

Health Information Infrastructure Advisory Committee
Wednesday, Aug. 20, 2008
1:00 – 5:00 pm
Portland State Office Building
800 NE Oregon Street
Portland, OR

PRELIMINARY AGENDA

Desired Outcome:

- **Confirm selected strategies**

Time (est)	Item	Lead	Action Items
1:00 pm	Call to Order and Approval of 8/06 Minutes	Ree Sailors Dick Gibson	X
1:10 pm	Review Agenda, Desired Outcomes	Ree Sailors	
1:15 pm	Confirm Selected Strategies (Goals, Action Steps, Rationale)	Whole Group/ Carol Turner	
4:15 pm	Draft Report	Ilana Weinbaum	
4:30 pm	Next Steps	Ree Sailors Dick Gibson	
4:40 pm	Debrief Meeting	Dick Gibson	
4:45 pm	Public Testimony		
5:00 pm	Adjourn	Ree Sailors Dick Gibson	

Health Information Infrastructure Advisory Committee (HIIAC) Meeting

Wednesday, July 23, 2008

1:00 – 5:00 pm

PSOB

Committee Members Present:

Dick Gibson, Andi Miller, Barbara Prowe, Chris Apgar, Dave Widen, Dick Gibson, Jim Edge, Joyce DeMonnin, Ken Carlson, Nancy Clarke, Ree Sailors.

Committee Members Absent:

Abby Sears, Andrew Perry, Andy Davidson, Bart McMullan, Denise Honzel, , Gina Nikkel, Grant Higginson, Homer Chin, Laura Etherton, Lauren O'Brien, Nan Robertson, Paul Gorman, Sally Sparling.

Staff:

Ilana Weinbaum, Judy Morrow, Sean Kolmer, Tina Edlund.

Call to Order and Approval of July 9, 2008 Minutes

HIIAC co-chairs Ree Sailors, Governor Kulongoski's Health Care Policy Advisor, and Dick Gibson, Chief Information Officer, Legacy Health Systems, called the meeting to order and welcomed HIIAC members and thanked them for their hard work.

It was moved and seconded to approve the July 9, 2008 HIIAC Meeting Minutes as proposed.

Review of Agenda and Desired Outcomes

Sailors reviewed the revised HIIAC statements concerning: elements of a productive process, elements of productive recommendations, HIIAC decision-making process, vision statement, mission and goals of HIIAC for summer 2008.

Sailors presented the guiding principles, with two options for Guiding Principle #2. There was group consensus, selecting the second option.

Subgroups' Recommendations – Initial Feedback

Subgroups formed at the July 9 meeting included:

- Adoption of Electronic Health Records and Health Information Technology
- Clinical Decision Making and Evidence Based Medicine
- Health Information Exchange and Data Sharing
- Privacy and Security Standards

Sailors conveyed that members of the adoption subgroup were not able to attend today's meeting, but would be holding a breakfast meeting the following week to further develop their ideas.

Full group provided feedback on initial subgroup proposals and made suggestions about issues for the subgroups to consider (notes from group discussion available).

Sailors described new survey of providers in Oregon about adoption of health records, which will go out to providers in the next few weeks. This version of the survey will include questions about functionality.

Sailors relayed that someone from the National Governor's Association (NGA) will be at the August 20th meeting to talk about the NGA e-health and e-prescribing initiatives. In addition, staff has submitted a request to NGA and the Robert Wood Johnson Foundation for technical assistance around issues of ownership of health data.

Clarify Strategies

Full group broke into subgroups to further develop recommendations.

Report Back on Strategies

The Clinical Decision Making and Evidence Based Medicine, Health Information Exchange and Data Sharing, and Privacy and Security Standards each provided a brief report on the progress they had made on developing recommendations (group notes available).

The recorder from each group will type up the notes and email them out to the subgroup for feedback. Staff will then send all of the notes out to the full HIIAC.

Next Steps

The next HIIAC meeting is scheduled for Wednesday, August 6, 2008, 1 – 5 pm at the PSOB.

Public Testimony

No official public testimony. Members of the public stated that they were impressed with the amount of progress made in the meeting.

Meeting Debrief

It was agreed that notes from the sub-groups would be sent to all HIIAC members for review before the next meeting.

Meeting was adjourned.

Health Information Infrastructure Advisory Committee (HIIAC) Meeting

Wednesday, August 6, 2008

1:00 – 5:00 pm

PSOB

Committee Members Present:

Dick Gibson, Ree Sailors, Jim Edge, Nancy Clarke, Joyce DeMonnin , Laura Etherton, Grant Higginson, Denise Honzel, Laureen O'Brien, Sally Sparling, Dave Widen

Committee Members Absent:

Chris Apgar, Ken Carlson, , Andy Davidson, Homer Chin, Paul Gorman, Bart McMullan, Barbara Prowe, Andi Miller, Gina Nikkel , Andrew Perry, Nan Robertson, Abby Sears,

Staff:

Tina Edlund, Dawn Bonder, Ilana Weinbaum, Judy Morrow

Call to Order
HIIAC co-chairs Ree Sailors, Governor Kulongoski's Health Care Policy Advisor, and Dick Gibson, Chief Information Officer, Legacy Health Systems, called the meeting to order and welcomed HIIAC members and guests.
Review of Agenda and Desired Outcomes
Gibson and Sailors reviewed the agenda. Sailors said the final versions of the Vision, Mission and Guiding Principles were included in the members' packets and would be added to the HIIAC web page.
Continuation of Group Work
<p>The HIIAC members went through each of the summaries of the four workgroups. Members asked clarifying questions and gave input and feedback to each of the groups.</p> <p>The small groups reconvened and continued to refine their recommendations based upon the input and feedback from the earlier conversation. Workgroups 1 and 2 worked together.</p> <p>The small group summaries will be distributed before the next meeting and the August 20th meeting will begin with the HIIAC reviewing the progress of the work groups.</p>
Next Meeting
The next HIIAC meeting is scheduled for Wednesday, August 20, 2008, 1 – 5 pm at the PSOB.
Public Testimony
<p>Andrea Meyer of the American Civil Liberties Union distributed a proposed federal bill on privacy and security as well as an article from the Washington Post .privacy standards group.</p> <p>Alex Harkin expressed his appreciation for being invited to participate in the workgroup discussions.</p> <p>Dr. Jody Pettit spoke to recent news articles on the misuse of individuals' health information with respect to insurance coverage. Ree Sailors pointed out that Oregon's insurance laws already prohibit the use of information in this way.</p>
Meeting Debrief
It was agreed that the work product from the sub-groups would be sent to all HIIAC members for review before the next meeting.

Meeting was adjourned.

Health Information Exchange HIIAC Workgroup
Summary of Discussion at 8-6-08 HIIAC Meeting

Discussion Group Members:

Grant Higginson
Nancy Clarke
Jim Edge
Dave Widen
Ree Sailors
Sean Kolmer

Recommendation 1

The Oregon Health Fund Board should recommend statutory language creating a Health Information Exchange, including:

- By December 31, 2012, the Oregon Health Authority shall assure the existence of an electronic health information exchange system that allows key patient health information to be available at the time of treatment.
- By December 31, 2009, the Oregon Health Authority shall have a plan for how the Health Information Exchange will be developed.
- Patients must go through a meaningful and robust current process in order to participate in the Health Information Exchange.
- Health information will be readily available to patients at all times.
- Information will only be accessible to the patient, his or her premutative, and treating health care providers.
- Key health information will include but not be limited to: list of current conditions; medications; lab reports; imaging reports.
- To ensure the timeliness of data, key health information will be entered into the Health Information Exchange within 1 business day.
- For strategic planning purposes, the Oregon Health Authority shall ensure that there is a robust education campaign for health consumers and providers regarding the value of health information exchanges.

Recommendation 2

The Oregon Health Fund Board should help to ensure that the DMAP Oregon Health Records Bank will be built in such a way that it will at a minimum be interoperable with the Oregon Health Information Exchange, and potentially be the initial building block for the Oregon Health Information Exchange.

To ensure the coordination between the Oregon Health Records Bank and the Oregon Health Information Exchange to be developed, the Oregon Health Fund Board will provide ongoing advice to the Oregon Health Records Bank project. Advice from the Oregon Health Fund Board needs to incorporate input from the private sector health care providers, patients and advocates.

ADOPTION OF ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION TECHNOLOGY

Strategy Group One

First group work session – July 9, 2008

PROBLEM #1: LACK OF MONEY AND FUNDING

- Capital funding needed (66%)
- Return on Investment (50%)
- Loss of productivity

SOLUTION: Provide financial support and funding options that are flexible and independent from health systems and hospitals.

HOW? :

1. Create new models for reimbursement; collaborate with creative financial people to design cost-neutral, quality improvement funding schemes for the State to provide.
2. Use the State's purchasing power for hardware, software and expertise
3. Have the State select a limited number of solutions and ties incentives and reimbursement to those solutions only.

PROBLEM #2: LACK OF EXPERTISE

- Technical
- Operational
- System selection/Expertise

SOLUTION: Provide technical and implementation support; provide operational support for implementation and on an ongoing basis

HOW? :

1. Design a model for the State to provide/fund local expertise to support implementation and ongoing EMR use and optimization.
2. Support/fund remove technical support and technology infrastructure
3. State vets and contracts with consultants to support adoption and optimization.
4. Incentives for existing health systems to support adoption and optimization for small, rural practices, others.

PROBLEM #3: RESISTANCE BY CLINICIANS AND STAFF

- Cannot find system to meet needs
- Resistance to change
- Hospital-practice/practitioner "trust" or lack of trust

SOLUTION: 1+2+4 >3

PROBLEM #4: NEED FOR INTEROPERABILITY

SOLUTION: State assurance/require interoperable standards for funding/expertise (*Note: this could be via the licensing Board that is being proposed*)

HOW? :

1. Only offer vendor and incent reimbursement for software solutions that can provide defined standards for interoperability (HIIAC or licensing board to determine standards?)
2. Vendors would have to supply system(s) that comply with agreed upon standards or they could not market their product in Oregon. Incentives?? Restrictions??

PROBLEM #5: LACK OF PATIENT ACCESS TO THEIR HEALTHCARE INFORMATION

SOLUTION: If patient adoption is stimulated it will drive demand for clinician adoption of EMRs.

HOW? :

1. Education to drive demand
2. Immunization information served up by the State via the Web
3. Support Medicaid Transformation Grant/ Health Record Bank through funding and resources to provide patient access model for testing and evaluation.

Feedback from HIIAC at-large – July 23, 2008

- Need to prioritize one or two
- Highlight desired outcomes rather than problems
- Need clarification of $1 + 2 + 4 > 3$

Second group work session – July 23, 2008

Aim: achieve widespread effective use of health information technology (HIT) in Oregon.

Three main issues we discussed: Standards, Support, Benchmarks.

Standards: “buy whatever you want, but it must meet standards.” Lack of standards is a barrier to adoption, by creating uncertainty about risk and value, return on investment, and possible obsolesce. State should enforce [encourage?] adoption of standards through multiple approaches at state’s disposal:

- Regulation/requirement – systems interacting with state (for whatever reason – health information exchange with Health Data Bank, payment, etc) must adhere to specified standards for interoperability, privacy, etc.
- Support and subsidies – state mechanisms for subsidizing or supporting adoption (loans, grants, group purchase, etc) limited to systems adhere to standards;
- Purchasing – state owned and operated systems can enforce standards;

- Development – state ensure adherence in its own projects, such as Health Data Bank. This project could be a major leverage point that could accelerate adoption of standards and thereby accelerate adoption of HIT.
- Personal health records - critical mass of PHR adoption (state Health Data Bank and others) will create leverage for all other HIT users to employ same standards in order to share patient information.

Support: “We can support you if it meets these standards...” EHR purchase and initial implementation are costly, and only the tip of the iceberg. Uncertainties about costs, impacts, obsolescence are a major barrier for physician adoption of EHR (NEJM article). State can increase adoption by increasing the availability of financial and logistical support, especially for small practices with no access to an IT department. Support will be an ongoing need as practices and systems evolve to realize greater value.

- Grants and loans for adoption, implementation, maintenance;
- Support of ASP and other models that remove burden from individual small practices;
- Two vendor model: state selects two vendors or systems, creates or facilitates creation of support mechanism for these systems.
- UK NHS model was discussed: each local trust chooses from a set of vendors. This enforces constraints that ensure interoperability, but allows for choice and local control
- Public utility model was discussed: local or regional private vendors provide service (HIT maintenance and support through ASP or whatever model) with public regulation to enforce standards, help control costs, etc.

Benchmarks: Need to set goals with benchmarks for adoption of EHR, CDS, eRx. Need to measure to improve.

Feedback from HIIAC at-large – August 6, 2008

- Clarify target of policies
- State to certify 2 EMRs
 - Use state leverage to design package and technical capabilities
 - Small practices don't have to do vendor selection
 - State facilitates group bulk purchasing through its RFP process
- EMR use optimization
 - State to offer services or offer grants/loans
 - State to endorse service (TA) vendors
- Primarily for small practices
- Standards
 - Interoperability (Including HRB)
 - Privacy
- Could be regionalized?
- State roles: Connector, Facilitator (of Group Process), Accelerator

Third work group session – August 6, 2008

The EMR Adoption and Clinical Decision Support Groups joined today because of overlap of purpose and recommendations.

It was felt that it was important for Oregon to endorse a limited subset of the 80+ Office EMR vendors in order to promote the following:

- Use state’s RFP process to identify “state endorsed” vendors and use this process to solicit the most aggressive price – giving those MDs who purchase from these vendors similar benefits as are obtained by group purchasing
- Guarantee the interoperability of the EMRs from at least a few EMR vendors - those chosen for endorsement.
- Increase confidence of providers in purchasing an EMR with the State's endorsement.
- Simplify the EMR choice for providers by limiting the number of different vendors to consider.
- Provide a pre-set menu of EMR features and pricing without the need for each practice to go through an expensive proposal process.
- Increase confidence of providers in choosing an EMR Services Company to support them on their new EMR.
- Subcommittee agrees with HIIAC recommendation for Oregon Quality Institute to standardize health outcome measures and reporting.
- State will endorse **four** EMR Vendors based on their EMR's exhibition of the following properties:
 - Meeting or exceeding CCHIT standards.
 - Valuable Clinical Decision Support Tools to be used by providers at the point of care.
 - Interoperable data exchange with other EMRs, Personal Health Records, and the Oregon Health Record Bank.
 - Adherence to HIIAC privacy principles.
 - Ability to record, store, and report quality of care and health outcome measures.
- State will endorse four EMR Service Companies that can provide the following services to provider groups using one of the four State-endorsed EMRs:
 - Implementation support.
 - Conversion from paper records or another EMR to a State-endorsed EMR.
 - Ongoing support of the EMR.
 - Interface support.
 - Practice optimization using the EMR.
 - Clinical process improvement using the EMR.
 - Quality reporting support.
 - Participation in health information exchange.
- State will subsidize physician use of the four EMR vendors and the four EMR Service Companies.
 - Subsidy will be a grant or low-interest loan.
 - Amount of grant will be based on the following:
 - Service to an underserved population.
 - Service to Oregon Medicaid population.

Note: **There was a question as to the number of vendors the state should endorse**

HIIAC Draft Recommendations to Oregon Health Fund Board

GOAL:

Accelerate widespread, effective use of health information technology (HIT) in Oregon

ACTIONS:

The State of Oregon should:

- Endorse **four** EMR Vendors based on their EMR's exhibition of the following properties:
 - Meeting or exceeding CCHIT standards
 - Valuable Clinical Decision Support Tools to be used by providers at the point of care
 - Interoperable data exchange with other EMRs, Personal Health Records, and the Oregon Health Record Bank
 - Adherence to HIIAC privacy principles
 - Ability to record, store, and report quality of care and health outcome measures
- Endorse **four** EMR Service Companies that can provide the following services to provider groups using one of State-endorsed EMRs:
 - Implementation support
 - Conversion from paper records or another EMR to a State-endorsed EMR
 - Ongoing support of the EMR
 - Interface support
 - Practice optimization using the EMR
 - Clinical process improvement using the EMR
 - Quality reporting support
 - Participation in health information exchange
- Use its RFP process to identify “state endorsed” vendors and use this process to solicit the most aggressive price – giving those providers who purchase from these vendors similar benefits as are obtained by group purchasing
- Subsidize provider use of the endorsed EMR Vendors and the endorsed EMR Service Companies
 - Subsidies in the form of a grant or low-interest loan, with amount based on:
 - Service to an underserved population
 - Service to Oregon Medicaid population
- Set benchmarks for the adoption of electronic medical records, clinical decision support tools and e-prescribing and evaluate progress toward meeting those goals.

RATIONALE:

By creating certainty, the state can diminish a number of the barriers currently preventing the adoption and use of health information technology. Certainty can be created by instituting standards and providing ongoing support for those systems meeting standards. Using the state’s RFP process and negotiating power, costs of both the systems themselves and the ongoing support necessary to maintain these systems, can be made more affordable and more reliable.

By guaranteeing the interoperability of EMRs, simplifying the choice of vendors and providing a pre-set menu of features and pricing, the state will increase confidence among providers and encourage the adoption of health information technology systems. Additionally, assistance with the large investment these systems require will be very effective, especially among rural and Medicaid providers.

Benchmarks and evaluation are necessary to continue improvement in this area.

CLINICAL DECISION MAKING AND EVIDENCE BASED MEDICINE

Strategy Group Two

First work group session – July 9, 2008

Problem:

1. Clinicians are not following evidence based guidelines
2. As a result, there are variations in costs, treatments and outcomes

Underlying Causes:

1. Only a small amount of care, about 20%, have defined evidence based guidelines to treat patients
2. There is no defined process to reach agreement about which guidelines should be standardized. There are many organizations providing recommendations, but how and who determines the ones to be used?
3. Of those using Electronic Health Records the system does not have the capacity to embed guidelines; or the clinicians have turned off the functionality because they are “clunky” and inefficient and don’t add value.
4. There are no financial incentives to follow guidelines and change behavior.
5. Cultural norms may not support new practices. Physicians “have only done it this way, why should I change?”
6. There must be a clinical safety zone for following guidelines, and safe harbor to establish.

Potential Solutions:

1. State can provide financial and technical assistance to MD’s who adopt electronic health records that have the functionality to provide decision support tools and the use of evidence-based guidelines.
2. State could establish a centralized source (expanded HRC?) for development of evidence-based guidelines for existing and emerging guidelines for new technologies for all to follow. These would be considered the “standard of care” in Oregon.
3. Medical malpractice protection could be given for compliance with these guidelines and the standard of care.
4. Start with 5 major chronic diseases and preventive care

5. State could provide a safe harbor for plans and providers to develop standardized pay for performance models
6. An all payer/all claims database would need to be built to monitor progress, compliance and provide feedback to providers, consumers, and payers.
7. Ensure that consumers have access to these guidelines so that they can discuss them with their clinician and are incented to comply with them.
8. Plans would pay benefits in accordance with standards of care.
9. Align State purchasing agencies to contract with plans/clinicians who follow guidelines
10. At some point, do not contract with clinicians who do not follow these guidelines. For example, if MD is not following by 20XX, they are dropped from the network. Purchasers fully support this decision
11. Rural areas would need to be addressed specifically.

Bottom Line Approach:

Adopt electronic health records with the capacity to provide efficient and effective decision support processes and tools so that clinicians can easily follow evidence-based guidelines. Develop benefits plans/incentives for clinicians and patients to follow and have health benefit purchasers require compliance with evidence-based guidelines as a term of contracting.

Feedback from HIIAC at-large – July 23, 2008

- Important to know who is writing/financing decision support tools
- Should be public/private mechanism to select key sets of guidelines and align with systems monitoring providers
- Need to be education of providers about utilizing/selecting EHRs that have good guideline functionality
- P4P should be aligned with encouraging EBM
 - Is P4P adequate to encourage desired behavior?
 - P4P must be consistent across payers
 - State role for standardizing measures?
- Suggested two-pronged approach: (1) P4P, (2) Provider education and development of tools to evaluate EHRs for their EBM functionality
- Need to consider other incentives and tools to encourage EBM
 - Predictive modeling
 - Quality measurement
- Suggested recommendation: Require transparency and clarity around financing and creation of decision support tools.
 - Not just disclosure, but state role to make sure credible source
- Suggested recommendation: State should create a safe harbor and convene public and private payers to develop common P4P guidelines.

Second group work session – July 23, 2008

Recommendation 1: The Oregon Quality Institute is created to convene and collaborate with plans and providers to align around a common set of health quality measures.

- A. Primary goal is to develop a common sets of health care measures (based on evidence nationally recognized organizations). The process to evaluate measures should involve private and public partnerships within Quality Institute to provide more standardization of measures used by differing monitoring organizations (health insurance companies, hospitals, individual medical practices). Goals of this recommendation is to increase the positive influence of quality measures on direct medical practice by providing a more consistent subset of existing measures applied by organizations on providers, increasing their common influence.
- B. Evaluate and endorse clinical guidelines to provide Oregon based resource for providers and patients. Priority will be given to guidelines that are endorsed by nationally recognized professional organizations that write and evaluate guidelines based on evidence based medicine and transparency exists regarding authors of such guidelines. Preference would be given to guidelines that support health care measures chosen by Quality Institute. Goal of this recommendation is to provide an additional “seal of approval” for Oregon medical providers and assist in aligning along common set of guidelines for more consistent medical care between disparate medical offices and specialties.
- C. State requires PEBB, Medicaid, and other public purchasers of health care to choose from a common set of clinical quality measures in evaluating medical provider performance and health outcomes. One potential role of the state is through purchasing of health care and the use of consistent quality measures would greatly speed up their adoption and influence. This would be greatly amplified if voluntary “buy in” from private insurers was added.

Recommendation 2: If the state develops a program to support implementation of EHRs in medical practice, programs should be chosen that include clinical decision support tools. Preference would be given for effective support tools that align with quality measures chosen by Quality Institute.

For Example:

- Point of care reminders that support implementation of clinical guidelines (prevention and chronic care)
- Supporting population health through interface with disease registries (patients with chronic diseases)
- Supporting the ongoing monitoring of health status of patients (internal clinic measures)
- PHR: Allows patients to track/monitor own health measures/services
- Covers e-prescribing and associated decision support
- Transparent source of data (where did guidelines come from?)

