-7205*
Oregon State Police:	*503-378-3720*

Not valid without signature page.

Instructions by section

When submitting the form, it is not necessary to include these instruction pages.

Creating pre-set templates

To save time, you can pre-set the number and type of sections and prefill your organization's information, then save template versions of this form for quick printing. Use the non-printing "Template" field in the top right corner of the form to name the template for your future reference.

REQUESTING and **RELEASING** AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL sections

Purpose of the requested disclosure, sharing and use	• Give specific reasons why the information disclosure, sharing and use are needed. • The requesting entity may include the statement "at the request of the individual" as the purpose when an individual initiates the authorization and does not choose to provide a reason in this field.
Entity name (*drop-down list*)	• Choose an entity from the drop-down list. • If the entity is not listed, choose "Other (please type in here):" and type in the entity's name. An entity's name must be specific. For example, listing "medical" or "service provider" is not adequate. Please list the name of the medical or service provider. For an individual or other type of organization, such as a school or employer, list the name of the individual or other type of organization.
Specific information to be disclosed (*pops up after an entity is selected*)	• Choose a document type from the drop-down list. • If an information type is not listed, choose "Other (please type in here):" and type in the information type. Some examples of specific information are assessments, treatment plans, results of urinalysis, psychological reports, financial information, case plans and Medicaid billing summaries. • Do not indicate "entire record" unless it is necessary to accomplish the purpose (*see "Purpose of the requested disclosure, sharing and use", above*). • Use the buttons to add or delete additional requested information types, if needed.
Date of records	• Indicate the specific date range for the requested records.
Expiration date or event	• This authorization is valid for one year from the date of signing unless a specific expiration date or expiration event, such as "hospital discharge" or "end of litigation," is specified.
Mutual exchange	• A "Yes" allows the specific information listed on the form to go back and forth between the record holder and the people or programs listed on this authorization. Mutual exchange opens all requested records for discussion between the record requestor and the specified record holders.
Are you requesting special health information to be released?	• Choosing "Yes" will display a section where special health information types can be specified. • A check mark in the space next to the type of health information is not sufficient; initials must be placed in the space next to the information if the individual agrees to release this information. • If you need this section visible in a printed copy, please make sure to choose "Yes" prior to printing.
Is there any specific information **not** to release?	• Choosing "Yes" will display a text box where specific information can be listed. • If any specific information should ***not*** be included when the records are released, please list them here. • If you need this section visible in a printed copy, please make sure to choose "Yes" prior to printing.

Re-disclosure	• Re-disclosure is the disclosure of information by the recipient. • There may be restrictions on the re-disclosure of information released under this form. • Federal and state regulations prohibit re-disclosure of alcohol and drug, and HIV/AIDS information without specific authorization.
Adding additional requesting and releasing entities	• If multiple requesting or releasing entities are needed, use the ADD or REMOVE buttons to add or remove additional "Releasing agency(ies), business(es), organization(s) or individual(s)" sections before you print the form.

CLIENT ACKNOWLEDGMENT section	
Signature of individual or a person legally authorized to act on behalf of the individual	• An individual or person legally authorized to act on behalf of the individual should never be asked to sign a blank or incomplete authorization form.

FOR RELEASING AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL USE ONLY section

- Entity shall maintain a copy of the completed authorization form, either electronically or in paper file, following agency retention schedules.
- If completed authorization forms are stored electronically, a process shall be in place for revocation (*cancellation*). If a signed authorization is later revoked (*cancelled*), that revocation must be noted electronically.
- Do not use labels on the authorization form.
- When completed properly, the form can stand alone to process a requested disclosure.

Sample qualified service organization agreements

This section outlines how providers can use qualified services organization agreements (QSOAs) to allow appropriate behavioral health information sharing. This includes substance use treatment information between a part 2 provider and a qualified service organization. Sample QSOA language is on page 33.

HIPAA generally permits protected health information disclosure without patient consent for treatment, payment or health care operations. However, 42 CFR part 2 is not as permissive and requires patient consent for such disclosure. However, restrictions on disclosures under 42 CFR part 2 do not apply to communications between a part 2 program and a qualified service organization (QSO) involving information needed by the QSO to provide services to the program (42 CFR § 2.12(c)(4)).

A qualified service organization (QSO) means a person/entity that:

(a) Provides services to a part 2 program (an individual or entity that is federally assisted and holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment), such as population health management, bill collection, laboratory analyses, professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(b) Has entered into a written agreement with a part 2 program under which that person:

  (1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and

  (2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

QSOAs under part 2 are similar to a business associate agreement under §§ 164.314(a) and 164.504(e) of the HIPAA Security and Privacy Rules. Both types serve as mechanisms that allow for disclosure of information between a part 2 program and an organization that provides services to the program, including health information exchanges (HIEs). (1)

A part 2 program should only disclose information to the QSO that is necessary for the QSO to perform its duties under the QSOA. Also, the QSOA does not permit a QSO to re-disclose information to a third party unless that third party is a contract agent of the QSO, helping them provide services described in the QSOA, and only as long as the agent only further discloses the information back to the QSO or to the part 2 program from which the information originated. For additional information, see Number 10 of the 2010 Frequently Asked Questions published by SAMHSA and the Office of the National Coordinator at: https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf (PDF | 381 KB). (2)

42 FR 2 requires the following terms in a written QSOA:

- Acknowledgement that receiving, storing, processing or otherwise dealing with any patient records from the part 2 program is fully bound by the regulations in 42 CFR part 2; and
- Agreement to resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment or referral for treatment except as permitted by 42 CFR part 2.

Other common terms in a QSOA, though not required by 42 CFR 2, might include HIPAA-required terms for business associates under HIPAA.

Sample qualified service organization agreements language

42 CFR 2.11 requires specific acknowledgements to be contained in a qualified service organization agreement. Following is sample language for a qualified service organization agreement.

This is an agreement between ________ ("the service entity") and _______ ("the program"). The service entity will be providing the following qualified services to the program: ____________________________. To provide these services, the service entity acknowledges it will receive, store, process or otherwise deal with patient records from the program.

- Service entity acknowledges that — in receiving, storing, processing or otherwise dealing with any patient records from the program — it is fully bound by 42 CFR part 2 and, if necessary, shall resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment or referral for treatment except as permitted by the regulations in 42 CFR part 2.
- In compliance with 42 CFR part 2, the program allows the service entity to access, receive, store, process or otherwise deal with patient records from the program while providing services to the Program under this agreement.

________________________________ Date: __________
Signature of service entity

________________________________ Date: __________
Signature of the program

Other resources

SAMHSA guidance:
https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines

Electronic Code of Federal Regulations:
https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

Federal Register:
https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records

Federal Register:
https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records

SAMHSA fact sheets regarding substance abuse confidentiality regulations:
https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

Oregon Department of Justice Confidentiality Guidance:
https://justice.oregon.gov/ConfidentialityGuide/

Office of Health Information Technology:
https://www.oregon.gov/oha/HPA/OHIT/Pages/index.aspx

OHA's Minor Rights: Access and Consent to Health Care:
https://www.oregon.gov/oha/PH/HealthyPeopleFamilies/Youth/Documents/minor-rights.pdf

Information on H.R. 6 (2018):
https://www.congress.gov/bill/115th-congress/house-bill/6

Endnotes

1. Legal Action Center for Substance Abuse and Mental Health Services Administration. Applying the substance abuse confidentiality regulations to health information exchange (HIE). 2010. [Cited 2019 April 8.] Available at: https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf.

2. Substance Abuse and Mental Health Services Administration. Applying the substance abuse confidentiality regulations: frequently asked questions. [Cited 2019 March 14.] Available at: https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs.

Oregon Health Authority
ADDICTIONS AND MENTAL HEALTH
HSD Behavioral Health Policy

500 Summer St NE
Salem, OR 97301

You can get this document in other languages, large print, braille or a format you prefer. Contact Behavioral Health at 503-XXX-XXXX or email XXXXXXX@dhsoha.state.or.us. We accept all relay calls or you can dial 711.

Oregon Health Information Technology Program and HITOC Updates – June 2019

Oregon's Health Information Technology Oversight Council (HITOC) is legislatively established and reports to the Oregon Health Policy Board. This document provides HITOC updates on OHA's health IT efforts. OHA's Office of HIT (OHIT) staffs HITOC and the Oregon HIT Program.