Feedback from HIIAC at-large – August 6, 2008

- Issue: How would state deal with standards for different vendors?
- Not just having decision support but how to ensure use?
 - Incentives + sticks
- Practicality/Reliability of tools
- Focus on chronic conditions
- Role of public purchasers
 - Only contract with ones that use
 - OR
 - Incentives for use
- Does state want to pay for outcomes or use of tools?
- Different standards for specialties?
 - Can be updated?
 - Must not disrupt workflow
- Should look at incentives to use tools + outcome based incentives → does require use of HIT + clinical support tools?
- Standard clinical guidelines
- Comparative effectiveness
- State role – provide information about support tools recommend minimum functionality and standards.
- State shouldn't focus on incentive tools → incent outcomes
- Base on CCHIT standards
- How do you leverage existing work and money
- What can do for patients?
 - State role – transparency around source
- Technical Assistance to providers for redesign and work development

Third work group session – August 6, 2008

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- Increase confidence of providers in choosing an EMR Services Company to support them on their new EMR.
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 - Subsidy will be a grant or low-interest loan.
 - Amount of grant will be based on the following:
 - Service to an underserved population.
 - Service to Oregon Medicaid population.

Note: There was a question as to the number of vendors the state should endorse

HIIAC Draft Recommendations to Oregon Health Fund Board

GOAL:

Increase statewide adoption of electronic health records with the capacity to provide efficient and effective decision support processes and tools so that clinicians can easily follow evidence-based guidelines to improve health outcomes and reduce cost.

ACTIONS:

The State of Oregon should:

- Create and support The Oregon Quality Institute to convene and collaborate with health plans and providers to align around a common set of health quality measures. The Quality Institute should:
 - Develop a common set of health care measures based on evidence endorsed by nationally recognized organizations

- Evaluate and endorse clinical guidelines to provide Oregon based resource for providers and patients
- Require PEBB, Medicaid, and other public purchasers of health care to choose from a common set of clinical quality measures in evaluating medical provider performance and health outcomes.
- Require State endorsed health information technology systems to include effective clinical decision support tools that align with quality measures chosen by Quality Institute

RATIONALE:

By providing clear treatment guidelines and health quality measures, the state, through the Quality Institute, can increase the positive influence of quality measures on direct medical practice. By giving priority to guidelines that are endorsed by nationally recognized professional organizations that write and evaluate guidelines based on evidence based medicine, necessary transparency will be provided. The state will, in effect, provide a “seal of approval” for Oregon medical providers and assist in aligning along a common set of guidelines for more consistent medical care between disparate medical offices and specialties.

The state’s use of its purchasing power in the area of health care, and its use of consistent quality measures, would greatly increase the adoption and influence of these measures. This would be greatly amplified if the Quality Institute could elicit the voluntary “buy in” from private insurers.

HEALTH INFORMATION EXCHANGE

Strategy Group Three

First work group session – July 9, 2008

- 1) Info not being shared
 - Poor health outcomes
 - Excessive costs
 - No useful info for public/providers
- 2) Need better standards
 - What data to share
 - How to share
 - Some data systems not interoperable
 - Providers/plans need incentives to share
 - No funding for change
 - Loss of competitive edge
 - More services = more money
 - Must see value in sharing
 - Value needs to be consumer-driven
 - Patient fears of sharing data

Recommendations:

- Support Health Records Bank
 - Consistent vision with HIIAC
 - No \$ for other pilots now
- State to use purchasing/payment powers
- Both of above must support the use of national standards

Other Issues

- Some recommendations about “exchange” but about other data sharing and Quality Institute, need to support, but another group should review
- Data analysis/research needs to be “called out” in recommendations
- One privacy recommendation

Also, the second to the last recommendation, beginning with "The state should coordinate with and support the HISPC..." seemed like a privacy work group issue to us.

Feedback from HIIAC at-large – July 23, 2008

- National standards do not exist in some areas
- Need to look at standards accepted by the Healthcare Information Technology Standards Panel (HITSP)
- Support Health Records Bank in a way that builds infrastructure for all of OR
 - Building blocks, foundation, starting point
- Consider legislation to standardize billing – incentives vs. mandate
- Consider higher payment rates for those who participate
- Consider grants to rural physicians
- Use state purchasing power to incentivize submission of data and use of data to provide high-quality, efficient care

Second group work session – July 23, 2008

[Strong Consensus]

Recommendation #1: The Oregon Health Record Bank (HRB) is a critical, innovative project that should be the building block for health information exchange in Oregon. To further that mission, the HIIAC recommends Medicaid convene formal input about the design and implementation of the HRB from, at a minimum, the commercial health plans servicing the Public Employees Benefit Board, the Oregon Education Benefit Board and Corrections. Through this collaboration, the HRB can be developed with enhanced ability to be used as a building block for health information exchange across all payers in Oregon.

[Agreement about concept but more discussion is necessary for consensus]

Recommendation #2: In order to maximize the opportunity for large-scale adoption of the Health Record Bank across public and private payers through Oregon, Medicaid should collaborate with interested stakeholders to conduct a large-scale public education program. Critical elements of the

education program should focus on patients and providers in order to create demand for participation in the Health Record Bank.

[Some discussion but no agreement or consensus achieved]

Recommendation #3: The Oregon Health Fund Board should study whether the Health Record Bank could be used to measure efficiency in the health care system as well as the potential for using the Health Record Bank as a tool for payment reform.

What is the Oregon Health Record Bank?

A Health Record Bank (HRB) would operate in a broad sense like a financial bank. As an electronic repository developed to collect, store, and distribute a patient's health records, an HRB would offer comprehensive information to providers about an individual, controlled by that individual, and stored in one secure location. Patients or payers could pay a fee to establish an account with HRBs of their choosing. Advertising, payment by researchers for queried data, value-added services or public subsidies may reduce or eliminate subscription fees.

Patients would have full access to their records through an online user interface designed by their HRB. Patients would determine who has consent to retrieve their health records. Providers could access a patient's health record bank to retrieve data, but only if approved by the patient. Each time a patient visits a healthcare provider or facility, records from that encounter would be transferred from the provider's electronic health record into the patient's HRB. Patients could also submit their own health data into the bank. Because the patient directly controls access to his or her information, complex discussions about each state's rules for exchange are unnecessary. The burden for consent would be on the patient.

An HRB could be a public utility, operated by the state, or a privately operated and funded enterprise governed by preset standards and regulations, and potentially certified or accredited by an independent organization.

(Definition adapted from an article in the Journal of the American Health Information Management Association)

What are the positives of using the Health Record Bank as a building block for health information exchange in Oregon?

- The HRB allows the state to provide seed money for development of a complete, functioning health record bank. Might have the leverage and independence to make a HIE functional where other regional collaboratives have failed.
- Centralization of records increases the accuracy and efficiency of querying records from a variety of locations

What are the concerns and issues to be further discussed if the Health Record Bank is the building block for health information exchange in Oregon?

- Since it is voluntary enrollment, how does DMAP maximize potential enrollment to create the "critical mass" necessary to make a larger impact to all Oregonians?
 - What is the value proposition for patients? Providers? What are the essential components for patients and providers to hear during the public education piece?
- Interoperability with existing electronic medical records and other electronic medical system.
- Carrot v Stick for participation:

- How do you appropriately incent use of the HRB? Is there an extra payment for participation (carrot)?
- Payment is reduced or no payment made (by a certain date) if the HRB is not utilized?
- What is the business plan?
 - Sustainability for further expansion to the commercial market?
 - How does the HRB live beyond the initial seed money?
 - How does the HRB succeed where other RHIOs with similar models have not?

Feedback from HIIAC at-large – August 6, 2008

- Temporal implementation
 - 1 + 2 before 3
 - Must be good product before “convincing people”
- Private payers to inform process → importance of interface with providers
- Medicaid → all public → commercial statewide model for HIE

HRB Controversial Issues

- Privacy concerns
- Patient ownership – right to edit / amend
- Public education and engagement
 - How implemented?
- Model – public utility or market based? Financial feasibility?
- Data in not as important as data out
- Encourage use of HRB data for quality improvement
- Interactive system of banks so long as they interact / interoperate
- EMR for physicians through HRB

Third work group session – August 6, 2008

Recommendation 1

The Oregon Health Fund Board should recommend statutory language creating a Health Information Exchange, including:

- By December 31, 2012, the Oregon Health Authority shall assure the existence of an electronic health information exchange system that allows key patient health information to be available at the time of treatment.
- By December 31, 2009, the Oregon Health Authority shall have a plan for how the Health Information Exchange will be developed.
- Patients must go through a meaningful and robust current process in order to participate in the Health Information Exchange.
- Health information will be readily available to patients at all times.
- Information will only be accessible to the patient, his or her representative, and treating health care providers.
- Key health information will include but not be limited to: list of current conditions; medications; lab reports; imaging reports.

- To ensure the timeliness of data, key health information will be entered into the Health Information Exchange within 1 business day.
- For strategic planning purposes, the Oregon Health Authority shall ensure that there is a robust education campaign for health consumers and providers regarding the value of health information exchanges.

Recommendation 2

The Oregon Health Fund Board should help to ensure that the DMAP Oregon Health Records Bank will be built in such a way that it will at a minimum be interoperable with the Oregon Health Information Exchange, and potentially be the initial building block for the Oregon Health Information Exchange.

To ensure the coordination between the Oregon Health Records Bank and the Oregon Health Information Exchange to be developed, the Oregon Health Fund Board will provide ongoing advice to the Oregon Health Records Bank project. Advice from the Oregon Health Fund Board needs to incorporate input from the private sector health care providers, patients and advocates.

HIIAC Draft Recommendations for the Oregon Health Fund Board

GOAL:

Support use of DMAP's Health Record Bank (currently being created with funding from a Medicaid Transformation Grant) as a fundamental building block for a statewide system for health information exchange which ensures that patients' medical information is available and accessible when and where they need it.

ACTIONS:

The State of Oregon should:

- Ensure the DMAP Oregon Health Record Bank will be built to be interoperable with the commercial plans servicing PEBB, OEBC and Corrections , and ultimately all commercial plans
- Ensure the DMAP HRB encompasses strong privacy and security protections and resolves the issues of patients' rights with respect to the use and ownership of their information
- Design and implement a public education program targeted at both providers and patients

RATIONALE:

DMAP's Health Record Bank provides an opportunity for the state to build upon the investment and work that is already being done in this area.

The input of the private sector will be a key to ensuring the HRB will be interoperable with those outside Medicaid and ultimately PEBB, OEBC and Corrections. With little or no funding available for pilot projects, Oregon can build a comprehensive health information exchange system by leveraging the money already received for the HRB project.

Privacy and security concerns, by both providers and patients, must be appropriately addressed in order to gain their trust and confidence so that they will agree to participate in these systems.

Note: During the last work session, the group recommended two separate exchanges, an Oregon HIE and a HRB. The explanatory notes did not provide background on why the group wanted to do this.

PRIVACY AND SECURITY

Strategy Group Four

First work group session – July 9, 2008

Initial Proposal for Health Information Exchange Licensing Board

Concept:

It is felt that one of the risks to privacy and confidentiality of electronic health information data is a security breach or misuse of a person's medical information. It is also believed that there is a great deal of value from the thorough exchange of such data to support the healthcare needs of the patient. It is important that efforts with an Oregon strike the right balance between adequately exchanging health information data and the maintenance of privacy, security, confidentiality of such data. To that end, we propose a law Licensing Board that would have statutory authority in this area.

Details:

The Licensing Board would be authorized by statutory law. The statutes would declare that the Board shall develop and promulgate administrative rules about the storage and exchange of health information data. Parties to such an exchange would be required to obtain a license for the transfer electronic health data. In the same way that a researcher might describe their plans for conducting research in a healthcare setting, applicants for the Health Information Transfer License would describe their plans for transferring health information while maintaining security, privacy, and confidentiality.

Statutory law would guarantee that patients and consumers provide adequate informed consent before their health information is included in transfer services. Further, consumers and patients would be guaranteed notice when their information was exchanged and if there was any breach of privacy and confidentiality of their records during transfer. Statutory law would state what due process would be followed after discovery of a breach. Consumers and patients would be guaranteed specific remedies. Attorneys general would also be guaranteed remedies in the case of improper health information transfer practices where the individual is unable to pursue a private right of action.

The Board would have the authority to create administrative rules according to approved and established national standards in health information transfer. The Board would be authorized to perform periodic and random audits and inspections of licensees' health information transfer practices. Licensees would be subject to periodic relicensing. Simply holding a health information transfer license would not indemnify a licensee, who could still be litigated against for unprofessional or improper practices.

Feedback from HIIAC at-large – July 23, 2008

- Original concept should be split into two components
 - (1) Patient's right to control information (paragraph 2)
 - (2) Technology/processes to assure privacy (paragraphs 1 and 3)
- Should be statutory based patient rights – right to participate must stay with patients
- Must consider tension created when provider decides practice will use HER/electronic exchange
- Funding? Certification Board should be funded by those being licensed
- Who should be licensed? Individuals/practices/institutions?
 - Institutions already creating security policies for HIPAA
- Certification vs. Licensing? Suggestion that certification is more feasible and appropriate.
- What would certification requirements be for entities outside of OR?
- Tension between national standards of technology and in absence of standards what OR can do.
- How does Certification Board fit in with Health Records Bank?

Second group work session – July 23, 2008

Recommendation #1: Statutory Content - Privacy and Individual Rights - these are general concepts that need to be elaborated upon and discussed at length. These concepts may be mutually incompatible or technically difficult or impossible. They are included for completeness of discussion.

- There shall be notice to and authorization from the patient or patient's personal representative prior to sharing a patient's data through a health information exchange (HIE).
- There shall be an opportunity for the patient to not agree to sharing data through a HIE without penalty.
- The patient can request that part of that patients' record NOT be shared and that request must be honored.
- Providers shall not be penalized by a patient's unwillingness to allow their data to be shared through a HIE.
- Patients shall be timely notified of a breach and provided a meaningful remedy [it's more than just "notification" existing].
- There will be a private right of action for the consumer and patient after breach has occurred.
- The State Attorney General has the right to bring an action on behalf of individuals to seek remedy.
- Patient shall have access to their record in a timely manner and an opportunity to correct errors.

Recommendation #2: Certification Board

- A Certification Board will be created by statute, providing some detailed requirements in statute as well as providing the authority to create administrative rules.
- In the statute there will be an explanation of why the Board exists: to create the gold standard for regulating exchange of healthcare information within Oregon and requirement that entities are certified.
- The statute will require that each certified entity has administrative, physical, and technical safeguards in place consistent with HIPAA and Oregon state law. The Board will create additional standards for certified entities to ensure the privacy and security of information

transmitted through an electronic exchange is based on current and emerging national standards where available. These standards will be regularly updated to account for new national standards and the improvement of technology.

- Requirements for Certification will include:
 - Submission of documents, including but not limited to policies and procedures, disaster readiness plan, recovery plan, and so forth.
 - The entity will sign an attestation (subject to some form of penalty for false attestation) that it is following the above privacy and security statutes subject to random audit by the Certification Board.
 - If applicable, the entity will use only EMR/EHRs that have been certified by the Certification Commission for Health Information Technology (CCHIT) or other equivalent nationally recognized health care technology certification board. (If this goes into statute, need to be flexible regarding technical certification.)
 - The Certification Commission for Healthcare Information Technology or CCHIT is a nonprofit organization recognized certification body (RCB) for electronic health records and their networks, and an independent, voluntary, private-sector initiative. It is our mission to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program.
- Statutory law will probably have to provide some measure of due process if certification is withheld or revoked from an entity.
- Each "end" of an exchange will be certified. For example, if a physician clinic participates in an exchange with the Oregon Health Records Bank, the physician clinic will be certified to exchange data, and the Oregon Health Records Bank will also be certified separately to exchange data.
 - Option 1: Require all entities exchanging electronic information to be certified immediately
 - Option 2 (more realistic): Allow initially for voluntary certification (associated with fee), with required certification by X date
- Each entity will only be certified once even if it participates in multiple exchanges.
- Certification will require renewal on a periodic basis.
- Periodic certification shall require that the entity upgrade its technology, policies, procedures, or practices to meet current national standards, as determined by the Certification Board.
- Certified entities will be allowed to exchange electronic health information only with other certified entities.
- Statute shall set forth the number and types of representation on the certification board, length of service, who has the authority to appoint (it can be from multiple sources), authorization around fees, authority to have staff, reimbursement for the board members, etc.

Feedback from HIIAC at-large – August 6, 2008

- Need to clarify who will be using
 - Who will use information?
 - How can you ensure exchange is limited?
- Authorization = opt in
- Who statute will apply to?
 - Standards for state information system all EMR vs. PHR

- Ownership
- Balance expectation that data will be available at time of need with patients' rights to limit exchange
- Common theme: state standards
 - One entity or multiple?
- Are insurance claims subject to HIE?
- Cost?
 - What is the value add of certification board?
 - What does it do that HIPAA doesn't?
- Emergency "break the glass" provision?

Third work group session – August 6, 2008

The group focused discussion on the feedback from some HIIAC members regarding Recommendation #2 – Certification Board. Feedback consisted of comments on the burden this would place on the state and the question about how it differed from what HIPAA currently requires of organizations exchanging health information.

Only one member of the group that proposed this idea was present for this discussion and the group felt it needed to give the original group members an opportunity to respond to the feedback and criticism raised by the HIIAC members. We hope to have this opportunity at the August 20th meeting.

The group reviewed the goal that gave rise to the Certification Board idea: ensure the best, most efficient, most advanced HIE systems would be adopted and used in Oregon. The assumption underlying this goal is that to best ensure privacy and security protections Oregon should mandate that systems in use in Oregon have an appropriate level of privacy and security protections.

Possible Alternate Recommendation #2

If the HIIAC is not inclined to recommend a Certification Board, as an alternative, the group discussed using meaningful penalties for breaches and misuse as a way to drive the adoption of systems with the highest level of protections. If entities engaged in the electronic exchange of health information know that strong penalties will be enforced against them in the event of a breach to the system or the misuse of information, it follows that they will adopt systems that are most likely to prevent a breach or misuse of information. It was noted that strong penalties and enforcement would be necessary to achieve the deterrent effect.

There was also discussion that the standard of care giving rise to penalties should include all levels, from negligence to intentional release, recognizing that the penalties may differ based on negligence, reckless or intentional release.

Prompt notice of any breach also needs to be a part of this to ensure that the consumers actually know when there has been a breach or misuse and can seek recourse and appropriate remedies.

There was some concern that although HIPAA has remedies for breaches, those remedies exist on paper but are rarely used, leaving the consumer with little or no recourse. This model would need to

require meaningful enforcement and remedy to the individual consumer (and the state through the Attorney General) to fulfill its intended goal.

Additionally, the group noted that “No third party access to information” should be added as a bullet point under Recommendation #1. This is intended to make it clear at the outset to consumers that the information collected through an HIE can only be used for the purposes set out and never migrate, in any manner, to another use.

The group discussed proposed federal legislation – HR 5442 (110th Congress) also known as the “Trust Act.” There is language in the preamble to the bill that would be useful to include in the report to the Oregon Health Fund Board. The preamble sets out the need for privacy and security protections and will give context to the recommendations of to the OHFB on privacy and security issues.

The group discussed that there would need to be exceptions to the prohibitions on exchanging information listed in Recommendation #1 such as what happens in a medical emergency. The workgroup recommends the HIIAC review any current law in this area before developing new recommendations.

Note: The ability of this group to move forward was somewhat hampered by the lack of continuity in group attendance.

HIIAC Draft Recommendations to Oregon Health Fund Board

GOAL:

Ensure the highest level of privacy and security of Oregonian’s personal health information in an electronic exchange environment

ACTIONS:

The State of Oregon should:

- Statutorily prescribe when and with whom an individual’s personal health information may be exchanged electronically. Legislation should address:
 - Notice to and authorization from the patient or patient’s personal representative prior to sharing a patient’s data through a health information exchange (HIE)
 - An opportunity for the patient to not agree to sharing data through a HIE without penalty
 - A patient request that part of that patients’ record NOT be shared and that request must be honored
 - Providers not being penalized by a patient's unwillingness to allow their data to be shared through a HIE
 - Timely notification to patient of a breach and a meaningful remedy
 - A private right of action for the consumer and patient after breach has occurred
 - A State Attorney General right of action on behalf of individuals to seek remedy
 - Patient access to their record in a timely manner with an opportunity to correct errors

- No third party access to information
- Establish a Certification Board for all entities involved in the electronic exchange of personal health information

AND/OR

- Provide for strict enforcement of meaningful penalties for the negligent, reckless or intentional release or misuse of personal health information

Oregon Health Fund Board



Health Information Infrastructure Advisory Committee

Report to the Oregon Health Fund Board

September 2008

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Committee Membership

[Add roster here]

Oregon Health Fund Board – Health Information Infrastructure Advisory Committee Recommendations

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Oregon Health Fund Board – Health Information Infrastructure Advisory Committee

Section 1: Background and Committee Process

I. Introduction

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care.

Recognizing the need for Oregon to develop a strategy for health information technology (HIT) as a part of this comprehensive reform and long-term system transformation, Governor Kulongoski created the Health Information Infrastructure Advisory Committee (HIIAC) by Executive Order 08-09 (See Appendix A) in early 2008. The Governor appointed 23 members to the HIIAC, representing a wide variety of provider groups, payers, purchasers, consumers, researchers and state government.

The HIIAC was designated to make recommendations about policies to: reduce barriers to health information exchange, while maintaining the privacy and security of individuals' health information; establish an appropriate role for the state in building and maintaining health information infrastructure; facilitate the adoption of state health information infrastructure standards and interoperability requirements, based on federal requirement and national standards; facilitate collaboration between statewide partners; and develop evaluation metrics to measure the implementation of health information technology and the efficiency of health information exchange in Oregon.

As its first official task, the Executive Order directed the HIIAC to provide a report to the Oregon Health Fund Board by the end of July 2008, with recommendations to be considered as part of the Board's comprehensive reform plan. The HIIAC members strongly believe that a carefully developed, secure, widespread HIT system must be a keystone to any successful and sustainable reform plan. The following report explores challenges in the current health care system and opportunities to transform the system through wider adoption and utilization of HIT and provides specific, actionable recommendations to facilitate and accelerate this transformation.