HITOC is charged with the following roles:

- Identify and make specific recommendations to the Board related to health information technology (HIT) to achieve the goals of health system transformation.
- Regularly review and report to the Board on:
    - OHA's HIT efforts, including the Oregon HIT Program, toward achieving the goals of health system transformation;
    - Efforts of local, regional, and statewide organizations to participate in HIT systems;
    - Oregon's progress in adopting and using HIT by providers, health systems, patients and others.
- Advise the Board or the Congressional Delegation on changes to federal laws affecting HIT that will promote this state's efforts in utilizing HIT.

HITOC Update: Policy, environmental scan, and strategic planning

Federal Updates/ Changes *For more information:* *Lisa.A.Parker@state.or.us*	ONC and CMS Interoperability Proposed Rules: • The comment period deadline for both rules was extended to **June 3, 2019** • CMS proposed rule: https://www.regulations.gov/docket?D=CMS-2019-0039 • ONC proposed rule: https://www.regulations.gov/document?D=HHS-ONC-2019-0002-0001 HIPAA Right of Access, Apps, and APIs • The HHS Office for Civil Rights (OCR) issued FAQs about provider liability concerns when a patient exercises their right of access using apps:https://www.hhs.gov/hipaa/for-professionals/faq/health-information-technology/index.html Trusted Exchange Framework and Common Agreement (TEFCA) • The second draft of the TEFCA, the second draft of the Mandatory Required Terms and Conditions (MRTCs), and the first draft of the Qualified Health Information Network (QHIN) Technical Framework were posted at http://healthIt.gov/TEFCA where you can also submit your comments. • Comments for all three TEFCA documents are due **June 17, 2019** Notice of Funding Opportunity (NOFO): Trusted Exchange Framework Recognized Coordinating Entity (RCE) Cooperative Agreement • Learn about the NOFO at https://www.healthit.gov/topic/onc-funding-opportunities/trusted-exchange-framework-and-common-agreement-recognized • Applications are due **June 17, 2019**
Landscape / Scan Activities *For more information:* *Marta.M.Makarushka@state.or.us*	OHIT engages in ongoing HIT environmental scan activities to inform HIT efforts and ensure strategies and programs address evolving needs. OHIT continues compiling data across the agency and other sources to serve various purposes, including informing HITOC's progress monitoring, program oversight, and reporting priorities.

	OHIT is developing a Data Reporting Framework and set of Executive Summaries in support of HITOC' s data-related responsibilities and to inform HITOC's 2020 Strategic Plan update. Input on draft documents was obtained from a variety of stakeholders; revised documents were then discussed at HITOC's April retreat. HITOC will remain involved in developing data reporting that meets their needs throughout 2019. Past work includes a Behavioral Health HIT/HIE Scan Report based on survey and interview data. See Behavioral Health Health IT Workgroup for more information.
HIT Strategic Plan Update *For more information:* *Francie.J.Nevill@state.or.us*	The HITOC HIT 2017-2020 Strategic Plan was approved by the Oregon Health Policy Board in October 2017 and provides a roadmap for Oregon's HIT work ahead, including strategies for a "network of networks" approach to statewide health information exchange and the HIT Commons public/private partnership model of governance. In February 2019, OHPB approved HITOC's major 2019 priorities (under the approved Strategic Plan): exploratory work in social determinants of health/health equity and patient engagement, next steps for statewide health information sharing ("network of networks") efforts (includes physical, behavioral, oral, and other information), wrapping up planning for behavioral health and HIT work, showing Oregon's HIT progress via dashboards and milestones, and potentially updating the Strategic Plan in fall 2019. Ongoing priorities include continued oversight work on partnerships/programs and new landscape assessment as appropriate. The work to update the Strategic Plan will begin in 2020.
Behavioral Health HIT Work *For more information:* *Kristin.M.Bork@state.or.us*	Per HITOC's request, OHIT convened a Behavioral Health HIT Workgroup to learn how best to support HIT within Oregon's behavioral health system. The workgroup's recommendations were presented to HITOC in December 2018 and added to the Report as an addendum. HITOC requested the BH HIT Workgroup continue in 2019 to provide input and guidance as OHA pursues strategies in support of behavioral health.
Oregon HIT Program: Partnerships	
HIT Commons *For more information:* *Britteny.J.Matero@state.or.us*	The HIT Commons is a public/private partnership to coordinate investments in HIT, leverage funding opportunities, and advance HIE across the state. HIT Commons is co-sponsored by the Oregon Health Leadership Council (OHLC) and OHA, and is jointly funded by OHA, hospitals, and health plans. The HIT Commons Governance Board began meeting in January 2018. In the 4th quarter of 2018, HIT Commons established an LLC, confirmed a Board of Managers and approved Board terms. See below for more information about the HIT Commons initiatives, as well as work to support the Oregon Provider Directory. For more information see the HIT Commons website. The HIT Commons is beginning new work in the evolving landscape of social determinants of health (SDOH)—including conceptual development of an Oregon Community Information Exchange—to connect the health care and social services sectors. This will result in a proposal to the HIT Commons Governance Board later this year.