II. Health Information Technology Background

A. Why is Health Information Important?

1. Challenges in the Current System

Health care delivery in Oregon and across the nation faces many significant challenges. Health care spending in the U.S. represents 16 percent of GDP, with health care spending in Oregon alone exceeding \$19 billion in 2008.¹ At the same time, the system is highly fragmented and in many instances does not deliver high-quality, efficient, and safe care. Research shows that Americans receive only 55 percent of recommended care² and one-third of patients experience coordination problems, including lab test results or records that were not available at the time of the appointment or duplicated tests.³

Patient safety is a major concern, with the Institute of Medicine estimating that between 44,000 and 98,000 people are killed every year in hospitals by preventable medical errors. Beyond the human toll, medical errors in hospitals cost the health care system between \$17 and \$29 billion every year.⁴ In addition, at least 1.5 million adverse drug events occur in the U.S. every year.⁵

Physicians and patients often do not have the information they need to make informed health care decisions. In an age defined by significant advancements in technology and electronic information exchange, a significant portion of the health care industry remains dependent on fax, mail, and telephone transactions. Furthermore, clinicians often do not have point-of-care access to clinical support guidelines and other tools to help them maximize quality of care. 10 to 81 percent of the time, physicians report that they cannot find necessary information in a paper-based medical record, which often leads to duplicative services and inefficient care.⁶

¹ J. McConnell. 2007. Health Care Reform Reference: 2008 Oregon Health Care Spending Estimates. Office for Oregon Health Policy and Research. Available at:

<http://www.oregon.gov/OHPPR/OHREC/Docs/OregonHealthCareSpendingEstimates06thru08.pdf>

² E. McGlynn, et al. 2003. The Quality of Care Delivered to Adults in the United States, *New England Journal of Medicine*. 248(26): 2635-2645.

³ C. Schoen, et al. 2005. Taking the Pulse of Health Care Systems: Experiences with Patients with Health Problems in Six Countries. The Commonwealth Fund. Available at:

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=313012.

⁴ L. Cohen, J. Corrigan, and M. Donaldson, eds. 2000. *To Err is Human: Building a Safer Health Care System*. Committee on Quality of Health Care in America. The Institute of Medicine. National Academy Press: Washington, DC.

⁵ P. Aspden, J. Wolcott, L. Bootman, and L. Cronenwett, eds. 2007. *Preventing Medication Errors*, Committee on Identifying and Preventing Medication Errors. Institute of Medicine. National Academies Press: Washington, DC.

⁶ J. Marchibroda. 2004. Testimony Before the Subcommittee on Health of the House Committee on Ways and Means. United States House of Representatives. Available:

<http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1654>.

2. How Health Information Technology Can Improve Health Care Delivery

An emerging body of research supports the use of HIT to improve quality and safety, most notably in the areas of adherence to clinical guidelines, enhanced surveillance and monitoring, and decreased medication errors.⁷ HIT can help ensure that the right information is available at the right time and access to high-quality information is a vital component of a high performing health care system. Many players in the health care system can benefit from more widespread use of HIT and the Minnesota e-Health Initiative has laid out a number of areas in which HIT can improve quality of care and care coordination and has provided the following examples.⁸

Effective use of the growing array of information technologies in health care enables clinicians to:

- Ensure a newly prescribed medication does not conflict with existing medications.
- Avoid duplicate tests because the previous results can be transmitted electronically.
- Readily access clinical guidelines and other evidence-based information most relevant to the patient's current condition.
- Avoid medication and other errors due to illegible or misinterpreted handwriting.
- Improve continuity of care by being able to exchange information with patients' other providers.
- Receive reminders about preventive services that patients are due to receive.
- Receive alerts when a prescribed action may be contraindicated.
- Improve clinical workflow processes to achieve greater efficiencies while also improving outcomes.
- Access a patient's record from home when receiving a call at night.
- Support delivery of telehealth and telemedicine services, enabling patient access to care otherwise unavailable in their community.

HIT can also have tremendous value in increased patient satisfaction and patient engagement by:

- Enabling the patient to access their health information online, including links to tailored prevention, disease management, and other information resources.
- Allowing patients to contact their providers through email.

⁷ B. Chandhry, et al. 2006. Systematic Review: Impact of Health Information technology on Quality, Efficiency, and Costs of Medical Care. *Annals of Internal Medicine*. 144:E-12-E-22.

⁸ Adapted from: Minnesota e-Health. 2008. *Vision to Action: The Minnesota e-Health Initiative*, Report to the Minnesota Legislature. Minnesota Department of Health.

- Synchronizing information as a patient moves between a clinic, hospital, and long-term care facility and making the patient's records available at whichever site the patient visits.
- Easily graphing and displaying a person's key biometric data over time.

In addition, HIT has the potential to reduce health care spending by increasing efficiency. A few examples of opportunities to use HIT to reduce administrative and clinical costs for hospitals or practices include⁹:

- Directly dictating to an electronic health record versus paying for transcription services.
- No longer having to pull, manage, and store paper records.
- Reducing duplication of services and repeated tests.
- Experiencing enhanced revenue capture and fewer claims denials.
- Having fewer pharmacy call-backs.
- Increasing productivity by decreasing time spent tracking down health information.
- Alerting physicians if a generic version of a prescribed drug is available.
- Contributing to lower malpractice premiums.

In 2007, the Office for Oregon Health Policy and Research and the Oregon Health Quality Corporation sponsored a study of the potential impact of widespread HIT on health care spending in Oregon. The researchers found that the widespread adoption of advanced health information technology, including electronic health records (EHR) systems with capabilities for the authorized and secure electronic exchange of information between hospitals, physicians and other service providers, could result in a net savings of \$1.0 to \$1.3 billion per year within 12 years.¹⁰

3. Barriers to Adoption of HIT

Although HIT can provide the health care industry with tools to improve efficiency, contain costs, and achieve better health outcomes adoption rates remain low throughout the country. Currently, only 17% of physicians have access to an EHR system, with only 4% of physicians having a fully functioning EHR.¹¹ Oregon is ahead of the national trends in EHR adoption, but even here only an estimated 53% of non-federal clinicians are working in practices or clinics

⁹ Ibid.

¹⁰ D. Witter and T. Ricciardi. 2007. Potential Impact of Widespread Adoption of Advanced Health Information Technologies on Oregon Health Expenditures. Oregon Health Care Quality Corporation and Office for Oregon Health Policy and Research. Available at: <http://www.q-corp.org/q-corp/images/public/pdfs/OR-HIT%20Impact%20Final.pdf>

¹¹ The George Washington University, Massachusetts General Hospital, and The Robert Wood Johnson Foundation. 2008. Health Information Technology in the United States: Where We Stand, 2008. Available at: <http://www.rwjf.org/files/research/062508.hit.exsummary.pdf>.

where EHRs are present.¹² Hospitals also show low levels of adoption with only 37% with electronic health records, 46% utilizing clinical decision support and only 13.9 with computerized physician order entry.¹³

A range of barriers to HIT adoption have been discussed in the literature. A recent article in the *New England Journal of Medicine* acknowledged prohibitive capital costs as the most common barrier cited by providers. In addition, providers without access to electronic health record system also widely indicated the following barriers: not finding a system that met their needs, uncertainty about their return on investment, and concern that a system would become obsolete.¹⁴ In addition, many providers who have access to EHRs and other HIT do not fully utilize their capabilities because they are difficult to use or providers feel they interrupt workflow.

Many will say that the most powerful utilization of HIT comes with interoperable systems that allow for the exchange of information between care sites. Currently, efforts to create interoperability are hampered by a lack of standard sets of requirements and standards for technology systems utilized for exchange throughout the state. In addition, health information exchange concerns many individual patients, who do not believe current systems offer enough privacy and security standards. Stronger consumer protections are needed before there will be widespread patient participation in health information exchange.

4. HIT as Part of Comprehensive Health Care Reform

The evidence supports the important role for information technology in any reform effort aimed at improving the quality, safety and efficiency of Oregon's health care system. The Oregon Health Fund Board's Delivery System Committee clearly stated the need for a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across the state. The Delivery Systems Committee also called for state action to facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensures that the right information is available at the right time to patients, providers and payers. Many of the Committee's recommendations focused on improving transparency of clinical and performance data across the system and technologies are needed to make this information easier to collect and disseminate. The Oregon Health

¹² D. Witter, Jr., J. Pettit, D. Nicholson and T. Edlund. 2007. Oregon Electronic Health Record Survey Ambulatory Practices and Clinics, Fall 2006. Office for Oregon Health Policy and Research and Oregon Health Care Quality Corporation.

¹³ M.Furukawa, et al. 2008. Adoption of Health Information Technology for Medication Safety in U.S. Hospitals, 2006. *Health Affairs*, 27(3): 865-875.

¹⁴ C. DesRoches. 2008. Electronic Health Records in Ambulatory Care – A National Survey of Physicians. *New England Journal of Medicine*. 359: 50-60.

Fund Board and other state agencies must align with national and Oregon-based efforts to overcome the barriers to HIT adoption and integrate the utilization of interoperable technology across the health care sector.

B. Current Efforts to Promote the Adoption of Health Information Technology

There is a great deal of work going on at the national and state levels in both the public and private sectors to overcome the barriers to widespread implementation of advanced EHRs, e-prescribing, and other HIT to improve overall safety, quality and effectiveness of health and health care. Brief descriptions of several key examples of these initiatives are below. Oregon should be careful not to use limited resources to duplicate existing efforts, but must coordinate and build upon other initiatives and whenever possible, align standards and requirements.

1. The National Landscape¹⁵ (should this be in an Appendix?)

The National Committee on Vital and Health Statistics (NCVHS) performs the vital role of reviewing and recommending approval of health-related data standards to the U.S. Department of Health and Human Services. Throughout this process, NCVHS solicits advice from a broad spectrum of public and private-sector stakeholders, as well as leading organizations actively involved in efforts to standardize health information. See <http://www.ncvhs.hhs.gov>.

The National Health Information Infrastructure (NHII) initiative of the Department of Health and Human Services has proposed a network of interoperable systems covering key health information areas: clinical, personal, research, and public health. See <http://aspe.hhs.gov/sp/nhii/index.html>.

The Office of the National Coordinator for Health Information Technology (ONCHIT) collaborates with public, private, and non-profit sectors to facilitate the widespread adoption of interoperable electronic health records for all Americans. See <http://www.hhs.gov/healthit/mission.html#>.

The Consolidated Health Informatics (CHI) initiative establishes a portfolio of existing clinical vocabularies and messaging standards that enable federal agencies to build interoperable health data systems that “speak the same language” and share information. CHI standards will work in conjunction with the Health Insurance Portability and Accountability Act (HIPAA – See Glossary) transaction records and code sets, and HIPAA security and privacy provisions. See www.ncvhs.hhs.gov.

¹⁵ Adapted from materials of the Minnesota e-Health Initiative including: The 2005 Roadmap and Preliminary Recommendations for Strategic Action: Report to the Minnesota Legislature and The 2008 Prescription for Meeting Minnesota’s 2015 Interoperable Electronic Health Record Mandata.

The Public Health Information Network (PHIN) initiative of the Center for Disease Control is developing a network for crosscutting and unifying data streams to enhance the detection of public health issues and emergencies. See <http://www.cdc.gov/phn/>.

The Doctors' Office Quality-Information Technology (DOQ-IT) project of the Center for Medicaid and Medicare Services promotes the adoption of EHR and other health information technology systems in small-to-medium sized physician offices. See <http://www.doqit.org/doqit/jsp/index.jsp>.

The Foundation for the National e-Health Initiative was created to serve as a national forum for the discussion of the policy issues relevant to the application of technology to support health and to articulate and execute a vision of a better health care system enabled by technology, to improve the quality, safety, and efficiency of health care, as well as consumers' experiences with managing their health. See <http://www.ehealthinitiative.org/about/foundation.mspx>.

The Markle Foundation's Connecting for Health initiative is a collaborative of public and private sector participants focused on addressing the policy, technical, and legal barriers to establishing an interconnected health information infrastructure. See <http://www.connectingforhealth.org>.

The Certification Commission for Healthcare Information Technology (CCHIT) certifies EHR software and HER networks based on objective criteria. CCHIT's mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. See <http://www.cchit.org>.

The Health Information Technology Standards Panel (HITSP) is a public-private cooperative working to develop a widely accepted and useful set of standards specifically to enable and support widespread interoperability among health care software applications, as they will interact in local, regional and national health information networks. See <http://www.hitsp.org>.

The Bridges to Excellence (BTE) Physician Link Program encourages adoption of HIT by providing monetary incentives to physicians for utilizing health information technology and information systems that improve quality of care. See <http://bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=19>.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) provided critical provisions that will promote the adoption of data standards, including the standards requirements included in the electronic prescription program. In addition, the MMA created the Commission on System

Interoperability which will develop a comprehensive strategy, timelines and priorities for the adoption and implementation of healthcare information technology standards.

The Agency for Healthcare Research and Quality has established a Health Information Technology grant program for providers and other healthcare stakeholders planning and implementing health information technology-related projects. See <http://healthit.ahrq.gov>.

The Nationwide Health Information Network (NHIN) program of the U.S. Department of Health and Human Services is attempting to build a “network of networks” by developing and testing prototypes to connect state and regional health information exchanges. See <http://www.hhs.gov/healthit/healthnetwork>.

The Health Information Security and Privacy Collaborative (HISPC) is a national collaborative of states and territories working together to address privacy and security policy questions affecting interoperable health information. Oregon is one of the 41 states and territories participating in the project. See <http://www.rti.org/hispc>.

The NGA Center for Best Practices State Alliance for e-Health initiative is a collaborative body that enables states to increase the efficiency and effectiveness of the health information technology (HIT) initiatives they develop. The Alliance provides a nationwide forum through which stakeholders can work together to identify inter- and intrastate-based health information technology policies and best practices and explore solutions to programmatic and legal issues related to the exchange of health information. See <http://www.nga.org/center/ehealth>.

Various states and regional efforts to establish *health information exchanges* (HIE) have been established across the country. In 2006, an eHealth Initiatives survey identified 165 HIE efforts in 49 states, the District of Columbia, and Puerto Rico. While many of these initiatives were still in the planning phase, one-third reported transmitting a broad range of data electronically and 26 identified themselves as fully functional. A great deal can be learned from studying the successes and failures of various HIE efforts around the country.¹⁶ **(List any specific states?)**

¹⁶ eHealth Initiatives. 2006. Third Annual Survey of Health Information Exchange Activities at the State, Regional and Local Levels. Available at: <http://toolkits.ehealthinitiative.org/assets/Documents/eHI2006HIESurveyReportFinal09.25.06.pdf>

2. The Oregon Landscape

The Health Records Bank (HRB) of Oregon is Oregon's Medicaid Transformation grant project funded through a \$5.5 million grant from the Centers for Medicare and Medicaid Services. The HRB project is currently in the planning stage, but will eventually store Medicaid clients' health information electronically and make it available on a secure-web site. Goals of HRB Oregon are to: assemble existing patient information from multiple sources and provide one place for patients and their providers to share that information; provide a reliable and trusted repository of patient-specific health information; improve quality and coordination of care by providing patient-specific historical health information and decision support tools and resource information to enhance patient participation in their health and health care; and protect patient privacy. Initial implementation plans will limit HRB participation to a specific geographic area. See <http://healthrecodbank.oregon.gov>.

OCHIN is a non-profit organization with the mission to improve the health of the medically underserved through the best use of information and information technology. OCHIN is collaborative of 21 member organizations serving both rural and urban populations and leverages the size of the collaborative to make electronic medical records (EMR) affordable for safety-net clinics to implement and maintain. See <http://www.community-health.org>

(Should be included?) In 2007, *The Oregon Health Quality Corporation* and *Oregon Business Council* supported a team to explore opportunities to begin building a system for sharing health information in the Portland Metropolitan area. The group prepared a complete Metropolitan Portland Health Information Exchange Mobilization Plan, which included business and operational plans for the first steps for implementing a results and reports viewing system. The project is currently identifying and addressing barriers to mobilization. See <http://www.q-corp.org/default.asp?id=13>.

III. Committee Process, Vision, Mission and Guiding Principles

A. Committee Meeting Processes

The HIIAC first met in April 2008 and held a total of 9 meetings between April and then end of September. Dick Gibson, senior vice president and chief information officer at Legacy Health Systems and Ree Sailors, senior health policy analyst for the governor, were elected as co-chairs of the HIIAC.

The group spent significant time during its first few meetings developing and revising a set of statements and principles to guide the committee process and recommendation development. In particular, the HIIAC members agreed on a mission, vision, and guiding principles, as well as the elements of a productive process, the elements of productive recommendations/findings, a decision making process for HIIAC, and the role of the HIIAC in summer 2008. The final

versions of these statements, which were confirmed by the HIIAC on July 23, 2008 can be found in sections B below. The group also developed a logic model to create a pictorial representation of the elements of system transformation the HIIAC plans to address and the inputs and strategies the HIIAC will need to utilize in order to reach these system improvement goals. The logic model can be found in section J below.

At the second meeting, the HIIAC members brainstormed an initial list of recommendations to encourage HIT adoption and utilization across the state. At the next meeting (**do I have this process right?**), members rated each option based on the following criteria: time frame (short or long term), impact on cost containment, availability of privacy protections, scope of impact, potential to improve care, support of the Delivery Committee recommendations, degree to which scalable or amenable to pilots or demos, technical feasibility, degree to which supports public-private partnerships and fosters shared responsibility, support of population research and intervention, and creation of staging opportunities. Based on these ratings and HIIAC member discussion, this large initial list was condensed into a list of twenty-five potential strategies.

The twenty-five remaining strategies were sorted into topic “buckets” which included: HIT adoption, evidence based medicine and clinical decision support, health information exchange, and privacy and security. The HIIAC was divided into four subgroups that coincided with these topic areas and each subgroup was asked to develop a limited number of recommendations in their assigned areas. The meetings in late July, August, and September were designed to allow the subgroups to work individually to develop recommendations and allow opportunities for each subgroup to report on their progress and receive feedback from the HIIAC group as a whole. These finalized recommendations and the rationale used in developing them can be found in Section 2 of this report.

B. HIIAC Vision, Mission, and Guiding Principles

1. HIIAC Vision

In order to improve health and reduce costs, an Oregonian’s health information:

- Is available when and where it is needed to support clinical-decision making and high quality care
- Is private and secure and only exchanged with the authorization of the individual in ways that comply with federal and state law
- Improves public health and population-based care decision-making
- Enables individuals to take an active role in their health through access and control of their health information and tools to help them make informed choices.

2. HIIAC Mission

From the Executive Order No. 08-09, Office of the Governor (See Appendix A):

To fulfill the **MISSION** of developing a strategy for the implementation of an Oregon health information infrastructure, the HIIAC shall:

- Review and identify obstacles to the implementation of an effective health information exchange infrastructure in Oregon and provide policy recommendations to remove or minimize those obstacles;
- Outline the role of the State in developing, financing, promoting and implementing a health information infrastructure;
- Recommend how to facilitate the statewide adoption of health information system standards and interoperability requirements to enable secure exchange of health information exchange;
- Monitor the development of federal and applicable international standards, coordinate input to the Nationwide Health Information Network, and ensure that Oregon's recommendations are consistent with emerging federal and applicable international standards;
- Identify partnership models and collaboration potential for implementing electronic health records and exchange systems, including review of current records and exchange systems, including review of current efforts in the state and opportunities to build upon those efforts;
- Recommend a plan for the creation of a health information infrastructure that preserves the privacy and security of Oregonian's health information, as required by state and federal law; and
- Develop evaluation metrics to measure the implementation of health information technology and the efficacy of health information exchange in Oregon.

3. Guiding Principles

1. We will operate from a model of collaboration and partnership between the private and public sectors and will leverage that collaboration whenever possible to seek solutions for all Oregonians.
2. We will only support solutions that meet or exceed national and industry standards, or that promote their development and adoption where no standards exist.

3. We will enable individuals to take an active role in their health through access and control of their health information and tools to help them make informed choices.
4. We will only recommend plans/strategies for health information exchange that protect the integrity, availability and confidentiality of the consumer's information.
5. We will identify and align incentives for all stakeholders to support HIT adoption and interoperability.

(Note from Carol Turner: The following sections may not need to be included in the report since they were developed to structure the committee's work.)

i. Elements of a Productive Process

If this a productive process, we as HIIAC members will:

- Be willing to compromise for the betterment of the whole
- Learn and draw from the work of others
- Commit to action, continuity of service and advocacy for the recommendations
- Increase trust among members through direct communication and comfort in expressing diverse views
- Have resources necessary for timely and comprehensive decision-making
- Make good use of everyone's time
- Share all relevant information
- Take time to test assumptions
- Discuss the un-discussables
- All share in responsibility for process

ii. Elements of Productive Recommendations/Findings

Productive HIIAC recommendations for this fall will:

- Make a difference in Oregon
- Develop a long-term vision that engages and inspires people
- Represent various perspectives and be responsive to concerns of constituents and stakeholders
- Have actionable, specific, affordable and realistic recommendations
- Have short-term deliverables that include incremental and sequential steps
- Outline the structure for responsibility and accountability
- Be bold and willing to try new things
- Include evaluation/assessment of HIIAC's work and recommendations

iii. HIIAC Decision Making

The committee agreed to use a 5 point consensus scale in making decisions (5 being strong support and 1 being not agreeing), with 3-5 indicating consensus. When coming to conclusions, if there is no consensus, the report will note the areas of concern and differences, as well as areas of agreements.

iv. Role of HIIAC this Summer

Committee agreed that HIIAC would provide to the Health Fund Board:

- v. Context: barriers, problems, stakeholder concerns
- vi. Guiding principles, goals

- vii. Strategies and discreet tactics: meaty, specific next steps with links to other HFB committees' recommendations, costs (cost savings?) if possible
- viii. Recommendation of commitment to move this forward.

IV. ADOPTION OF ELECTRONIC MEDICAL RECORDS AND HEALTH INFORMATION TECHNOLOGY

GOAL:

Achieve widespread, effective use of health information technology (HIT) in Oregon

ACTIONS:

The State of Oregon should:

- Endorse four EMR Vendors based on their EMR's exhibition of the following properties:
 - Meeting or exceeding CCHIT standards
 - Valuable Clinical Decision Support Tools to be used by providers at the point of care
 - Interoperable data exchange with other EMRs, Personal Health Records, and the Oregon Health Record Bank
 - Adherence to HIIAC privacy principles
 - Ability to record, store, and report quality of care and health outcome measures
- Endorse four EMR Service Companies that can provide the following services to provider groups using one of State-endorsed EMRs:
 - Implementation support
 - Conversion from paper records or another EMR to a State-endorsed EMR
 - Ongoing support of the EMR
 - Interface support
 - Practice optimization using the EMR
 - Clinical process improvement using the EMR
 - Quality reporting support
 - Participation in health information exchange
- Use its RFP process to identify "state endorsed" vendors and use this process to solicit the most aggressive price - giving those providers who

- purchase from these vendors similar benefits as are obtained by group purchasing
- Subsidize provider use of the endorsed EMR Vendors and the endorsed EMR Service Companies
 - Subsidies in the form of a grant or low-interest loan, with amount based on:
 - Service to an underserved population
 - Service to Oregon Medicaid population
- Set benchmarks for the adoption of electronic medical records, clinical decision support tools and e-prescribing and evaluate progress toward meeting those goals.

RATIONALE:

By creating certainty, the state can diminish a number of the barriers currently preventing the adoption and use of health information technology. Certainty can be created by instituting standards and providing ongoing support for those systems meeting standards. Using the state's RFP process and negotiating power, costs of both the systems themselves and the ongoing support necessary to maintain these systems, can be made more affordable and more reliable.

By guaranteeing the interoperability of EMRs, simplifying the choice of vendors and providing a pre-set menu of features and pricing, the state will increase confidence among providers and encourage the adoption of health information technology systems. Additionally, assistance with the large investment these systems require will be very effective, especially among rural and Medicaid providers.

Benchmarks and evaluation are necessary to continue improvement in this area.

V. CLINICAL DECISION MAKING AND EVIDENCE BASED MEDICINE**GOAL:**

Adopt (statewide?) electronic health records with the capacity to provide efficient and effective decision support processes and tools so that clinicians can easily follow evidence-based guidelines to improve health outcomes and reduce cost.

ACTIONS:

The State of Oregon should:

- Create and support The Oregon Quality Institute to convene and collaborate with health plans and providers to align around a common set of health quality measures. The Quality Institute should:
 - Develop a common set of health care measures based on evidence endorsed by nationally recognized organizations
 - Evaluate and endorse clinical guidelines to provide Oregon based resource for providers and patients
- Require PEBB, Medicaid, and other public purchasers of health care to choose from a common set of clinical quality measures in evaluating medical provider performance and health outcomes.
- Require State endorsed health information technology systems to include effective clinical decision support tools that align with quality measures chosen by Quality Institute

RATIONALE:

By providing clear treatment guidelines and health quality measures, the state, through the Quality Institute, can increase the positive influence of quality measures on direct medical practice. By giving priority to guidelines that are endorsed by nationally recognized professional organizations that write and evaluate guidelines based on evidence based medicine, necessary transparency will be provided. The state will, in effect, provide a “seal of approval” for Oregon medical providers and assist in aligning along a common set of guidelines for more consistent medical care between disparate medical offices and specialties.

The state’s use of its purchasing power in the area of health care, and its use of consistent quality measures, would greatly increase the adoption and influence of these measures. This would be greatly amplified if the Quality Institute could elicit the voluntary “buy in” from private insurers.

VI. HEALTH INFORMATION EXCHANGE

GOAL:

Support use of DMAP’s Health Record Bank (currently being created with funding from a Medicaid Transformation Grant) as a fundamental building block for a statewide system for health information exchange which ensures that

patients' medical information is available and accessible when and where they need it.

ACTIONS:

The State of Oregon should:

- Ensure the DMAP Oregon Health Record Bank will be built to be interoperable with the commercial plans servicing PEBB, OEBC and Corrections , and ultimately all commercial plans
- Ensure the DMAP HRB encompasses strong privacy and security protections and resolves the issues of patients' rights with respect to the use and ownership of their information
- Design and implement a public education program targeted at both providers and patients

RATIONALE:

DMAP's Health Record Bank provides an opportunity for the state to build upon the investment and work that is already being done in this area.

The input of the private sector will be key to ensuring the HRB will be interoperable with those outside Medicaid and ultimately PEBB, OEBC and Corrections. With little or no funding available for pilot projects, Oregon can build a comprehensive health information exchange system by leveraging the money already received for the HRB project.

Privacy and security concerns, by both providers and patients, must be appropriately addressed in order to gain their trust and confidence so that they will agree to participate in these systems.

Note: During the last work session, the group recommended two separate exchanges, an Oregon HIE and a HRB. The explanatory notes did not give me enough to expound on why the group wanted to do this. db

VII. PRIVACY AND SECURITY

GOAL:

Ensure the highest level of privacy and security of Oregonian's personal health information in an electronic exchange environment

ACTIONS:

The State of Oregon should:

- Statutorily prescribe when and with whom an individual's personal health information may be exchanged electronically. Legislation should address:
 - Notice to and authorization from the patient or patient's personal representative prior to sharing a patient's data through a health information exchange (HIE)
 - An opportunity for the patient to not agree to sharing data through a HIE without penalty
 - A patient request that part of that patients' record NOT be shared and that request must be honored
 - Providers not being penalized by a patient's unwillingness to allow their data to be shared through a HIE
 - Timely notification to patient of a breach and a meaningful remedy
 - A private right of action for the consumer and patient after breach has occurred
 - A State Attorney General right of action on behalf of individuals to seek remedy
 - Patient access to their record in a timely manner with an opportunity to correct errors
 - No third party access to information
- Establish a Certification Board for all entities involved in the electronic exchange of personal health information

AND/OR

- Provide for strict enforcement of meaningful penalties for the negligent, reckless or intentional release or misuse of personal health information

RATIONALE:

Health information exchange will yield better health outcomes and reduce costs – but patients need to agree to have their personal health information exchanged electronically in order to achieve these benefits. Patients will need to trust that their personal health information is being appropriately shared and used – and

their privacy protected – before they will agree to participate in electronic health information exchange. Oregon needs to ensure the privacy of personal health information in order to enjoy the benefits of better health outcomes and reduced costs.

Statutory rights in this area will allow both patients and providers to participate in electronic health information exchange with full trust and confidence.

Another way to engender consumer confidence is to ensure that only the most secure exchange systems are adopted in Oregon. By certifying exchange participants, Oregon can determine that the systems in use will provide the level of privacy and security Oregonians expect and require.

Penalties for negligent, reckless and intentional breach and/or misuse of personal health information could also serve to drive only the most secure and protective systems to be adopted and implemented in Oregon.

VIII. NEXT STEPS

HIIAC First Draft of Formatted Recommendations

GROUP 1 – ADOPTION OF ELECTRONIC MEDICAL RECORDS AND HEALTH INFORMATION TECHNOLOGY

GOAL:

Accelerate widespread, effective use of health information technology (HIT) in Oregon

ACTIONS:

The State of Oregon should:

- Endorse **four** EMR Vendors based on their EMR's exhibition of the following properties:
 - Meeting or exceeding CCHIT standards
 - Valuable Clinical Decision Support Tools to be used by providers at the point of care
 - Interoperable data exchange with other EMRs, Personal Health Records, and the Oregon Health Record Bank
 - Adherence to HIIAC privacy principles
 - Ability to record, store, and report quality of care and health outcome measures
- Endorse **four** EMR Service Companies that can provide the following services to provider groups using one of State-endorsed EMRs:
 - Implementation support
 - Conversion from paper records or another EMR to a State-endorsed EMR
 - Ongoing support of the EMR
 - Interface support
 - Practice optimization using the EMR
 - Clinical process improvement using the EMR
 - Quality reporting support
 - Participation in health information exchange
- Use its RFP process to identify “state endorsed” vendors and use this process to solicit the most aggressive price – giving those providers who purchase from these vendors similar benefits as are obtained by group purchasing

- Subsidize provider use of the endorsed EMR Vendors and the endorsed EMR Service Companies
 - Subsidies in the form of a grant or low-interest loan, with amount based on:
 - Service to an underserved population
 - Service to Oregon Medicaid population
- Set benchmarks for the adoption of electronic medical records, clinical decision support tools and e-prescribing and evaluate progress toward meeting those goals.

RATIONALE:

By creating certainty, the state can diminish a number of the barriers currently preventing the adoption and use of health information technology. Certainty can be created by instituting standards and providing ongoing support for those systems meeting standards. Using the state's RFP process and negotiating power, costs of both the systems themselves and the ongoing support necessary to maintain these systems, can be made more affordable and more reliable.

By guaranteeing the interoperability of EMRs, simplifying the choice of vendors and providing a pre-set menu of features and pricing, the state will increase confidence among providers and encourage the adoption of health information technology systems. Additionally, assistance with the large investment these systems require will be very effective, especially among rural and Medicaid providers.

Benchmarks and evaluation are necessary to continue improvement in this area.

HIIAC First Draft of Formatted Recommendations

GROUP 2 – CLINICAL DECISION MAKING AND EVIDENCE BASED MEDICINE

GOAL:

Increase statewide adoption of electronic health records with the capacity to provide efficient and effective decision support processes and tools so that clinicians can easily follow evidence-based guidelines to improve health outcomes and reduce cost.

ACTIONS:

The State of Oregon should:

- Create and support The Oregon Quality Institute to convene and collaborate with health plans and providers to align around a common set of health quality measures. The Quality Institute should:
 - Develop a common set of health care measures based on evidence endorsed by nationally recognized organizations
 - Evaluate and endorse clinical guidelines to provide Oregon based resource for providers and patients
- Require PEBB, Medicaid, and other public purchasers of health care to choose from a common set of clinical quality measures in evaluating medical provider performance and health outcomes.
- Require State endorsed health information technology systems to include effective clinical decision support tools that align with quality measures chosen by Quality Institute

RATIONALE:

By providing clear treatment guidelines and health quality measures, the state, through the Quality Institute, can increase the positive influence of quality measures on direct medical practice. By giving priority to guidelines that are endorsed by nationally recognized professional organizations that write and evaluate guidelines based on evidence based medicine, necessary transparency will be provided. The state will, in effect, provide a “seal of approval” for Oregon medical providers and assist in aligning along a common set of guidelines for more consistent medical care between disparate medical offices and specialties.

The state’s use of its purchasing power in the area of health care, and its use of consistent quality measures, would greatly increase the adoption and influence of these measures. This would be greatly amplified if the Quality Institute could elicit the voluntary “buy in” from private insurers.

HIIAC First Draft of Formatted Recommendations

GROUP 3 – HEALTH INFORMATION EXCHANGE

GOAL:

Support use of DMAP's Health Record Bank (currently being created with funding from a Medicaid Transformation Grant) as a fundamental building block for a statewide system for health information exchange which ensures that patients' medical information is available and accessible when and where they need it.

ACTIONS:

The State of Oregon should:

- Ensure the DMAP Oregon Health Record Bank will be built to be interoperable with the commercial plans servicing PEBB, OEBC and Corrections , and ultimately all commercial plans
- Ensure the DMAP HRB encompasses strong privacy and security protections and resolves the issues of patients' rights with respect to the use and ownership of their information
- Design and implement a public education program targeted at both providers and patients

RATIONALE:

DMAP's Health Record Bank provides an opportunity for the state to build upon the investment and work that is already being done in this area. The input of the private sector will be key to ensuring the HRB will be interoperable with those outside Medicaid and ultimately PEBB, OEBC and Corrections. With little or no funding available for pilot projects, Oregon can build a comprehensive health information exchange system by leveraging the money already received for the HRB project.

Privacy and security concerns, by both providers and patients, must be appropriately addressed in order to gain their trust and confidence so that they will agree to participate in these systems.

Note: During the last work session, the group recommended two separate exchanges, an Oregon HIE and a HRB. The explanatory notes did not give me enough to expound on why the group wanted to do this. db

HIIAC First Draft of Formatted Recommendations

GROUP 4 – PRIVACY AND SECURITY

GOAL:

Ensure the highest level of privacy and security of Oregonian's personal health information in an electronic exchange environment

ACTIONS:

The State of Oregon should:

- Statutorily prescribe when and with whom an individual's personal health information may be exchanged electronically. Legislation should address:
 - Notice to and authorization from the patient or patient's personal representative prior to sharing a patient's data through a health information exchange (HIE)
 - An opportunity for the patient to not agree to sharing data through a HIE without penalty
 - A patient request that part of that patients' record NOT be shared and that request must be honored
 - Providers not being penalized by a patient's unwillingness to allow their data to be shared through a HIE
 - Timely notification to patient of a breach and a meaningful remedy
 - A private right of action for the consumer and patient after breach has occurred
 - A State Attorney General right of action on behalf of individuals to seek remedy
 - Patient access to their record in a timely manner with an opportunity to correct errors
 - No third party access to information
- Establish a Certification Board for all entities involved in the electronic exchange of personal health information

AND/OR

- Provide for strict enforcement of meaningful penalties for the negligent, reckless or intentional release or misuse of personal health information

RATIONALE:

Health information exchange will yield better health outcomes and reduce costs – but patients need to agree to have their personal health information exchanged electronically in order to achieve these benefits. Patients will need to trust that their personal health information is being appropriately shared and used – and their privacy protected – before they will agree to participate in electronic health information exchange. Oregon needs to ensure the privacy of personal health information in order to enjoy the benefits of better health outcomes and reduced costs.

Statutory rights in this area will allow both patients and providers to participate in electronic health information exchange with full trust and confidence.

Another way to engender consumer confidence is to ensure that only the most secure exchange systems are adopted in Oregon. By certifying exchange participants, Oregon can determine that the systems in use will provide the level of privacy and security Oregonians expect and require.

Penalties for negligent, reckless and intentional breach and/or misuse of personal health information could also serve to drive only the most secure and protective systems to be adopted and implemented in Oregon.

Health Information Infrastructure Advisory Committee
Wednesday, August, 2008
1:00 – 5:00 pm
Portland State Office Building
800 NE Oregon Street
Portland, OR

PRELIMINARY AGENDA

Desired Outcomes:

- Further clarify key strategies

Time (est)	Item	Lead	Action Items
1:00 pm	Call to Order and Approval of 7/23 Minutes	Ree Sailors Dick Gibson	X
1:15 pm	Sub-Groups' Recommendations: Initial Feedback <ul style="list-style-type: none"> • Clarifying questions • Strengths • Concerns 	Dick Gibson	
2:30 pm	Clarify Strategies (include break)	Sub-groups *	
4:00 pm	Report Back on Strategies	Dick Gibson	
4:30 pm	Next Steps	Ree Sailors Dick Gibson	
4:40 pm	Debrief Meeting	Ree Sailors	
4:45 pm	Public Testimony		
5:00 pm	Adjourn	Ree Sailors Dick Gibson	

- HIIAC members who did not attend the previous meeting(s) will join the current sub-groups.

Health Information Infrastructure Advisory Committee (HIIAC) Meeting

Wednesday, July 23, 2008

1:00 – 5:00 pm

PSOB

Committee Members Present:

Dick Gibson, Andi Miller, Barbara Prowe, Chris Apgar, Dave Widen, Dick Gibson, Jim Edge, Joyce DeMonnin, Ken Carlson, Nancy Clarke, Ree Sailors.

Committee Members Absent:

Abby Sears, Andrew Perry, Andy Davidson, Bart McMullan, Denise Honzel, , Gina Nikkel, Grant Higginson, Homer Chin, Laura Etherton, Lauren O'Brien, Nan Robertson, Paul Gorman, Sally Sparling.

Staff:

Ilana Weinbaum, Judy Morrow, Sean Kolmer, Tina Edlund.

Call to Order and Approval of July 9, 2008 Minutes

HIIAC co-chairs Ree Sailors, Governor Kulongoski's Health Care Policy Advisor, and Dick Gibson, Chief Information Officer, Legacy Health Systems, called the meeting to order and welcomed HIIAC members and thanked them for their hard work.

It was moved and seconded to approve the July 9, 2008 HIIAC Meeting Minutes as proposed.

Review of Agenda and Desired Outcomes

Sailors reviewed the revised HIIAC statements concerning: elements of a productive process, elements of productive recommendations, HIIAC decision-making process, vision statement, mission and goals of HIIAC for summer 2008.

Sailors presented the guiding principles, with two options for Guiding Principle #2. There was group consensus, selecting the second option.

Subgroups' Recommendations – Initial Feedback

Subgroups formed at the July 9 meeting included:

- Adoption of Electronic Health Records and Health Information Technology
- Clinical Decision Making and Evidence Based Medicine
- Health Information Exchange and Data Sharing
- Privacy and Security Standards

Sailors conveyed that members of the adoption subgroup were not able to attend today's meeting, but would be holding a breakfast meeting the following week to further develop their ideas.

Full group provided feedback on initial subgroup proposals and made suggestions about issues for the subgroups to consider (notes from group discussion available).

<p>Sailors described new survey of providers in Oregon about adoption of health records, which will go out to providers in the next few weeks. This version of the survey will include questions about functionality.</p> <p>Sailors relayed that someone from the National Governor’s Association (NGA) will be at the August 20th meeting to talk about the NGA e-health and e-prescribing initiatives. In addition, staff has submitted a request to NGA and the Robert Wood Johnson Foundation for technical assistance around issues of ownership of health data.</p>
<p>Clarify Strategies</p>
<p>Full group broke into subgroups to further develop recommendations.</p>
<p>Report Back on Strategies</p>
<p>The Clinical Decision Making and Evidence Based Medicine, Health Information Exchange and Data Sharing, and Privacy and Security Standards each provided a brief report on the progress they had made on developing recommendations (group notes available).</p> <p>The recorder from each group will type up the notes and email them out to the subgroup for feedback. Staff will then send all of the notes out to the full HIIAC.</p>
<p>Next Steps</p>
<p>The next HIIAC meeting is scheduled for Wednesday, August 6, 2008, 1 – 5 pm at the PSOB.</p>
<p>Public Testimony</p>
<p>No official public testimony. Members of the public stated that they were impressed with the amount of progress made in the meeting.</p>
<p>Meeting Debrief</p>
<p>It was agreed that notes from the sub-groups would be sent to all HIIAC members for review before the next meeting.</p>

Meeting was adjourned.

HIIAC VISION, MISSION, GUIDING PRINCIPLES

Health Information Infrastructure Advisory Committee Meeting

Thursday, July 23, 2008

Portland State Office Building, Portland, OR

I. ELEMENTS OF A PRODUCTIVE PROCESS

If this a productive process, we as HIIAC members will:

- A. Be willing to compromise for the betterment of the whole
- B. Learn and draw from the work of others
- C. Commit to action, continuity of service and advocacy for the recommendations
- D. Increase trust among members through direct communication and comfort in expressing diverse views
- E. Have resources necessary for timely and comprehensive decision-making
- F. Make good use of everyone's time
- G. Share all relevant information
- H. Take time to test assumptions
- I. Discuss the un-discussables
- J. All share in responsibility for process

II. ELEMENTS OF PRODUCTIVE RECOMMENDATIONS/FINDINGS

Productive HIIAC recommendations for this fall will:

- A. Make a difference in Oregon
- B. Develop a long-term vision that engages and inspires people
- C. Represent various perspectives and be responsive to concerns of constituents and stakeholders
- D. Have actionable, specific, affordable and realistic recommendations
- E. Have short-term deliverables that include incremental and sequential steps
- F. Outline the structure for responsibility and accountability
- G. Be bold and willing to try new things
- H. Include evaluation/assessment of HIIAC's work and recommendations

III. HIIAC DECISION MAKING

The committee agreed to use a 5 point consensus scale in making decisions (5 being strong support and 1 being not agreeing), with 3-5 indicating consensus. When coming to conclusions, if there is no consensus, the report will note the areas of concern and differences, as well as areas of agreements.

IV. HIIAC VISION

Revised draft:

In order to improve health and reduce costs, an Oregonian's health information:

- **Is available when and where it is needed to support clinical-decision making and high quality care**
- **Is private and secure and only exchanged with the authorization of the individual in ways that comply with federal and state law**
- **Improves public health and population-based care decision-making**
- **Enables individuals to take an active role in their health through access and control of their health information and tools to help them make informed choices.**

IV. HIIAC MISSION

From the Executive Order No. 08-09, Office of the Governor:

To fulfill the **MISSION** of developing a strategy for the implementation of an Oregon health information infrastructure, the HIIAC shall:

- a. Review and identify obstacles to the implementation of an effective health information exchange infrastructure in Oregon and provide policy recommendations to remove or minimize those obstacles;

- b. Outline the role of the State in developing, financing, promoting and implementing a health information infrastructure;
- c. Recommend how to facilitate the statewide adoption of health Information system standards and interoperability requirements to enable secure exchange of health information exchange;
- d. Monitor the development of federal and applicable international standards, coordinate input to the Nationwide Health Information Network, and ensure that Oregon's recommendations are consistent with emerging federal and applicable international Standards;
- e. Identify partnership models and collaboration potential for Implementing electronic health records and exchange systems, including review of current records and exchange systems, including review of current efforts in the state and opportunities to build upon those efforts;
- f. Recommend a plan for the creation of a health information Infrastructure that preserves the privacy and security of Oregonian's health information, as required by state and federal law; and
- g. Develop evaluation metrics to measure the implementation of health information technology and the efficacy of health information exchange in Oregon.

V. ROLE OF HIIAC THIS SUMMER

Committee agreed that HIIAC would provide to the Health Fund Board:

- 1. Context: barriers, problems, stakeholder concerns
- 2. Guiding principles, goals
- 3. Strategies and discreet tactics: meaty, specific next steps with links to other HFB committees' recommendations, costs (cost savings?) if possible
- 4. Recommendation of commitment to move this forward.

VI. GUIDING PRINCIPLES

- 1. We will operate from a model of collaboration and partnership between the private and public sectors and will leverage that collaboration whenever possible to seek solutions for all Oregonians.
- 2. We will only support solutions that meet or exceed national and industry standards, or that promote their development and adoption where no standards exist.
- 3. Enables individuals to take an active role in their health through access and control of their health information and tools to help them make informed choices.
- 4. We will only recommend plans/strategies for health information exchange that protect the integrity, availability and confidentiality of the consumer's information.
- 5. We will identify and align incentives for all stakeholders to support HIT adoption and interoperability.

Notes edited by: Ree Sailors

Strategy Group One:

ADOPTION OF ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION TECHNOLOGY

- Need to prioritize one or two
- Highlight desired outcomes rather than problems
- Need clarification of $1 + 2 + 4 > 3$

Strategy Group Two:

CLINICAL DECISION MAKING AND EVIDENCE BASED MEDICINE (EBM)

- Important to know who is writing/financing decision support tools
- Should be public/private mechanism to select key sets of guidelines and align with systems monitoring providers
- Need to be education of providers about utilizing/selecting EHRs that have good guideline functionality
- P4P should be aligned with encouraging EBM
 - Is P4P adequate to encourage desired behavior?
 - P4P must be consistent across payers
 - State role for standardizing measures?
- Suggested two-pronged approach: (1) P4P, (2) Provider education and development of tools to evaluate EHRs for their EBM functionality
- Need to consider other incentives and tools to encourage EBM
 - Predictive modeling
 - Quality measurement
- Suggested recommendation: Require transparency and clarity around financing and creation of decision support tools.
 - Not just disclosure, but state role to make sure credible source
- Suggested recommendation: State should create a safe harbor and convene public and private payers to develop common P4P guidelines.