Emergency Department Information Exchange (EDie)/PreManage *For more information:* *Britteny.J.Matero@state.or.us*	The Emergency Department Information Exchange (EDIE) allows Emergency Departments (EDs) in real-time to identify patients with complex care needs who frequently use the emergency room for their care. In addition to utilization alerting, EDIE also provides succinct but critical information to ED physicians, such as: security alerts, care guidelines entered by the patient primary care home, and contact information for case managers. All hospitals with emergency departments (excepting the VA) in Oregon are live with EDIE. PreManage is a web-based application that expands the services in EDIE to other users such as health plans, Coordinated Care Organizations (CCOs), and physical, behavioral or dental clinics to improve coordination of patient care. PreManage adoption continues to increase across Oregon. All of Oregon's CCOs receive hospital notifications through PreManage or are in contract. Most major Oregon health plans are using PreManage, as well as 6 out of 9 of Oregon's Dental Care Organizations and 4 tribal clinics. Behavioral health continues to be a major category of PreManage users. All Type B Area Agency on Aging and Aging & People with Disability District offices are now using PreManage, and Developmental Disability programs through the Oregon Department of Human Services and the Oregon State Hospital are in phased roll out. Recent highlights: • For hospitals who have integrated EDIE into their electronic health record (EHR), EDIE alerts may now include PDMP data (see below). • A 2019 Collective/PreManage Technical Assistance calendar of events has been established through the HIT Commons. • As of February 1, 2019, hospitals who receive EDIE notifications via fax now receive a Physician Order for Life Saving Treatment (POLST) as a print out along with the EDIE notification. Coming Spring 2019: POLST for hospitals with integrated EDIE and POLST for PreManage users. As of March 2019, PreManage users may request POLST forms in their portal for their assigned patients. • PreManage is rolling out to Skilled Nursing Facilities across Oregon in 2019. More than 60 out of nearly 200 are live.
Oregon's Prescription Drug Monitoring Program (PDMP) Integration Initiative *For more information:* *Britteny.J.Matero@state.or.us*	Oregon's PDMP Integration initiative connects EDIE, HIEs, EHRs, and pharmacy management systems to Oregon's PDMP, which includes prescription fill information on controlled substances, and is administered by OHA's Public Health Division. HIT Commons is overseeing the PDMP Integration work with guidance from the Oregon PDMP Integration Steering Committee and in coordination with OHA's Public Health PDMP program. PDMP Integration capabilities went live in summer of 2017 and the statewide subscription funding officially launched through the HIT Commons in Spring 2018. • More than 6,900 prescribers, 78 health care entities, and 3 retail pharmacies (representing 570 pharmacists) are live with PDMP integrated directly into their health IT system or through EDIE alerts.