Strategy Group Three:

HEALTH INFORMATION EXCHANGE

- National standards do not exist in some areas
- Need to look at standards accepted by the Healthcare Information Technology Standards Panel (HITSP)
- Support Health Records Bank in a way that builds infrastructure for all of OR
 - Building blocks, foundation, starting point
- Consider legislation to standardize billing – incentives vs. mandate
- Consider higher payment rates for those who participate
- Consider grants to rural physicians
- Use state purchasing power to incentivize submission of data and use of data to provide high-quality, efficient care

Strategy Group Four:

PRIVACY AND SECURITY

- Original concept should be split into two components
 - (1) Patient's right to control information (paragraph 2)
 - (2) Technology/processes to assure privacy (paragraphs 1 and 3)
- Should be statutory based patient rights – right to participate must stay with patients
- Must consider tension created when provider decides practice will use HER/electronic exchange
- Funding? Certification Board should be funded by those being licensed
- Who should be licensed? Individuals/practices/institutions?
 - Institutions already creating security policies for HIPAA
- Certification vs. Licensing? Suggestion that certification is more feasible and appropriate.
- What would certification requirements be for entities outside of OR?
- Tension between national standards of technology and in absence of standards what OR can do.
- How does Certification Board fit in with Health Records Bank?

HIIAC July 23, 2008
Notes from Group Discussions

CLINICAL DECISION MAKING AND EVIDENCE BASED MEDICINE

Recommendation 1: The Oregon Quality Institute is created to convene and collaborate with plans and providers to align around a common set of health quality measures.

- A. Primary goal is to develop a common sets of health care measures (based on evidence nationally recognized organizations). The process to evaluate measures should involve private and public partnerships within Quality Institute to provide more standardization of measures used by differing monitoring organizations (health insurance companies, hospitals, individual medical practices). Goals of this recommendation is to increase the positive influence of quality measures on direct medical practice by providing a more consistent subset of existing measures applied by organizations on providers, increasing their common influence.
- B. Evaluate and endorse clinical guidelines to provide Oregon based resource for providers and patients. Priority will be given to guidelines that are endorsed by nationally recognized professional organizations that write and evaluate guidelines based on evidence based medicine and transparency exists regarding authors of such guidelines. Preference would be given to guidelines that support health care measures chosen by Quality Institute. Goal of this recommendation is to provide an additional “seal of approval” for Oregon medical providers and assist in aligning along common set of guidelines for more consistent medical care between disparate medical offices and specialties.
- C. State requires PEBB, Medicaid, and other public purchasers of health care to choose from a common set of clinical quality measures in evaluating medical provider performance and health outcomes. One potential role of the state is through purchasing of health care and the use of consistent quality measures would greatly speed up their adoption and influence. This would be greatly amplified if voluntary “buy in” from private insurers was added.

Recommendation 2: If the state develops a program to support implementation of EHRs in medical practice, programs should be chosen that include clinical decision support tools. Preference would be given for effective support tools that align with quality measures chosen by Quality Institute.

For Example:

- Point of care reminders that support implementation of clinical guidelines (prevention and chronic care)
- Supporting population health through interface with disease registries (patients with chronic diseases)
- Supporting the ongoing monitoring of health status of patients (internal clinic measures)
- PHR: Allows patients to track/monitor own health measures/services
- Covers e-prescribing and associated decision support
- Transparent source of data (where did guidelines come from?)

Health Information Exchange

[Strong Consensus]

Recommendation #1: The Oregon Health Record Bank (HRB) is a critical, innovative project that should be the building block for health information exchange in Oregon. To further that mission, the HIIAC recommends Medicaid convene formal input about the design and implementation of the HRB from, at a minimum, the commercial health plans servicing the Public Employees Benefit Board, the Oregon Education Benefit Board and Corrections. Through this collaboration, the HRB can be developed with enhanced ability to be used as a building block for health information exchange across all payers in Oregon.

[Agreement about concept but more discussion is necessary for consensus]

Recommendation #2: In order to maximize the opportunity for large-scale adoption of the Health Record Bank across public and private payers through Oregon, Medicaid should collaborate with interested stakeholders to conduct a large-scale public education program. Critical elements of the education program should focus on patients and providers in order to create demand for participation in the Health Record Bank.

[Some discussion but no agreement or consensus achieved]

Recommendation #3: The Oregon Health Fund Board should study whether the Health Record Bank could be used to measure efficiency in the health care system as well as the potential for using the Health Record Bank as a tool for payment reform.

What is the Oregon Health Record Bank?

A Health Record Bank (HRB) would operate in a broad sense like a financial bank. As an electronic repository developed to collect, store, and distribute a patient's health records, an HRB would offer comprehensive information to providers about an individual, controlled by that individual, and stored in one secure location. Patients or payers could pay a fee to establish an account with HRBs of their choosing. Advertising, payment by researchers for queried data, value-added services or public subsidies may reduce or eliminate subscription fees.

Patients would have full access to their records through an online user interface designed by their HRB. Patients would determine who has consent to retrieve their health records. Providers could access a patient's health record bank to retrieve data, but only if approved by the patient. Each time a patient visits a healthcare provider or facility, records from that encounter would be transferred from the provider's electronic health record into the patient's HRB. Patients could also submit their own health data into the bank. Because the patient directly controls access to his or her information, complex discussions about each state's rules for exchange are unnecessary. The burden for consent would be on the patient.

An HRB could be a public utility, operated by the state, or a privately operated and funded enterprise governed by preset standards and regulations, and potentially certified or accredited by an independent organization.

(Definition adapted from an article in the Journal of the American Health Information Management Association)

What are the positives of using the Health Record Bank as a building block for health information exchange in Oregon?

- The HRB allows the state to provide seed money for development of a complete, functioning health record bank. Might have the leverage and independence to make a HIE functional where other regional collaboratives have failed.
- Centralization of records increases the accuracy and efficiency of querying records from a variety of locations

What are the concerns and issues to be further discussed if the Health Record Bank is the building block for health information exchange in Oregon?

- Since it is voluntary enrollment, how does DMAP maximize potential enrollment to create the “critical mass” necessary to make a larger impact to all Oregonians?
 - What is the value proposition for patients? Providers? What are the essential components for patients and providers to hear during the public education piece?
- Interoperability with existing electronic medical records and other electronic medical system.
- Carrot v Stick for participation:
 - How do you appropriately incent use of the HRB? Is there an extra payment for participation (carrot)?
 - Payment is reduced or no payment made (by a certain date) if the HRB is not utilized?
- What is the business plan?
 - Sustainability for further expansion to the commercial market?
 - How does the HRB live beyond the initial seed money?
 - How does the HRB succeed where other RHIOs with similar models have not?

PRIVACY AND SECURITY

Recommendation #1: Statutory Content - Privacy and Individual Rights - these are general concepts that need to be elaborated upon and discussed at length. These concepts may be mutually incompatible or technically difficult or impossible. They are included for completeness of discussion.

- There shall be notice to and authorization from the patient or patient's personal representative prior to sharing a patient's data through a health information exchange (HIE).
- There shall be an opportunity for the patient to not agree to sharing data through a HIE without penalty.
- The patient can request that part of that patients' record NOT be shared and that request must be honored.
- Providers shall not be penalized by a patient's unwillingness to allow their data to be shared through a HIE.
- Patients shall be timely notified of a breach and provided a meaningful remedy [it's more than just "notification" existing].
- There will be a private right of action for the consumer and patient after breach has occurred.
- The State Attorney General has the right to bring an action on behalf of individuals to seek remedy.
- Patient shall have access to their record in a timely manner and an opportunity to correct errors.

Recommendation #2: Certification Board

- A Certification Board will be created by statute, providing some detailed requirements in statute as well as providing the authority to create administrative rules.
- In the statute there will be an explanation of why the Board exists: to create the gold standard for regulating exchange of healthcare information within Oregon and requirement that entities are certified.
- The statute will require that each certified entity has administrative, physical, and technical safeguards in place consistent with HIPAA and Oregon state law. The Board will create additional standards for certified entities to ensure the privacy and security of information transmitted through an electronic exchange is based on current and emerging national standards where available. These standards will be regularly updated to account for new national standards and the improvement of technology.
- Requirements for Certification will include:
 - Submission of documents, including but not limited to policies and procedures, disaster readiness plan, recovery plan, and so forth.
 - The entity will sign an attestation (subject to some form of penalty for false attestation) that it is following the above privacy and security statutes subject to random audit by the Certification Board.
 - If applicable, the entity will use only EMR/EHRs that have been certified by the Certification Commission for Health Information Technology (CCHIT) or other equivalent nationally recognized health care technology certification board. (If this goes into statute, need to be flexible regarding technical certification.)

- The Certification Commission for Healthcare Information Technology or CCHIT is a non profit organization recognized certification body (RCB) for electronic health records and their networks, and an independent, voluntary, private-sector initiative. It is our mission to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program.
- Statutory law will probably have to provide some measure of due process if certification is withheld or revoked from an entity.
- Each "end" of an exchange will be certified. For example, if a physician clinic participates in an exchange with the Oregon Health Records Bank, the physician clinic will be certified to exchange data, and the Oregon Health Records Bank will also be certified separately to exchange data.
 - Option 1: Require all entities exchanging electronic information to be certified immediately
 - Option 2 (more realistic): Allow initially for voluntary certification (associated with fee), with required certification by X date
- Each entity will only be certified once even if it participates in multiple exchanges.
- Certification will require renewal on a periodic basis.
- Periodic certification shall require that the entity upgrade its technology, policies, procedures, or practices to meet current national standards, as determined by the Certification Board.
- Certified entities will be allowed to exchange electronic health information only with other certified entities.
- Statute shall set forth the number and types of representation on the certification board, length of service, who has the authority to appoint (it can be from multiple sources), authorization around fees, authority to have staff, reimbursement for the board members, etc.

ADOPTION of EHR/EMR

Aim: achieve widespread effective use of health information technology (HIT) in Oregon.

Three main issues we discussed: Standards, Support, and Benchmarks.

Standards: “buy whatever you want, but it must meet standards.” Lack of standards is a barrier to adoption, by creating uncertainty about risk and value, return on investment, and possible obsolescence. State should enforce [encourage?] adoption of standards through multiple approaches at state’s disposal:

- Regulation/requirement – systems interacting with state (for whatever reason – health information exchange with Health Data Bank, payment, etc) must adhere to specified standards for interoperability, privacy, etc.
- Support and subsidies – state mechanisms for subsidizing or supporting adoption (loans, grants, group purchase, etc) limited to systems adhere to standards;
- Purchasing – state owned and operated systems can enforce standards;
- Development – state ensure adherence in its own projects, such as Health Data Bank. This project could be a major leverage point that could accelerate adoption of standards and thereby accelerate adoption of HIT.
- Personal health records - critical mass of PHR adoption (state Health Data Bank and others) will create leverage for all other HIT users to employ same standards in order to share patient information.

Support: “We can support you if it meets these standards...” EHR purchase and initial implementation are costly, and only the tip of the iceberg. Uncertainties about costs, impacts, obsolescence are a major barrier for physician adoption of EHR (NEJM article). State can increase adoption by increasing the availability of financial and logistical support, especially for small practices with no access to an IT department. Support will be an ongoing need as practices and systems evolve to realize greater value.

- Grants and loans for adoption, implementation, maintenance;
- Support of ASP and other models that remove burden from individual small practices;
- Two vendor model: state selects two vendors or systems, creates or facilitates creation of support mechanism for these systems.
- UK NHS model was discussed: each local trust chooses from a set of vendors. This enforces constraints that ensure interoperability, but allows for choice and local control
- Public utility model was discussed: local or regional private vendors provide service (HIT maintenance and support through ASP or whatever model) with public regulation to enforce standards, help control costs, etc.

Benchmarks: Need to set goals with benchmarks for adoption of EHR, CDS, eRx. Need to measure to improve.

Health Information Infrastructure Advisory Committee
Wednesday, July 23, 2008
1:00 – 5:00 pm
Portland State Office Building
800 NE Oregon Street
Portland, OR

AGENDA

Desired Outcomes:

- Further clarify key strategies

Time (est)	Item	Lead	Action Items
1:00 pm	Call to Order and Approval of 7/09 Minutes	Ree Sailors Dick Gibson	X
1:10 pm	Review Agenda, Desired Outcomes	Ree Sailors	
1:15 pm	Sub-Groups' Recommendations: Initial Feedback <ul style="list-style-type: none"> • Clarifying questions • Strengths • Concerns 	Dick Gibson	
2:15 pm	Clarify Strategies (include break)	Sub-groups *	
3:45 pm	Report Back on Strategies	Dick Gibson	
4:30 pm	Next Steps	Ree Sailors Dick Gibson	
4:40 pm	Debrief Meeting	Ree Sailors	
4:45 pm	Public Testimony		
5:00 pm	Adjourn	Ree Sailors Dick Gibson	

- HIIAC members who did not attend the last meeting will join the current sub-groups.

Health Information Infrastructure Advisory Committee (HIIAC) Meeting

Wednesday, July 9, 2008

1:00 – 5:00 pm

PSOB

Committee Members Present:

Dick Gibson, Ree Sailors, Chris Apgar, Ken Carlson, Jim Edge, Grant Higginson, Paul Gorman, Denise Honzel, Bart McMullan, Barbara Prowe, Laureen O'Brien, Nan Robertson, Abby Sears, Sally Sparling, Dave Widen

Committee Members Absent:

Nancy Clarke, Andy Davidson, Joyce DeMonnin, Laura Etherton, Homer Chin, Andi Miller, Gina Nikkel, Andrew Perry

Staff:

Dawn Bonder, Ilana Weinbaum, Judy Morrow

Call to Order and Approval of June 19, 2008 Minutes

HIIAC co-chairs Ree Sailors, Governor Kulongoski's Health Care Policy Advisor, and Dick Gibson, Chief Information Officer, Legacy Health Systems, called the meeting to order and welcomed HIIAC members and guests.

It was moved and seconded to approve the June 19, 2008 HIIAC Meeting Minutes as proposed.

Review of Agenda and Desired Outcomes

Gibson and Sailors reviewed the agenda and introduced Carol Turner. Carol will again be facilitating the meeting.

Medicaid Transformation Grant

Sailors introduced Jim Edge of DMAP and informed the group that he would now be sitting on the committee in place of Jeany Phillips.

Edge updated the HIIAC on the \$5.5 million grant Oregon has received to design a Health Record Bank for the Medicaid population in Oregon. Edge said the project has a new director, Barry Kast. Edge reviewed a summary of the project and the plans to move forward. He shared that much of the grant money will be used to purchase hardware and software for the Health Record Bank.

Chris Apgar expressed a concern about the legal ramifications of a Health Record Bank given the current landscape of Oregon law. Edge noted that the Justice Department would be contacted if necessary.

Confirm Vision and Guiding Principles
<p>Carol Turner reviewed the decision making process and the group confirmed using the 5 point scale to assess consensus.</p> <p>Carol walked the members through a review of last meeting's work on and further modifications were made.</p> <p>Nan Robertson and Paul Gorman agreed to work on the wording of bullet #4 in the vision statement.</p> <p>Paul Gorman and Chris Apgar agreed to work on the wording of #2 of the Guiding Principles.</p> <p>#3 of the Guiding Principles will be amended to reflect the change in wording from bullet #4 of the Vision Statement.</p> <p>Apgar's concern about having a specific reference to administrative costs in the Vision Statement preamble was added to open issues.</p>
Committee work on Strategy Recommendations
<p>Gibson reviewed the committee's work from the May 29, 2008 meeting where the original 140 strategy recommendations were pared down to 80 and then further pared down to 27.</p> <p>Staff has organized the 27 recommendations into four main categories:</p> <ul style="list-style-type: none"> • Adoption of Electronic Health Records and Health Information Technology • Clinical Decision Making and Evidence Based Medicine • Health Information Exchange and Data Sharing • Privacy and Security Standards
Next Meeting
<p>The next HIIAC meeting is scheduled for Wednesday, July 23, 2008, 1 – 5 pm at the PSOB.</p>
Public Testimony
<p>Andrea Meyer of the American Civil Liberties Union thanked Gibson for inviting her participation in the privacy standards group. She reiterated that the ACLU would like to see statutory protections for privacy. She also suggested the word "enable" be used in the Vision Statement in place of "engage."</p>
Meeting Debrief
<p>It was agreed that the work product from the sub-groups would be sent to all HIIAC members for review before the next meeting.</p>

Meeting was adjourned.

Incentives to Promote the Adoption of HIT
Prepared by HIAC Staff
DRAFT – FOR BACKGROUND ONLY

A 2006 report on Health Information Technology in the United States, prepared by the Institute for Health Policy at Massachusetts General Hospital and the School of Public Health and Health Services at George Washington University with support from the Robert Wood Johnson Foundation, summarized the barriers to health information technology adoption and potential policies to overcome these barriers as follows. The entire report can be found at http://hitadoption.org/downloads/annual_report_2006.pdf

Domain	Barrier	Policy
Financial incentives	Lack of a business case for performance	<ul style="list-style-type: none"> ■ Pay for performance: practices and hospitals that adopt EHRs to improve quality would receive a higher reimbursement rate from third-party payers ■ Public reporting of performance: information on the level of EHR adoption among providers and hospitals would be made publicly available
	Lack of a business case for HIT	<ul style="list-style-type: none"> ■ Pay for use of HIT: practices and hospital that adopt EHRs would receive a higher reimbursement rate from third-party payers ■ Grants to providers, including AHRQ implementation grants ■ Loans to providers to cover the costs of acquisition, training and/or maintenance ■ In kind assistance ■ Performance standards/certification (reduces the risk of wasting funds on substandard equipment/software) ■ Interoperability standards (reduces risk of lost investment due to poor choice of IT solution)
Legal/ Regulatory	Fraud and abuse related to HIT adoption, including "Stark Law"	<ul style="list-style-type: none"> ■ Modifications and exemptions
	Privacy and security obligations under HIPPA electronic health information standards	<ul style="list-style-type: none"> ■ Clarification
	Liability exposure from more and more accessible, health information	<ul style="list-style-type: none"> ■ Greater liability protection
State of Technology	Lack of interoperability	<ul style="list-style-type: none"> ■ Standards for interoperability
	Lack of interconnectedness	<ul style="list-style-type: none"> ■ Support for regional health information organizations (RHIOs)
Organizational	Lack of accountability for quality	<ul style="list-style-type: none"> ■ Internal reporting requirements
	Lack of workforce skills	<ul style="list-style-type: none"> ■ Workforce training/certification
	Leadership	<ul style="list-style-type: none"> ■ Training of health care leaders
	System attributes	<ul style="list-style-type: none"> ■ Providing incentives for practices to form networks and negotiate contracts
	Size	<ul style="list-style-type: none"> ■ Assistance to small providers
	Organizational Surplus/Capital Availability	<ul style="list-style-type: none"> ■ Assistance to safety net providers

Select Examples of Efforts to Promote the Adoption of HIT

Many of the examples below were found in a 2004 paper prepared as background for a meeting of the National Health Information Infrastructure Home program. The complete paper can be found at: http://aspe.hhs.gov/sp/NHII/Conference04/incentives_paper.pdf

- Pay-for-performance programs
 - The Bridges to Excellence (BTE) Physician Link program (<http://bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=19>) offers physicians up to \$50 per patient covered by participating employer for utilizing health information technology and information systems that improve the quality of care. There are three levels of practice assessment: Level I elements assess the use of registries to identify and follow-up with high risk patients; Level II elements assess practice use of electronic systems to maintain records, provide decision support, and order prescriptions and labs; and Level III assesses whether systems meet national standards and interoperate with other systems. The BTE medical home assessment program also rewards providers for their use of health information technology to provide high-quality, coordinated care.
 - The Integrated Healthcare Association (IHA) (www.ihc.org), a California health care leadership group comprised of major health plans, physician groups, and hospital systems, plus academic, consumer, purchaser, pharmaceutical and technology representatives, has implemented a statewide pay for performance program. Along with other measures of quality, the program assesses and rewards providers for investing in and utilizing health information technology to improve patient care.
 - Empire BCBS rewards hospitals, on behalf of five large self-insured purchasers, for adopting computer physician order entry systems
- Grants
 - A number of demonstration programs and other provisions focused on supporting the adoption of HIT were initiated by the 2003 Medicare Improvement and Modernization Act:
 - *Electronic prescribing*: The MMA stipulates that the new drug benefit should be applied in a delivery system that has broadly adopted e-prescribing. The Department of Health and Human Services (HHS) is authorized to give up to 50% matching grants for physicians that adopt certain tools for e-prescribing.
 - *Section 649 – Care Management Program*: This demonstration program will pay a financial reward to physicians that have adopted certain health information technologies, including electronic registries, e-prescribing, and EHRs, and can show that they used these tools in delivering better outcomes for patients with chronic conditions.
 - *Section 721 – Chronic Care Improvement*: This demonstration program encourages the better management of patients in Medicare FFS that have a chronic condition. The program encourages the use of health information technology in better tracking patient care.

- The Agency for Healthcare Research and Quality's (AHRQ) health information technology initiative has provided over \$260 million in grants in 41 states to promote HIT adoption and utilization. Grants have been used to: help clinicians develop higher-quality, safer health care; put the patient more squarely at the center of health care; stimulate planning and implementation of health IT, especially in rural and underserved areas; identify the most successful approaches, as well as barriers, to implementation; and make the business case for health IT by evaluating costs and benefits. AHRQ is also currently funding six states to develop regional health exchanges and collaborations, by establishing systems to allow for communication and information-sharing among providers, laboratories, purchasers, payers, hospitals, ambulatory care centers, home health and long-term care providers.
- Regulation
 - In 2008, the Minnesota Legislature passed health reform bill S.F. No. 3780. The legislation requires all providers, group purchasers, prescribers, and dispensers to establish and maintain electronic prescribing programs that comply with standards defined by the bill.

HIIAC VISION, MISSION, GUIDING PRINCIPLES

Health Information Infrastructure Advisory Committee Meeting

Thursday, July 9, 2008

Portland State Office Building, Portland, OR

I. ELEMENTS OF A PRODUCTIVE PROCESS

If this a productive process, we as HIIAC members will:

- A. Be willing to compromise on our own agendas for the betterment of the whole
- B. Learn and draw from the work of others
- C. Commit to action, continuity of service and advocacy for the recommendations
- D. Increase trust among members through direct communication and comfort in expressing diverse views
- E. Have resources necessary for timely and comprehensive decision-making
- F. Make good use of everyone's time
- G. Share all relevant information
- H. Take time to test assumptions
- I. Discuss the un-discussables
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4. Recommendation of commitment to move this forward.

VI. GUIDING PRINCIPLES

1. We will strive to operate from a model of collaboration and partnership between the private and public sectors and will leverage that collaboration whenever possible to seek solutions for all residents of our State **Oregonians**.

2. We will adopt **recommend** solutions that comply with or exceed agreed upon national and industry standards^[DHB3].

3. We will support solutions that allow **enable** consumers to take an active role in their health through access and control of their health information^[DHB4]

4. We will only adopt private and secure **recommend** plans/strategies for health information exchange that protect the integrity, availability and confidentiality of the consumer's information.

5. We will identify and align incentives for all stakeholders to support HIT adoption and interoperability.

6. To Review: We will only support solutions that empower each facility to maintain its own data.

Notes edited by:
Dawn Bonder

Health Information Exchange (Group #3)

HIIAC members

Nancy Clarke
Jim Edge
Andi Miller
Dave Widen

Other participants

D Vaughn Holbrook, Regence Assistant Director of Health Information
Barry Kast, Health Record Bank Project Director
Sean Kolmer, Oregon Health Policy & Research

[Strong Consensus]

Recommendation #1: The Oregon Health Record Bank (HRB) is a critical, innovative project that should be the building block for health information exchange in Oregon. To further that mission, the HIIAC recommends Medicaid convene formal input about the design and implementation of the HRB from, at a minimum, the commercial health plans servicing the Public Employees Benefit Board, the Oregon Education Benefit Board and Corrections. Through this collaboration, the HRB can be developed with enhanced ability to be used as a building block for health information exchange across all payers in Oregon.

[Agreement about concept but more discussion is necessary for consensus]

Recommendation #2: In order to maximize the opportunity for large-scale adoption of the Health Record Bank across public and private payers through Oregon, Medicaid should collaborate with interested stakeholders to conduct a large-scale public education program. Critical elements of the education program should focus on patients and provider in order to create demand for participation in the Health Record Bank.

[Some discussion but no agreement or consensus achieved]

Recommendation #3: The Oregon Health Fund Board should study whether the Health Record Bank could be used to measure efficiency in the health care system as well as the potential for using the Health Record Bank as a tool for payment reform.

What is the Oregon Health Record Bank?

[Barry to insert "elevator speech" describing the HRB/Transformation Grant]

What are the positives of using the Health Record Bank as a building block for health information exchange in Oregon?

- The HRB allows the state to provide seed money for development of a complete, functioning health record bank. Might have the leverage and

independence to make a HIE functional where other regional collaboratives have failed.

- Centralization of records increases the accuracy and efficiency of querying records from a variety of locations

What are the concerns and issues to be further discussed if the Health Record Bank is the building block for health information exchange in Oregon?

- Since it is voluntary enrollment, how does DMAP maximize potential enrollment to create the “critical mass” necessary to make a larger impact to all Oregonians?
 - What is the value proposition for patients? Providers? What are the essential components for patients and providers to hear during the public education piece?
- Interoperability with existing electronic medical records and other electronic medical system.
- Carrot v Stick for participation:
 - How to you appropriately incent use of the HRB. Is there an extra payment for participation (carrot)?
 - Payment is reduced or no payment made (by a certain date) if the HRB is not utilized?
- What is the business plan?
 - Sustainability for further expansion to the commercial market?
 - How does the HRB live beyond the initial seed money?
 - How does the HRB succeed where other RHIOs have not?

DRAFT

HIIAC July 9, 2088 Subgroup Reports

Strategy One:

ADOPTION OF ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION TECHNOLOGY

PROBLEM #1: LACK OF MONEY AND FUNDING

- Capital funding needed (66%)
- Return on Investment (50%)
- Loss of productivity

SOLUTION: Provide financial support and funding options that are flexible and independent from health systems and hospitals.

HOW? :

1. Create new models for reimbursement; collaborate with creative financial people to design cost-neutral, quality improvement funding schemes for the State to provide.
2. Use the State's purchasing power for hardware, software and expertise
3. Have the State select a limited number of solutions and ties incentives and reimbursement to those solutions only.

PROBLEM #2: LACK OF EXPERTISE

- Technical
- Operational
- System selection/Expertise

SOLUTION: Provide technical and implementation support; provide operational support for implementation and on an ongoing basis

HOW? :

1. Design a model for the State to provide/fund local expertise to support implementation and ongoing EMR use and optimization.
2. Support/fund remove technical support and technology infrastructure
3. State vets and contracts with consultants to support adoption and optimization.
4. Incentives for existing health systems to support adoption and optimization for small, rural practices, others.

PROBLEM #3: RESISTANCE BY CLINICIANS AND STAFF

- Cannot find system to meet needs
- Resistance to change
- Hospital-practice/practitioner "trust" or lack of trust

SOLUTION: 1+2+4 >3

PROBLEM #4: NEED FOR INTEROPERABILITY

SOLUTION: State assurance/require interoperable standards for funding/expertise (*Note: this could be via the licensing Board that is being proposed*)

HOW? :

1. Only offer vendor and incent reimbursement for software solutions that can provide defined standards for interoperability (HIIAC or licensing board to determine standards?)
2. Vendors would have to supply system(s) that comply with agreed upon standards or they could not market their product in Oregon. Incentives?? Restrictions??

PROBLEM #5: LACK OF PATIENT ACCESS TO THEIR HEALTHCARE INFORMATION

SOLUTION: If patient adoption is stimulated it will drive demand for clinician adoption of EMRs.

HOW? :

1. Education to drive demand
2. Immunization information served up by the State via the Web
3. Support Medicaid Transformation Grant/ Health Record Bank through funding and resources to provide patient access model for testing and evaluation.

Strategy Two:

CLINICAL DECISION MAKING AND EVIDENCE BASED MEDICINE

Problem:

1. Clinicians are not following evidence based guidelines
2. As a result, there are variations in costs, treatments and outcomes

Underlying Causes:

1. Only a small amount of care, about 20%, have defined evidence based guidelines to treat patients
2. There is no defined process to reach agreement about which guidelines should be standardized. There are many organizations providing recommendations, but how and who determines the ones to be used?
3. Of those using Electronic Health Records the system does not have the capacity to embed guidelines; or the clinicians have turned off the functionality because they are “clunky” and inefficient and don’t add value.
4. There are no financial incentives to follow guidelines and change behavior.
5. Cultural norms may not support new practices. Physicians “have only done it this way, why should I change?”
6. There must be a clinical safety zone for following guidelines, and safe harbor to establish.

Potential Solutions:

1. State can provide financial and technical assistance to MD's who adopt electronic health records that have the functionality to provide decision support tools and the use of evidence-based guidelines.
2. State could establish a centralized source (expanded HRC?) for development of evidence-based guidelines for existing and emerging guidelines for new technologies for all to follow. These would be considered the "standard of care" in Oregon.
3. Medical malpractice protection could be given for compliance with these guidelines and the standard of care.
4. Start with 5 major chronic diseases and preventive care
5. State could provide a safe harbor for plans and providers to develop standardized pay for performance models
6. An all payer/all claims database would need to be built to monitor progress, compliance and provide feedback to providers, consumers, and payers.
7. Ensure that consumers have access to these guidelines so that they can discuss them with their clinician and are incented to comply with them.
8. Plans would pay benefits in accordance with standards of care.
9. Align State purchasing agencies to contract with plans/clinicians who follow guidelines
10. At some point, do not contract with clinicians who do not follow these guidelines. For example, if MD is not following by 20XX, they are dropped from the network. Purchasers fully support this decision
11. Rural areas would need to be addressed specifically.

Bottom Line Approach:

Adopt electronic health records with the capacity to provide efficient and effective decision support processes and tools so that clinicians can easily follow evidence-based guidelines. Develop benefits plans/incentives for clinicians and patients to follow and have health benefit purchasers require compliance with evidence-based guidelines as a term of contracting.

Strategy Three:

HEALTH INFORMATION EXCHANGE

- 1) Info not being shared
 - Poor health outcomes
 - Excessive costs
 - No useful info for public/providers
- 2) Need better standards
 - What data to share
 - How to share
 - Some data systems not interoperable
 - Providers/plans need incentives to share
 - No funding for change
 - Loss of competitive edge

- More services = more money
- Must see value in sharing
- Value needs to be consumer-driven
 - Patient fears of sharing data

Recommendations:

- Support Health Records Bank
 - Consistent vision with HIIAC
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- Both of above must support the use of national standards

Other Issues

- Some recommendations about “exchange” but about other data sharing and Quality Institute, need to support, but another group should review
- Data analysis/research needs to be “called out” in recommendations
- One privacy recommendation

Also, the second to the last recommendation, beginning with "The state should coordinate with and support the HISPC..." seemed like a privacy work group issue to us.

Strategy Four:

PRIVACY AND SECURITY

Initial Proposal for Health Information Exchange Licensing Board

Concept:

It is felt that one of the risks to privacy and confidentiality of electronic health information data is a security breach or misuse of a person's medical information. It is also believed that there is a great deal of value from the thorough exchange of such data to support the healthcare needs of the patient. It is important that efforts with an Oregon strike the right balance between adequately exchanging health information data and the maintenance of privacy, security, confidentiality of such data. To that end, we propose a law Licensing Board that would have statutory authority in this area.

Details:

The Licensing Board would be authorized by statutory law. The statutes would declare that the Board shall develop and promulgate administrative rules about the storage and exchange of health information data. Parties to such an exchange would be required to obtain a license for the transfer electronic health data. In the same way that a researcher might describe their plans for conducting research in a healthcare setting, applicants for the Health Information Transfer License would describe their plans for transferring health information while maintaining security, privacy, and confidentiality.

Statutory law would guarantee that patients and consumers provide adequate informed consent before their health information is included in transfer services. [Patients and consumers would be given the right to not participate in an electronic records exchange system \(opt-out\) without penalty.](#) Further, consumers and patients would be guaranteed notice when their information was exchanged and if there was any breach of privacy and confidentiality of their records during transfer. Statutory law would state what due process would be followed after discovery of a breach. Consumers and patients would be guaranteed specific remedies. Attorneys general would also be guaranteed remedies in the case of improper health information transfer practices where the individual is unable to pursue a private right of action.

The Board would have the authority to create administrative rules according to approved and established national standards in health information transfer. The Board would be authorized to perform periodic and random audits and inspections of licensees' health information transfer practices. Licensees would be subject to periodic relicensing. Simply holding a health information transfer license would not indemnify a licensee, who could still be litigated against for unprofessional or improper practices.

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CLINICAL DECISION MAKING AND EVIDENCE BASED MEDICINE

1. Quality Institute is created to convene and collaborate with plans and providers to align around P4P
 - A. Endorse clinical guidelines – State requires PEBB and Medicaid to use guidelines/measures in contracting standards
 - Quality Institute will do a periodic review of guidelines
 - B. Develop common sets of measures (based on evidence nationally recognized organizations)

2. State should only fund EHRs that support Decision Support Tools

For Example:

- Point of care reminders that support implementation of clinical guidelines (prevention and chronic care)
- Support population health through registry (patients with chronic diseases)
- Ongoing monitoring of health status of patients (internal clinic measures)
- PHR: Allows patients to track/monitor own health measures/services
- Covers e-prescribing and associated decision support
- Transparent source of data (where did guidelines come from?)

Evidence-Based Medicine
Prepared for the HIIAC by Oregon Health Fund Board Staff
Draft – For Background Only

What information is available? - Clinical Guidelines and Comparative Effectiveness Research/Technology Assessment

Select Oregon Initiatives

- Oregon's Health Services Commission (HSC) is responsible for developing and maintaining the Prioritized List for the Oregon Health Program, which ranks health services based on the comparative benefits of each service to the entire population served. The Commission is directed to encourage effective and efficient medical evaluation and treatment by considering both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance. The Commission develops practice guidelines of both diagnostic and health services and publishes these guidelines along with the Prioritized List. The Health Services Commission reported a new Prioritized List of Health Services for the 2007-09 biennium, which places a new emphasis on preventive care and chronic disease. The current list and guidelines can be found at:
<http://www.oregon.gov/OHPPR/HSC/docs/Apr08Plist.pdf>.
- The Health Resources Commission (HRC) (<http://www.oregon.gov/OHPPR/HRC/index.shtml>) was created as part of the Oregon Health Plan to encourage the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. HRC is directed to conduct a medical technology assessments program (MedTAP); serve as a statewide clearinghouse for medical technology information; monitor the use, costs and outcomes associated with selected medical technologies in Oregon, using available data; identify information which is needed but lacking for informed decision making regarding medical technology, and fostering mechanisms to address such deficiencies; provide a public forum for discussion and development of consensus regarding significant emerging issues related to medical technology; and inform health care decision makers, including consumers, of its findings and recommendations regarding trends, developments, and issues related to medical technology.
- The Drug Effectiveness Review Project (DERP) (<http://www.ohsu.edu/ohsuedu/research/policycenter/DERP/index.cfm>) is a collaboration of organizations that have joined together to obtain the best available evidence on effectiveness and safety comparisons between drugs in the same class. The DERP produces a series of comprehensive, updated and unbiased systematic reviews conducted by Evidence Based Practice Centers (EPC) with oversight and coordination from the Oregon EPC. Current DERP participating organizations are: Arkansas; Canadian Agency for Drugs and Technologies in Health; Idaho; Kansas;

Michigan; Minnesota; Missouri; Montana; North Carolina; New York; Oregon; Washington; Wisconsin; Wyoming.

- The Medicaid Evidence-Based Decisions (MED) Project (<http://www.ohsu.edu/ohsuedu/research/policycenter/med/index.cfm>) was established in 2006 as a self-governing collaboration of state Medicaid agencies across the U.S. The project was developed as a response to the need for high quality evidence to support benefit design and coverage decisions. As part of OHSU's Center for Evidence-based Policy, the MED Project provides participants with a unique set of high quality resources designed to assist Medicaid agencies in providing better healthcare and improving their use of available resources. MED's clinical evidence reports (and other resources) clarify and interpret what evidence exists, documenting its quality and relevance. Current MED organizations include the following states: Alaska, Alabama, Arkansas, Kansas, Minnesota, North Carolina, Missouri, Montana, Oklahoma, Oregon, and Washington.
- Many of the private health plans in Oregon develop practice guidelines or endorse nationally accepted guidelines and distribute them to providers. For instance, Regence Blue Cross Blue Shield's website provides access to national clinical practice guidelines for both physical and mental health and chemical dependency treatments. (<http://www.or.regence.com/provider/utilization/practiceGuidelines/>) LifeWise Health Plan of Oregon also endorses or develops clinical practice guidelines to support physicians and other providers in the care of LifeWise members and posts guidelines on their website (https://www.lifewiseor.com/lwor/groups/public/documents/xcpproject/p_refinfo_clinical_pg.asp).

Other Select State and National Initiatives

- The Agency for Healthcare Research and Quality (<http://www.ahrq.gov/>) is an agency within the Department of Health and Human Services established to perform outcomes research and clinical practice guidelines development. There are a number of AHRQ programs that have been established to develop clinical guidelines and conduct technology assessments, comparative effectiveness research, pharmaceutical outcomes research, and economic valuations of health care services and treatments, respectively.
 - The National Guideline Clearinghouse (NGC) (<http://www.guideline.gov/>) is a comprehensive database of evidence-based clinical practice guidelines and related documents.
 - The U.S. Preventive Services Task Force (USPSTF) was established in 1984 as an independent federal advisory committee, under the U.S. Public Health Service and given the responsibility of developing clinical practice guidelines for primary care physicians. The guidelines, in general, focus on the prevention of diseases, and compare the preventative methods.
 - Centers for Education and Research on Therapeutics (CERTS) conducts pharmaceutical outcomes research that compares health, risks, benefits, cost-effectiveness, economic implications, and interactions of treatments.
 - The Developing Evidence to Inform Decisions about Effectiveness Program (DEcIDE) was created to conduct and support research on outcomes,

comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services.

- The Evidence-based Practice Centers Program (EPC) program was established to improve the quality, effectiveness, and appropriateness of health care through technology assessments, evidence reports, and research on the methods for systematic reviews. The reports inform public and private insurers' coverage decisions, and are used to develop quality measures, educational materials, clinical guidelines, and research agendas.
- Research Initiative in Clinical Economics (RICE) funds research on the cost-effectiveness, cost-benefit, and methods for estimating the value of health care interventions.
- The Puget Sound Health Alliance (<http://www.pugetsoundhealthalliance.org/services/guidelines.html>) convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region. Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain.
- The Institute for Clinical Systems Improvement (ICSI) (www.icsi.org) in Minnesota is an independent, non-profit organization that includes medical groups and hospital systems. ICSI produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota. ICSI's website provides the public with access to clinical guidelines under the following categories: behavioral health, cardiovascular, musculo-skeletal disorders, patient safety and rehabilitation, preventative and health maintenance, respiratory disease, and women's health. In addition, ICSI provides guidelines that are supplemented with descriptions and definitions to help patients understand their care.
- The Technology Evaluation Center (TEC) of the BlueCross BlueShield (BCBS) Association (<http://www.bcbs.com/blueresources/tec/>) has been assessing the relative effectiveness and appropriateness of different technologies since 1985. The Center's evaluations focus on the relative effectiveness of technologies, particularly with regard to the effect upon health outcomes, such as length of life, quality of life, and functional abilities.
- Consumer Reports' Best Buy Drugs Project (<http://www.consumerreports.org/health/best-buy-drugs/index.htm>) is a non-profit project of Consumer Reports that is primarily supported by educational grants. The project synthesizes DERP findings in order to provide comparative effectiveness information about drugs to health care consumers and providers, and selects "Best Buy picks" within drug classes; the most influential factor in the selection process is the drug's effectiveness.
- The Department of Defense PharmacoEconomic Center (<http://www.pec.ha.osd.mil/>) was established with the mission is to: improve the clinical, economic, and humanistic outcomes of drug therapy in support of the readiness and managed healthcare missions of the Military Health System. The center performs cost-

effectiveness analyses, establishes formulary lists, and provides drug treatment guidelines with the Veterans Health Administration.

- The State of Washington's Health Technology Assessment Program (<http://www.hca.wa.gov/shtap/>) was created in 2006 to ensure that health technologies purchased by the state are safe and effective and coverage decisions made by various state agencies are consistent, transparent, and based on evidence.
- Many professional organizations have programs dedicated to establishing clinical guidelines for widespread distribution. These include the Clinical Efficacy Assessment Project of the American College of Physicians, the Joint Guidelines of the American College of Cardiology and American Heart Association, and the Committee on Gynecologic and Obstetric Practice of the American College of Obstetrics and Gynecology.

Select International Initiatives

- The Cochrane Collaboration (<http://www.cochrane.org/index.htm>) is an international not-for-profit and independent organization, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions.
- The National Institutes for Clinical Excellence (NICE - UK) (<http://www.nice.org.uk/>) is the independent organization responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE produces guidelines in three areas: public health, health technologies, and clinical practice.

How has payment been restructured to encourage the use of evidence-based medicine?

Pay-for-Performance - In recent years, there has been significant experimentation with pay-for-performance, a method of reimbursing providers based on the achievement of pre-determined measures of quality. Many of the clinical quality indicators used in these programs are based on process measures associated with nationally accepted clinical guidelines and best practices. Examples of two pay-for-performance initiatives that specifically focus on encouraging care based on clinical guidelines are described below.

- **Prometheus Payment Model** (<http://www.prometheuspayers.org>) - Prometheus Payment, Inc. is developing a new system of payment based on what evidence-based medicine defines as appropriate for a patient with a particular condition. The system involves taking the clinical practice guideline for the condition, estimating the cost of delivering the care in the guideline, and then turning that into an "Evidence-Based Case Rate" to cover all of the care by all of the providers who will be involved with the patient's care. 10-20% of the payment amount is withheld and placed in a performance contingency fund which is paid to providers based on their performance on a multi-factor scorecard. An issue brief describing the plan is available at: http://www.commonwealthfund.org/usr_doc/deBrantes_evidence-informedcaserates_1022.pdf?section=4039.

A presentation describing the status of planning for the system with examples of how the detailed specifications would be developed is available at:

http://www.ehcca.com/presentations/pfpsummit2/debrantes_p2.pdf

- **Geisinger ProvenCare (<http://www.geisinger.org/provencare/index.html>)** – Geisinger Health System is a large integrated health system in central and northeastern Pennsylvania. Geisinger executive leadership and cardiac surgeons developed a pay-for-performance initiative for coronary bypass graft (CABG) based on the clinical guidelines developed by the American Heart Association and the American College of Cardiology. The surgeons critically examined the guidelines and translated the guidelines into actionable care processes. Information technology professionals then worked with clinical staff to develop the electronic health record-based tools necessary to “hardwire” each care process. Physician reimbursement was tied to successful adherence to the ProvenCare processes. Geisinger has created an elective CABG package for payers, which includes all pre-operative, hospital and professional fees, standard post-operative care, and any care resulting from complications for 90 days. The number of patients receiving recommended care has increased significantly after this program was initiated.

NOTES FROM 7/9/08 HIIAC MEETING

OPEN ISSUES:

1. Tension between control by individual and legal use of information.
2. "Voluntary": what does it mean?
3. Speak to high administrative costs, and potential savings

INFORMATION NEEDED FOR SUB-GROUP WORK:

Sub-group #1: Examples of financial models- which can hold the costs neutral

Sub-group #2: Pay-for-Performance models; Evidence-based guidelines

Sub-group #4: Examples of other states with comparable governance models,
Similar approaches

DEBRIEF OF MEETING:

Liked	Improve, change
Like having a facilitator	Want opportunity to meet as full group for feedback early in the meeting
Small group process	Recognize incremental nature of the recommendations
Appreciate members investment in process	Send summaries out - give general feedback by email

Website: www.oregon.gov/OHPPR/HIIAC.shtml

Health Information Infrastructure Advisory Committee
Wednesday, July 9, 2008
1:00 – 5:00 pm
Portland State Office Building
800 NE Oregon Street, Room 1D
Portland, OR

PRELIMINARY AGENDA

Desired Outcomes:

- **Affirm vision, guiding principles**
- **Clarify key strategies**

Time (est)	Item	Lead	Action Items
1:00 pm	Call to Order and Approval of 6/19 Minutes	Ree Sailors Dick Gibson	X
1:10 pm	Review Agenda, Desired Outcomes	Carol Turner	
1:20 pm	Medicaid Transformation Grant	Jim Edge	
1:30 pm	Confirm Vision, Guiding Principles	Ree Sailors Dick Gibson	X
1:50 pm	Review Groupings of Strategies	Carol Turner	
2:10 pm	Clarify and Develop Details to Strategies	Sub-groups	
4:15 pm	Report Back on Strategies	Carol Turner	
4:30 pm	Next Steps	Ree Sailors Dick Gibson	
4:40 pm	Debrief Meeting	Carol Turner	
4:45 pm	Public Testimony		
5:00 pm	Adjourn	Ree Sailors Dick Gibson	

Health Information Infrastructure Advisory Committee (HIIAC) Meeting

Thursday, June 19, 2008

1:00 – 5:00 pm

PSOB

Committee Members Present:

Dick Gibson, Ree Sailors, Chris Apgar, Nancy Clarke, Andy Davidson, Joyce DeMonnin , Laura Etherton, Grant Higginson, Denise Honzel, Andi Miller, Barbara Prowe, Laureen O'Brien, Jeany Phillips, Sally Sparling, Dave Widen

Committee Members Absent:

Ken Carlson, Homer Chin, Paul Gorman, Bart McMullan, Gina Nikkel , Andrew Perry, Nan Robertson, Abby Sears,

Staff:

Jody Pettit, Dawn Bonder, Judy Morrow

Welcome and Introductions
HIIAC co-chairs Ree Sailors, Governor Kulongoski's Health Care Policy Advisor, and Dick Gibson, Chief Information Officer, Legacy Health Systems, called the meeting to order and welcomed HIIAC members and guests. Introductions of first time attendees were made.
HIIAC Status Report
Gibson and Sailors recapped the activities of the two prior HIIAC meetings. Sailors explained the time line for recommendations to the Health Fund Board (HFB). Written recommendations are due to the HFB at the end of September. Given the additional month of working time, the co-chairs decided to revisit the group work on vision, mission and principles. Once these are defined, the group will return to working on the recommendations that were discussed at the May 29 th HIIAC meeting.
Meeting Facilitator
Gibson introduced Carol Turner. Turner will be facilitating the HIIAC's discussion around its vision, mission and principles.