	- Interstate data sharing is established with PDMPs in Idaho, Kansas, Nevada, Texas, and North Dakota. Alaska and Washington are in progress and California recently passed legislation allowing data sharing. - A streamlined process to initiate PDMP Integration is now available through the HIT Commons. Interested health care organizations can start the process at the PDMP Integration website. - Monthly legislative updates and the latest PDMP implementation reports can now be found on the HIT Commons website.
Oregon HIT Program: Programs in Development	
Oregon Provider Directory *For more information:* *Karen.Hale@state.or.us*	The Oregon Provider Directory will serve as Oregon's directory of accurate, trusted provider data. It will support care coordination, HIE, administrative efficiencies, and serve as a resource for heath analytics. Authoritative data sources that feed the Provider Directory will be matched and aggregated and data stewards will oversee management of the data to ensure the Provider Directory maintains initial and long-term quality information. The Provider Directory Advisory Committee provides stakeholder input and oversight to OHA's development of this program. OHA is engaged in implementation activities and is planning for a soft launch to a small set of users later in 2019. HIT Commons is working with OHA staff and stakeholder volunteers to develop an initial use case test for the soft launch. Additional users will be added in later phases as data become more robust.
Oregon HIT Program: Operational HIT Programs	
Medicaid EHR Incentive Program *For more information:* *Jessica.L.Wilson@state.or.us*	The Medicaid EHR Incentive Program (also known as the Promoting Interoperability Program) offers qualifying Oregon Medicaid providers federally-funded financial incentives for the adoption or meaningful use of certified electronic health records technology. Eligible professional types include physicians, naturopathic physicians, pediatric optometrists, nurse practitioners, certified nurse-midwives, dentists, and physician assistants in certain settings. As of May 2019, more than $200 million in federal incentive payments have been dispersed to 60 Oregon hospitals and 3,818 Oregon providers. The program ends 2021.
Oregon's Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) *For more information:* *Jessica.L.Wilson@state.or.us*	OMMUTAP helps certain Medicaid providers maximize their investments in EHRs, meet federal Meaningful Use requirements, improve efficiency and coordination of care, and improve the quality of EHR data. Through a contract with OCHIN, technical assistance is provided for the following services: 1) Certified EHR Adoption, Implementation, and Upgrade Assistance 2) Interoperability Consulting and Technical Assistance 3) Risk and Security Training and Assessment 4) Meaningful Use Education and Attestation Assistance To date, 1589 providers across 374 clinics are participating in the program. The program runs through May 2019.
Clinical Quality Metrics Registry *For more information:* *Katrina.M.Lonborg@state.or.us*	The Clinical Quality Metrics Registry (CQMR) collects, aggregates, and provides electronic clinical quality measure (eCQM) data to meet program requirements and achieve efficiencies for provider reporting. The CQMR launched in January 2019 to collect eCQMs for the 2018 program year for the Medicaid EHR Incentive Program and began offering support for eCQM

	reporting to CMS for the CPC+ and MIPS programs on February 1. Use of the CQMR for the CCO incentive measures that are EHR-based will begin later in 2019, with pilots ahead of 2019 reporting. Over time, other quality reporting programs could use the CQMR as well, which will support OHA's goal of streamlining and aligning quality metric reporting requirements and reducing provider burden. Onboarding materials and other resources are posted to the CQMR webpage.
HIE Onboarding Program *For more information:* *Kristin.M.Bork@state.or.us*	CMS released new guidance to states in 2016 allowing for the use of 90% federal match funding to support HIE onboarding for a broad array of Medicaid providers. Oregon's HIE Onboarding Program will increase Medicaid providers' capability to exchange health information by supporting the costs of an HIE entity to onboard providers, with or without an EHR. Reliance eHealth Collaborative was selected to provide onboarding services through an RFP process. The HIE Onboarding Program launched in January 2019. Reliance has submitted a workplan to start onboarding providers contracted with PacificSource Central Oregon and PacificSource Gorge. Reliance anticipates submitting for several more regions in the coming months.
Direct secure messaging Flat File Directory *For more information:* *Karen.Hale@state.or.us*	The Flat File Directory assists organizations with identifying Direct secure messaging addresses across Oregon to support use of Direct, including to meet federal Meaningful Use requirements for sharing Transitions of Care summaries. As of February 2019, the Flat File Directory includes more than 16,000 Direct addresses from 24 interoperable, participating entities who represent more than 713 unique health care organizations (primary care, hospital, behavioral health, dentistry, FQHC, etc.).