Group Work
The HIIAC Members worked with Turner to craft a vision and mission statement and to detail group goals. The outcomes of the discussions are reflected in Turner’s meeting notes which are an appendix to these minutes.
Logic Model
Sailors proposed a draft Logic Model as a way of thinking about the work product of the HIIAC. A copy of the 1 st draft of the Logic Model is part of the meeting materials. Committee members made comments on the model and Sailors agreed to incorporated comments into a 2 nd draft.
Next Meeting
The next HIIAC meeting is scheduled for Wednesday, July 9, 2008, 1 – 5 pm at the PSOB. Other meetings for July and August are being scheduled. Smaller working groups may mean less meetings will be required.
Public Testimony
Brad Hall -- Accumentra Health
Meeting Debrief
It was agreed that the work product from the meeting would be sent to those not in attendance for comments.

Meeting was adjourned.

Version 2 of Recommendations and Criteria post 6/19/08 meeting

Resorted with New Category Headings

	Feasibility	Impact
Adoption of Electronic Health Records and Health Information Technology		
The state (?) should provide clinics (esp. individual and small groups) with no/low -interest rate loans, grants, and/or tax credits, as well as technical assistance, to facilitate the adoption of interoperable EMRs.		
The state should require all providers, starting with ambulatory clinical settings, to adopt certified health information systems by X date.		
The state should require e-prescribing between the prescriber and dispenser no later than 2010.		
Payment reimbursement systems should be reformed to reward providers that use EBM.		
The state should use its purchasing power to require that all publicly contracted providers use e-prescribing and follow uniform claims submission requirements by X date. Standard compliance should only be included in state contracts if existing and available technology supports those contracts and must take into account the cost of adopting new technology.		
The state should partner with the private sector to expand the use of telemedicine, especially in rural areas of Oregon.		
The state should partner with private stakeholders to design and implement education campaigns for providers, health care managers, and the public about health information systems.		
Clinical Decision Making and Evidence Based Medicine		
The state should encourage the use of clinical decision support (CDS) with evidence based medicine through contracting decisions.		
The state should use its purchasing power to require contractors (MCOs and providers) to adhere to appropriate evidence based medicine practices.		
The state should establish P4P programs within medicaid programs that are designed to support and encourage preventive care (providers will need technical support to measure and report).		
Health Information Exchange and Data Sharing		

	<i>Feasibility</i>	<i>Impact</i>
The state should promote personal health records for all Oregonians that interoperate with the EHRs used by health systems and give consumers access to and control over their health information.		
The state should adopt nationally developed (emerging) standards regarding communication between HIEs (see NHIN, HITSP, CCHIT and HISPC projects).		
The state should require providers to utilize interoperable health information technologies, so systems interface with one another.		
The state should ensure that meaningful health data is easily accessible for all consumers from a single source.		
The state should partner with private stakeholders to ensure that consumers have access to the information needed to compare various health plans offered by a single payer and health plans offered by different payers.		
The state should partner with private stakeholders to provide vehicles for comparisons of provider performance and clinical quality.		
The state should collaborate with private stakeholders to ensure that information about cost, transparency, and efficiency is available to providers and consumers to increase the awareness of health care costs and practice variation.		
The state should use its regulatory and purchasing powers to force the advancement of health information exchange. The state should establish incremental health information exchange requirements that lead to all providers and health plans (?) to fully participating in health information exchange efforts by X date.		
The state needs to look beyond EMR/HER adoption and address interoperable communication directly or through a translator. Implementation of an EMR/HER does not lead to true HIE, so the state needs to take into account the current environment and develop incremental steps to move the agenda forward.		
The state should examine options and potential models for a health information exchange for Oregon that complies with emerging national standards. The state should select a model that will work best for Oregon and be financially sustainable and fund initial pilots in communities with a high level of readiness. The state should establish requirements for full activation of an Oregon health information exchange by X date.		
The state should coordinate with and support the HISPC Collaborative, charged with developing model privacy legislation that will accommodate faster electronic exchange of patient information while continuing to protect the privacy and security of that information.		
Support the use of electronic immunization registry, provider and consumer portals, and dashboards.		

	<i>Feasibility</i>	<i>Impact</i>
The state should collaborate with private industry to establish mechanisms where consumers can allow providers to access their PHRs as needed to tailor health care/wellness tools to individual consumer's needs.		
Privacy and Standards		
The state should collaborate with the Oregon Quality Corporation and other similar non-profits involved in developing quality indicators		
The state should establish/enforce security and privacy protocols that will assist in convincing consumers that the use of health information tools, especially for protected conditions, is safe and secure.		
The state should adopt nationally developed (emerging) standards regarding communication between HIEs (see NHIN, HITSP, CCHIT and HISPC projects).		
Establish policies on clinical data ownership and stewardship.		

HIIAC Flip Chart Notes – 7/9 Meeting

Group 3: Health Information Exchange

- 1) Info not being shared
 - Poor health outcomes
 - Excessive costs
 - No useful info for public/providers
- 2) Need better standards
 - What data to share
 - How to share
 - Some data systems not interoperable
 - Providers/plans need incentives to share
 - No funding for change
 - Loss of competitive edge
 - More services = more money
 - Must see value in sharing
 - Value needs to be consumer-driven
 - Patient fears of sharing data

Recommendations:

- Support Health Records Bank
 - Consistent vision with HIIAC
 - No \$ for other pilots now
- State to use purchasing/payment powers
- Both of above must support the use of national standards

Other Issues

- Some recommendations about “exchange” but about other data sharing and Quality Institute, need to support, but another group should review
- Data analysis/research needs to be “called out” in recommendations
- One privacy recommendation

Group 4: Privacy and Standards

Licensing and Review Board

- Statutory authority to require licensure
- Administrative rules
- Periodic relicensing
- Periodic and random audits and inspections
- Develop standard of practice of exchange [of health information]

Logic Model for Health Information Infrastructure Development

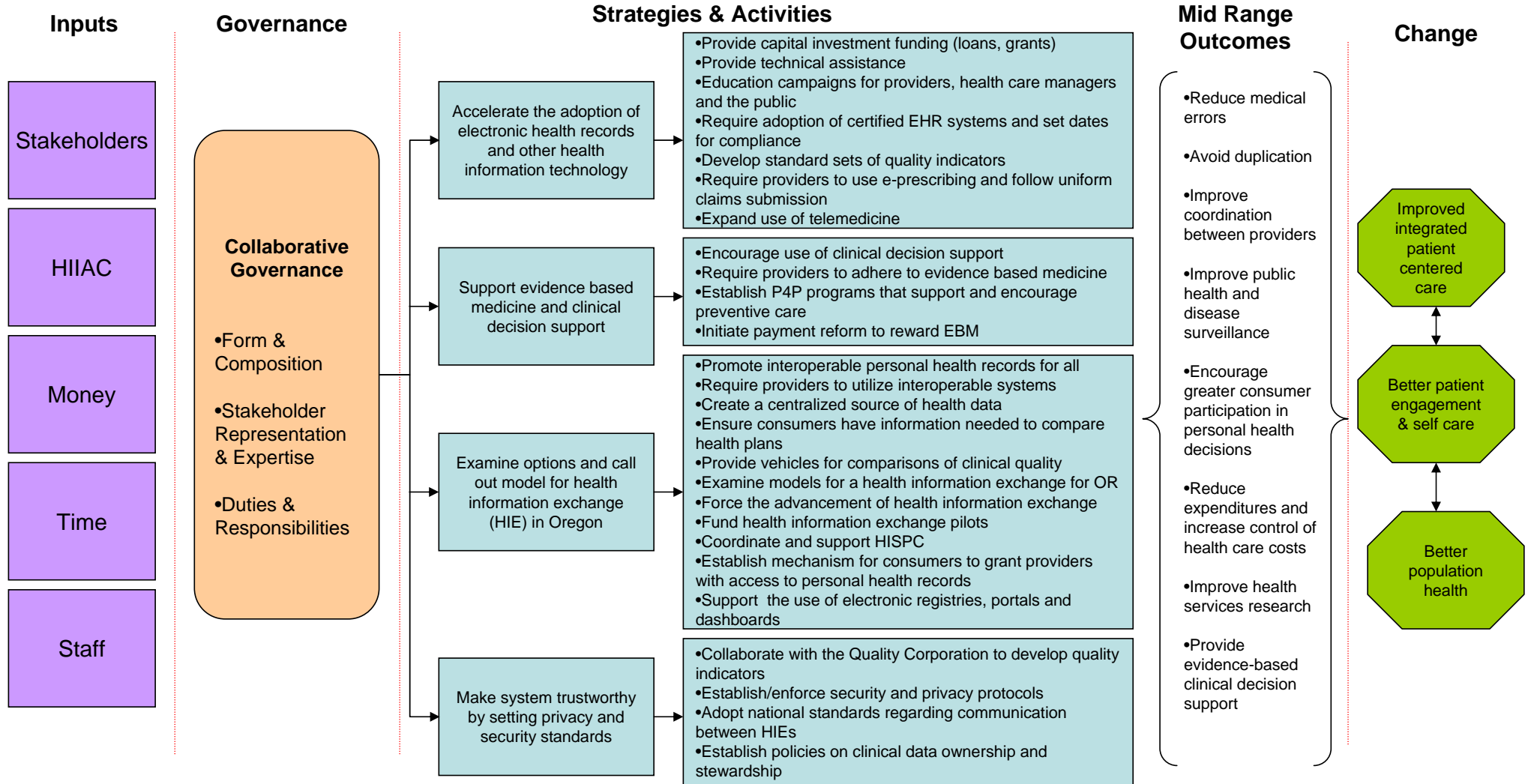


Table 5. Barriers to the Adoption of Electronic Health Records.*			
Variable	Any Electronic-Records System†	No Electronic-Records System	P Value
	<i>percent</i>		
Amount of capital needed			
Major barrier	47	66	<0.001
Minor barrier	30	22	
Uncertainty about return on investment			
Major barrier	33	50	<0.001
Minor barrier	34	31	
Resistance from physicians			
Major barrier	27	29	0.37
Minor barrier	42	42	
Capacity to select, contract, install, and implement			
Major barrier	26	39	<0.001
Minor barrier	45	42	
Concern about loss of productivity during transition			
Major barrier	35	41	0.02
Minor barrier	42	40	
Concern about inappropriate disclosure of patient information			
Major barrier	14	17	0.09
Minor barrier	43	45	
Concern about illegal record tampering			
Major barrier	14	18	0.007
Minor barrier	42	46	
Concern about the legality of accepting electronic records from hospital			
Major barrier	7	11	0.001
Minor barrier	27	33	
Concern about physicians' legal liability			
Major barrier	11	14	0.02
Minor barrier	34	38	
Finding an electronic-records system to meet needs			
Major barrier	38	54	<0.001
Minor barrier	38	32	
Concern that system will become obsolete			
Major barrier	27	44	<0.001
Minor barrier	44	40	

* Percentages were calculated with the use of a multivariable logistic-regression model. Variables included in the model were medical specialty (primary care vs. not primary care), the number of years since graduation (1 to 9, 10 to 19, 20 to 29, or ≥30), the number of physicians in the practice (1 to 3, 4 to 5, 6 to 10, 11 to 50, or >50), clinical setting (hospital, private office, or other), and region (Northeast, Midwest, South, or West). Separate models were fitted for each of these questions.

† The category includes both fully functional and basic electronic health records.

Health Information Infrastructure Advisory Committee

Thursday, June 19, 2008
1:00 – 5:00 pm
Portland State Office Building
800 NE Oregon Street, Room 1D
Portland, OR 97209
AGENDA

Desired Outcomes:

- Increased understanding of anticipated committee work
- Initial decisions on vision, values, principles

Time (est)	Item	Lead	Action Items
1:00 pm	Call to Order and Approval of 5/29 Minutes	Ree Sailors Dick Gibson	X
1:10 pm	Review Agenda, Desired Outcomes	Carol Turner	
1:20 pm	Clarify Expectations of HIIAC Work	Ree Sailors	
1:40 pm	Elements of Productive Process/Recommendations	Carol Turner	
2:10 pm	Affirm Decision Making Process	Carol Turner	
2:30 pm	Initial Determination of Vision, Values, Principles	Carol Turner	
4:00 pm	Logic Model Draft	Ree Sailors	
4:20 pm	Next Steps	Ree Sailors Dick Gibson	
4:40 pm	Debrief Meeting	Carol Turner	
4:45 pm	Public Testimony		
5:00 pm	Adjourn	Ree Sailors Dick Gibson	

Health Information Infrastructure Advisory Committee (HIIAC) Meeting

Thursday, May 29, 2008

1:00 – 5:00 pm

OGI/OHSU

Committee Members Present:

Dick Gibson, Ree Sailors, Chris Apgar, Ken Carlson, Homer Chin, Nancy Clarke, Joyce DeMonnin, Grant Higginson, Paul Gorman (via phone), Bart McMullan, Andi Miller (via phone), Gina Nikkel (via phone), Andrew Perry, Barbara Prowe, Nan Robertson, Abby Sears, Jeany Phillips, Dave Widen,

Committee Members Absent:

Andy Davidson, Laura Etherton, Denise Honzel, Laureen O'Brien, Sally Sparling, John Kenagy sat in for Laureen O'Brien

Staff:

Jody Pettit, Dawn Bonder

Welcome and Introductions

Shelley Charles of OHSU welcomed the HIIAC Members and presented information on their new Healthcare MBA program.

HIIAC co-chairs Ree Sailors, Governor Kulongoski's Health Care Policy Advisor, and Dick Gibson, Chief Information Officer, Legacy Health Systems, called the meeting to order and welcomed HIIAC members and guests.

Sailors explained that Jeany Phillips of DMAP will be replacing Greg Wenneson on the HIIAC.

HIIAC members and staff introduced themselves.

Bylaws and Executive Order

Sailors pointed out the Bylaws in the members' packets and asked members to review and send any comments to staff by email.

Sailors also reviewed the Executive Order.

Oregon Health Fund Board (HFB) Delivery Committee Report

Sailors introduced Jeanene Smith, Administrator of Oregon Health Policy and Research (OHPR) and the lead staff member for the HFB Delivery Systems Committee.

Smith reviewed the recommendations of the committee, which was closed down on May 27, 2008. A final report will be ready in mid-June.

The Report Executive Summary was part of the meeting materials for the HIIAC meeting.

Smith focused her comments on the areas where interoperable, electronic health records are necessary to support the Delivery Systems Committee's recommendations:

- Primary care and management of chronic disease through an integrated, patient-centered, health home
- Improved quality and increased transparency
- Accessing outcomes for payment reform
- Decision support tools as a vehicle to disseminate comparative effectiveness and medical technology assessment

- Patient engagement in shared decision making and systems such as a statewide POLST registry
- Device integration to track the progress on programs focused on chronic conditions to support public health, prevention and wellness goals
- Administrative simplification and standardization
- Reduced pharmaceutical spending

Committee members noted that small practitioners and safety-net providers need to be included in plans for HIT implementation.

Sailors reiterated that the HFB will review the recommendations and its responsibility is to negotiate any conflicts between recommendations and existing law or practice.

Discussion of DRAFT Vision Statement:

Dawn Bonder presented a revised DRAFT Vision Statement which encompassed comments from the last HIIAC meeting.

A sub-committee was formed to continue work on the statement:

- Nan Robertson
- Abby Sears
- Dave Widen

The sub-committee will present a third DRAFT Vision Statement at the June HIIAC meeting.

Committee Exercise:

The HIIAC Members discussed the criteria and recommendations on the merged spreadsheet.

Joyce DeMonnin requested to use “patient-centered” as a criteria to rate recommendations. There was discussion regarding this request with a decision to include patient-centered as a value rather than a criteria.

Nan Robertson moved and Paul Gorman seconded the initiation of a process to craft a values/guiding principles statement. Motion passed.

The sub-committee working on the Vision Statement agreed to add this as a committee task.

A staff/member review panel was formed to sharpen the culled recommendations and add the proposed state role to each of those recommendations.

The Review Panel will consist of staff and the following HIIAC members:

- Dick Gibson
- Grant Higginson
- Andrew Perry
- Nancy Clarke

Once the recommendations are sharpened and the state roles are added, the Review Panel’s work will be sent to the HIIAC membership for assessment based upon the agreed upon criteria:

1. Impact of Recommendation
2. Feasibility of Recommendation

There was a motion and a second with unanimous approval for this process.

Approval of Meeting Minutes

The HIIAC Meeting Minutes from April 25, 2008 were approved unanimously.

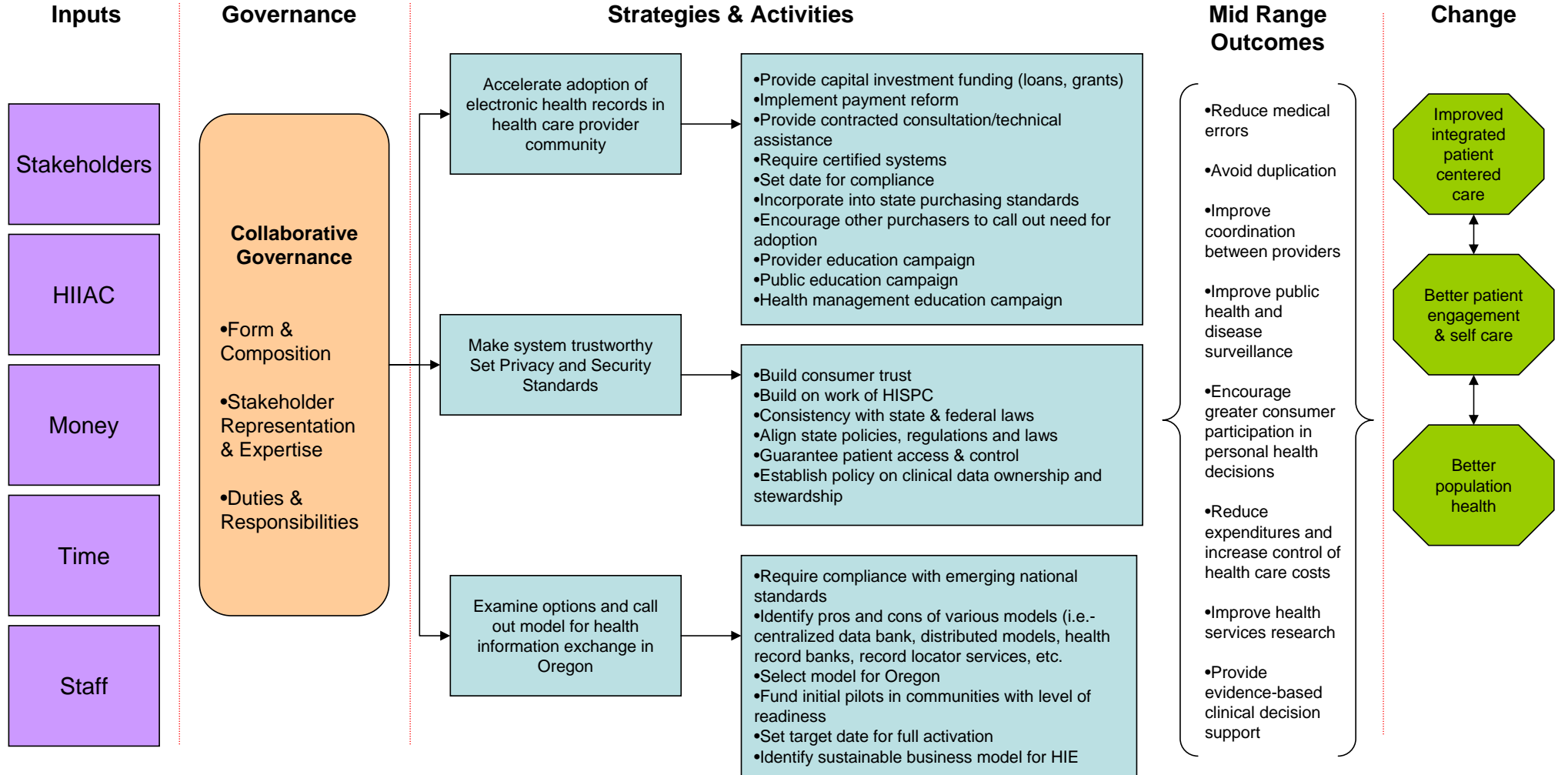
Public Testimony:

None

Next Meeting:

Thursday, June 19, 2008 1:00 – 5:00 pm Portland State Office Building

Logic Model for Health Information Infrastructure Development



Delivery Systems Report Recommendations:

Primary Care and Chronic Disease Management/ Integrated Health Homes Recommendations (1-8)

- 1 transform primary healthcare delivery system, guided by integrated health home (IHH), partnerships to do it
- 2 support patient-centered integrated health homes for all
 - support interactive systems of care (real and virtual) which connect IHH with community-based services, public health, behavioral health (including employee assistance programs, oral health and social services to improve
- 3 population health
- 4 workforce training, technical assistance, resources, support
- 5 plan for healthcare workforce
- 6 empower consumers to be more involved in their own care, encourage to partner with IHH
- 7 funding, payment, incentives that sustain IHH
- 8 strengthen the safety net

Improving Quality and Increasing Transparency Recommendations (1-3)

- 1 public-private quality institute (QI), long-term state funding
- 2 align efforts to improve quality and transparency
 - a. set goals
 - b. common quality metrics
 - c. ensure providers can produce and access info about quality, utilization and pt outcomes
 - d. collection & dissemination of data re: providers, HP's and pt experience, set standards for metrics
- 3 Quality Institute use data and evidence to identify opportunities for QI and transparency
 - a. QI demos
 - b. public/private collaborative endorse and disseminate guidelines
 - c. assess comparative effectiveness of technologies & procedures
 - d. lessen the burden of reporting
 - e. collaboration for QI and best practices
 - f. align with recommendations of the HIIAC about a strategy for implementing a secure, interoperable computerized health network to connect patients and healthcare providers across Oregon. Support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers and payers.

g. engage consumers in use of quality, utilization data and EB guidelines

Financial Transparency

- 1 greater cost transparency of health care providers

Accountable Care Districts (1-2)

- 1 define ACDs
- 2 incentivize communities to use ACD data for resource planning

Payment Reform Models (1-2)

- 1 P4P
- 2 test new payment models

Comparative Effectiveness and Medical Technology Assessment Recommendations (1-5)

- 1 support comparative effectiveness research, use best available evidence EBM
- 2 endorse patient decision aids
- 3 develop standard sets of EB guidelines based on comparative effectiveness research
develop common policies across public & private health plans re: coverage of services etc. based on comparative
- 4 effectiveness research
- 5 more immunity from litigation if follow EBM etc.

Shared Decision Making Recommendations (1-4)

- develop or endorse EB CDS for IHH and other care settings which account for pts cultural, ethnic, racial, language
- 1 needs
 - 2 reimburse providers for time spent in shared decision-making
 - 3 training courses in shared decision-making
 - 4 State-wide POLST registry

Administrative Simplification and Standardization Recommendations (1-3)

- 1 cost transparency for health plan and provider administrative spending
- 2 standard formats and processes for eligibility, claims, payment and remittance transactions
- 3 simplify prescribing processes esp. re: multiple formularies

Reduced Pharmaceutical Spending

- 1 utilize bulk purchasing arrangements to maximize savings in pharmaceutical spending

DRAFT FOR DISCUSSION

*VISION, MISSION, VALUES, PRINCIPLES
JUNE, 2008*

HIIAC Vision as of 05/29/08:

In order to improve health outcomes and reduce duplication and administrative costs, Oregonians' health information is

- Available when and where it is needed to support clinical decision-making and care; and to ensure and improve high-quality care
- Is private and secure and only exchanged with the authorization of the individual or pursuant to prevailing federal and state law
- Is used for public health and population-based care and research.

HIIAC Mission:

Senate Bill 329: " Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable. "

The purpose of HIIAC is to recommend a plan for creating an Oregon health information system (network?) with the infrastructure necessary to both preserve the privacy and security of health information and provide appropriate access for delivery of quality health care.

The purpose of HIIAC this summer is to recommend to the Oregon Health Fund Board on what building blocks are initially essential for the creation of an Oregon health information system.

HIIAC Values

*“Values are the deeply felt **qualities**, the essential tenets, you want to embody as an organization while taking action or developing strategy. When teams or organizations set their sights on ambitious visions, bold actions alone do not achieve success. Actions need to be rooted in core values people can trust. These values guide decisions and behavior whenever plans aren’t clear.”*

An organization usually has 4 to 6 essential, core values that it revisits to validate decisions and guide behavior.

- Patient-centric (define)
 - Empowered consumers
 - Guaranteed, convenient access
 - Consumer control over when and how their information is shared (specific or aggregate)
 - Transparency
 - Reliability
 - Security and privacy
 - Safety for all patients
 - Portability
 - Collaboration
 - Autonomy
 - Support risk taking
 - Inclusive
 - Voluntary
-
- Trust
 - Equality
 - Feasibility

HIIAC Principles

“Principles are specific rules of behavior to which the organization or team is committed.” The values HIIAC elects to adopt will help define the principles to which you are committed for all decisions made.

Examples might be:

We will only operate from a model of collaboration and partnership between the private and public sectors and will leverage that collaboration whenever possible to seek solutions for all residents of our State.

We will only support those solutions that comply with agreed upon national and industry standards.

We believe in consumers taking an active role in their health through ownership, access and control of their health information.

We will only adopt systems for health information exchange that protect the integrity, security and confidentiality of the consumer’s information.

We will align incentives for all stakeholders to support HIT adoption and interoperability.

We will use proven implementation strategies and methods.

We will only support solutions that empower each facility to maintain its own data.

DRAFT

The Oregon Health Information Infrastructure Advisory Council (HIIAC) Updated 06/08

Appointee:	Organization:	Constituency:	Domain Expertise:	Notes:	Contact:
Dick Gibson Co-Chair	Legacy Health Systems	Physicians, Health Systems	VP/CIO	MPHIE, HISPC	RFGIBSON@LHS.ORG 503.415.5198
Nancy Clarke	QCorp	Multi-stakeholder	Quality	MPHIE, HISPC, AF4Q	Nancy.clarke@q-corp.org 503.241.3571
Andy Davidson	OAHHS	H/HS & Oregon Health Net	HIE	MPHIE, FCC Grant, Acumentra Board	adavidson@oahhs.org 503.636.2204
Bart McMullan, M.D.	Regence BC/BS, President	Payers	Insurance, Payment	OBC/MPHIE	jbcmul@regence.org 503.225.5351
Abby Sears	OCHIN	Safety Net	Safety Net IT	HISPC	searsa@community-health.org 503.943.2500
Homer Chin	Kaiser	Hybrid	CMIO	OCHIN Board	Homer.L.Chin@kp.org 503.813.3838 503.813.4578 direct
Nan Robertson	Robertson Group	Clinics, IPAs	EHR Implementation	DOQ-IT	nan@therobertsongroup.org 503.704.2546
Denise Honzel	Oregon Business Council	Purchasers/Payers	Payment	OBC/MPHIE	honzelde@aol.com 503.860.1278
Jean Phillips	DHS/DMAP Deputy Director	Medicaid	HIT Projects		Jean.S.Phillips@state.or.us 503.945.6552
Laura Etherton	OSPIRG	Consumers			etherton@ospirg.org 503.231.4181 x-305
Barbara Prowe	OCHCP	Purchasers	Healthcare Purchasing	PDX Safety Net City Club	barbara.prowe@ochcp.org 503.830.0772
Paul Gorman	OHSU	Academia, Community HIE	Informatics, Medication Recon.	AHRQ, HIE, Open Source	gormanp@ohsu.edu 503.494.4025
Andi Miller	COEMR, COIPA	Clinicians	EHR, HIE, Practice Mgt.	HISPC	amiller@coipa.org 541.330.4965
Gina Nikkel	Mental Health	Consumers	Mental Health	HISPC	GNikkel@aocweb.org 503.399.7201 503.930.0349 cell

The Oregon Health Information Infrastructure Advisory Council (HIIAC) Updated 06/08

Grant Higginson	Public Health	Public Health	Public Health	HISPC	Grant.K.Higginson@state.or.us 971.673.12251
Andrew Perry	CEO Corvallis Clinic	Clinicians	Practice Mgt.		Andrew.Perry@corvallisclinic.com 541.758.2747 541.754.1374 Adm.
Sally Sparling	CEO, NW Cardiovascular Institute/NW Cardio Technologies	Clinic	Practice Mngmt.		sallysparling@nw-ci.com 503.219.8575 direct 503.703.6200 cell
Chris Apgar	Consultant			HISPC	capgar@apgarandassoc.com 503.977.9432
Ken Carlson M.D.	Childhood Health	Physician	Practitioner/Us er	Pediatrician	kcarlson@childhoodhealth.com Office (503) 364-2181 Cell (503) 510-0047
Laureen O'Brien	Providence Health System	Hospitals & Clinics & LTC	Corporate CIO		Laureen.obrien@providence.org 503.216.4516
Dave Widen	Safeway	Pharmacy	Retail Pharmacy	Patient Safety Comm.	Dave.widen@safeway.com 503.657.6272
Joyce DeMonnin	AARP	Consumers		HISPC	jdemonnin@aarp.org 503.513.7351
Ree Sailors Co-Chair	Governor's Office	Sr. Health Policy Advisor		HISPC	Ree.sailors@state.or.us 503.373.2315

AGENDA *Health Information Infrastructure Advisory Committee*

DATE: Thursday, May 29, 2008

TIME: 1:00 pm – 5:00 pm

PLACE: *** PLEASE NOTE LOCATION CHANGE FROM LAST MEETING***

Oregon Graduate Institute (OGI) aka OHSU West Campus

20000 NW Walker Rd Beaverton, OR 97006

Building: The Wilson Clark Center is building 3

Room: Main dining room

MAP: [Campus map](#)

DRIVING DIRECTIONS:

[From Portland](#)

[From Salem](#)

Please Note:

- Teleconferencing Information: Call: 1-888-422-7141; Use Guest Code: 242767
- Parking is available between Neumann Dr. & NW Walker Rd.
- Travel and parking expenses will be reimbursed. Return completed forms to: tina.huntley@state.or.us or Fax: 503.378.5511.



Form

1:00 – 1:15	Welcome, Introductions, Announcements, Bylaws	Sailors, Gibson Bonder
1:15 – 1:25	Review Executive Order	Sailors
1:25 – 1:45	Oregon Health Fund Board Delivery System recommendations to guide HIIAC	Sailors or Smith, Edlund
1:45 – 2:00	Revisiting the Vision: draft(s)	Pettit
2:00 – 3:00	<i>Committee Work:</i> Review Input and Synthesize Recommendations	Gibson, Pettit & All
3:00 – 3:15	BREAK	All
3:15 – 4:30	<i>Committee Work:</i> Select Criteria and Prioritize Recommendations	Gibson, Pettit & All
4:30 – 4:50	Public Testimony (ad hoc or prepared)	Any welcome!
4:50 – 5:00	Wrap-up and next meetings: 6.19.08 @ PSOB	Sailors, Gibson

~If you have suggestions, please notify us jody.pettit@state.or.us or mobile 503.706.2208~



EXECUTIVE ORDER NO. 08-09

**GOVERNOR'S HEALTH INFORMATION INFRASTRUCTURE
ADVISORY COMMITTEE**

Health care providers need full access to an individual's health information to make the best health care decisions possible. The fragmentation of Oregon's health information system, however, prevents health care providers from quickly and efficiently accessing health information when it is most needed. Currently, health information is stored across a wide array of disconnected paper and computerized systems. Without a standardized system for exchanging health information, health care providers are forced to practice based on incomplete information or to order duplicative and costly medical tests and procedures.

Creating a secure, computerized health information system that streamlines access to each individual's medical history will enable health care providers to quickly and efficiently access health information. Such a system will improve the delivery of care in the doctor's office, reduce medical errors and save patients money by decreasing the number of inappropriate and duplicative treatments. A health information system would also enable consumers to be more proactive in managing their own health care and wellness. Finally, health information technology offers great promise as a means of providing rural and underserved areas with additional health care access through technologies such as telemedicine.

NOW THEREFORE, IT IS HEREBY DIRECTED AND ORDERED:

1. The Governor's Health Information Infrastructure Advisory Committee (the "HIIAC") is established. The HIIAC shall replace the Oregon Health Information Security and Privacy Collaborative within the Office for Oregon Health Policy and Research.
2. The HIIAC shall be comprised of no more than 23 members, appointed by the Governor. Membership shall include representatives from the public, the health care provider community, health care insurance plans, public health organizations, safety-net health care providers, the information technology field, the research community and academia.
3. To develop a strategy for the implementation of an Oregon health information system, the HIIAC shall:



EXECUTIVE ORDER NO. 08-09
PAGE TWO

- a. Review and identify obstacles to the implementation of an effective health information exchange infrastructure in Oregon and provide policy recommendations to remove or minimize those obstacles;
 - b. Outline the role of the State in developing, financing, promoting and implementing a health information infrastructure;
 - c. Recommend how to facilitate the statewide adoption of health information system standards and interoperability requirements to enable secure exchange of health information exchange;
 - d. Monitor the development of federal and applicable international standards, coordinate input to the Nationwide Health Information Network, and ensure that Oregon's recommendations are consistent with emerging federal and applicable international standards;
 - e. Identify partnership models and collaboration potential for implementing electronic health records and exchange systems, including review of current efforts in the state and opportunities to build upon those efforts;
 - f. Recommend a plan for the creation of a health information infrastructure that preserves the privacy and security of Oregonian's health information, as required by state and federal law; and
 - g. Develop evaluation metrics to measure the implementation of health information technology and the efficacy of health information exchange in Oregon.
4. The Governor will appoint a chair of the HIIAC. The chair shall establish an agenda for the HIIAC and provide leadership and direction.
5. A quorum for HIIAC meetings shall consist of a majority of the appointed members. The HIIAC shall strive to operate by consensus; however, the HIIAC may approve measures and make recommendations based on an affirmative vote of a majority of members.
6. No member may grant a proxy for his or her vote to any other member or member designee. The Governor will fill any vacancy on the HIIAC by appointment.



EXECUTIVE ORDER NO. 08-09
PAGE THREE

7. The HIIAC shall provide an initial written report of findings and recommendations to the Oregon Health Fund Board on or before July 31, 2008. The HIIAC shall provide an initial written report of findings and recommendations to Governor on or before December 31, 2008, and annually thereafter.

8. The Governor's Office and the Office of Health Policy and Research shall provide staff support to the HIIAC. All other state agencies shall provide necessary assistance to the HIIAC upon request.

9. The members of the HIIAC shall receive no compensation for their activities as members of the HIIAC, but may be reimbursed for travel expenses incurred in attending HIIAC business pursuant to ORS 292.495(2) and subject to availability of funds.

10. This Order expires on December 31, 2014.

Done at Salem, Oregon, this 27th day of March, 2008.



A handwritten signature in black ink, appearing to read "Theodore R. Kulongoski".

Theodore R. Kulongoski
GOVERNOR

ATTEST:

A handwritten signature in black ink, appearing to read "Bill Bradbury".

Bill Bradbury
SECRETARY OF STATE

HEALTH INFORMATION INFRASTRUCTURE ADVISORY HIIAC

By-Laws

ARTICLE I

The Board and its Members

- The Health Information Infrastructure Advisory HIIAC (hereinafter “HIIAC” or “HIIAC”) is created pursuant to Executive Order 08-09, signed by Governor Kulongoski on March 27, 2008. The HIIAC’s function is to “develop a strategy for an Oregon health information system”.
- The Office for Oregon Health Policy and Research (OHPR) will support the work of the HIIAC in a manner mutually agreed upon by the HIIAC Chairs and members.
- The Members of the HIIAC shall be appointed by the Governor in accordance with Executive Order 08-09. HIIAC Members shall serve staggered terms of up to three-years. A Member whose term has expired, but whose successor has not been appointed and confirmed, may continue to serve until replaced.
- Members of the HIIAC are not entitled to compensation for services as a Member, but are entitled to expenses as provided in ORS 292.495(2).

ARTICLE II

Board Officers and Duties

- The Governor shall select a Chair or Co-Chairs from among the Members. The terms of office shall be 12 months.
- Duties of the Chair(s) are:
 - Preside at all meetings of the HIIAC.
 - Coordinate meeting agendas after consultation with staff.
 - Review all draft HIIAC meeting minutes prior to the meeting at which they are to be approved.
 - Be advised of all presentations or appearances of staff before Legislative or Executive HIIACs or agencies that relate to the work of the HIIAC.
 - The Chair may designate, in the absence of the Co-Chair or when expedient to HIIAC business, other HIIAC Members to perform duties related to HIIAC business such as, but not limited to, attending other agency or public meetings, meetings of HIIACs of the HIIAC, training programs, and approval and review of documents that require action of the Chair. In such cases, the HIIAC Member assigned the responsibility will be entitled to expenses as provided in ORS 292.495(2).

ARTICLE III

IIIAC Work Groups

- The HIIAC may establish work groups to undertake work chartered by the HIIAC. The work groups may include HIIAC Members and other persons with particular expertise and interest in the work of the group. A work group shall cease to exist upon a majority vote of the HIIAC to disband the work group
- The Chairs of work groups created by the HIIAC shall be Members of the HIIAC.

ARTICLE IV

Board Meetings

- The HIIAC shall meet at the call of the Chair in consultation with the HIIAC Members and staff or at the call of the majority of the Members. The HIIAC shall meet at least quarterly.
- The HIIAC and work groups established by the HIIAC shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws.
- The preliminary agenda will be available from the HIIAC staff and posted on the HIIAC website [*TBD*] at least two working days prior to the meeting. The final agenda will be established at the beginning of each HIIAC meeting.
- Twelve (12) HIIAC Members shall constitute a quorum for the transaction of business.
- All actions of the HIIAC shall be expressed by motion or resolution. Official action by the HIIAC requires the approval of a majority of a quorum of the Members of the HIIAC.
- On motions, resolutions, or other matters a voice vote may be used. At the discretion of the Chair, or upon the request of a HIIAC Member, a roll call vote may be conducted. Proxy votes are not permitted.
- If a HIIAC Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent HIIAC Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the HIIAC who speaks during the meeting. A HIIAC Member participating by such electronic means shall be considered in constituting a quorum.
- HIIAC Members shall inform the Chair with as much notice as possible if unable to attend a scheduled HIIAC meeting. HIIAC staff preparing the minutes shall record the attendance of HIIAC Members at the meeting for the minutes.
- The HIIAC will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE V

Amendments to the By-Law and Rules of Construction

- These By-laws may be amended upon the affirmative vote of fifteen (15) Members of the HIIAC. All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

Delivery Systems Committee Report

Revised Executive Summary

DRAFT for Discussion 5/21

NOTE: The underlined language reflects Committee discussion on 5/14 but the exact language has not yet been approved by Committee members

Background

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations on specific aspects of the reform plan. One of these committees, the Delivery Systems Committee, was assigned the difficult task of providing the Board with policy recommendations to create high-performing health delivery systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

While the Oregon Health Fund Board did not aim to limit the scope of the investigation and recommendations from the Delivery Systems Committee, the Committee's charter from the Board listed a number of priority areas of interest. These included: revitalizing primary care; managing chronic disease; developing new reimbursement models; increasing information transparency by collecting, measuring and reporting quality data; encouraging the diffusion of health information technology; ensuring the appropriate diffusion and utilization of clinical technology; strengthening public health and prevention; and improving end-of-life-care (See Appendix A for Delivery Systems Committee Charter).

Vision Statement

The Delivery Systems Committee has a bold vision for health care in Oregon: World Class Health Care for Each Oregonian. This includes world class physical, mental and oral health. Achieving world class care requires a radical transformation of Oregon's health care delivery system, as part of larger comprehensive reform. This must include a revitalization of primary care and focus on preventing and managing chronic diseases, while improving the quality of care across the health care system. The people and the economy of the state cannot wait any longer - transformation is needed now.

Delivery System Change as Part of Comprehensive Reform

The Committee developed a series of recommendations which the members believe will help to contain costs over the long-term, while improving population health and improving patient experience with care. Many of these recommendations are aligned with the Board's priority areas, with some additional ideas drawn from health service research and experience in other states. The main recommendations are captured in the Committee's "Framework for Delivery System Reform" presented in the next section. The Delivery System Committee recognizes that most of the recommendations put forth in this report represent long-term goals that cannot be accomplished in isolation and must be viewed as one piece of larger reform. In the short-term, many of the recommendations that follow will require an investment in sustainable change and the Health Fund Board must look for opportunities to reduce short-term spending in other parts of the system that can be reinvested in delivery system reform.

The recommendations presented below call for transformational change in the fundamental way things are done. The recommendations represent a significant cultural change in the organization and delivery of care and require strong public/private partnerships in the design, delivery, and monitoring of health care services. The Committee recognizes that there will be strong opposition to many of its proposals and challenges the Health Fund Board, the Oregon Legislature and the entire state to have the political will to push for the changes needed to move Oregon towards a world class health system.

Committee Recommendations

Primary Care and Chronic Disease Management/Integrated Health Homes

Primary Care/Integrated Health Homes Recommendation 1: Oregon's primary health care delivery system must be radically transformed in an effort to improve individual and population health and wellness. This transformation should be guided by the concept of the integrated health home and must involve a revitalization of primary care, as well as other health and social services that are vital components of a system equipped to meet the health needs of the population. The state should take bold steps to partner with consumers, providers, purchasers and payers around the common goal and vision of providing every Oregonian with an integrated health home.

Primary Care/Integrated Health Homes Recommendation 2: Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Board Program, with eventual

statewide adoption to ensure integrated health homes are available to all Oregonians.

Primary Care/Integrated Health Homes Recommendation 3: Create and support interactive systems of care (real and virtual) which connect integrated health homes with community-based services, public health, behavioral health (including Employee Assistance Programs), oral health, and social services to improve population health.

Primary Care/Integrated Health Homes Recommendation 4: Provide Oregon's health care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes.

Primary Care/Integrated Health Homes Recommendation 5: Develop a plan to ensure that Oregon has a workforce able to meet population need, especially those serving vulnerable populations.

Primary Care/Integrated Health Homes Recommendation 6: Develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.

Primary Care/Integrated Health Homes Recommendation 7: Develop funding, payment and incentivizing strategies that promote and sustain integrated health homes and other system of care partners.

Primary Care/Integrated Health Homes Recommendation 8: Recognize and strengthen the role of the safety net in delivering services to Oregon's vulnerable populations.

Improving Quality and Increasing Transparency

An Oregon Quality Institute

While there are numerous public and private efforts underway across the state to improve health care quality, SB 329 points to the need for a Quality Institute to serve as a leader and to unify existing efforts in the state around quality and transparency. The Committee recommends the state establish and provide substantial, long-term funding for a publicly chartered Oregon Quality Institute (See Appendix C for full Quality Institute Work Group Recommendations).

Quality Institute (QI) Recommendation 1: An Oregon Quality Institute should be established as a publicly chartered public-private organization. The state should provide stable long-term funding to support the Institute.

QI Recommendation 2: The Quality Institute’s overarching role will be to lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency.
2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services
3. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.
4. Ensure the collection and timely dissemination of meaningful and accurate data about providers, health plans and patient experience. Set standards for what metrics are collected and reported and how data is collected and reported. Set performance benchmarks that can be adapted over time.
5. Advise the Governor and the Legislature on policy changes/regulations to improve quality and transparency.

QI Recommendation 3: As the budget of the Quality Institute allows, the Board of the Quality Institute should use data and evidence to identify opportunities to improve quality and transparency through the following activities:

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects.
- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures.

- Lessen the burden of reporting that currently complicates the provision of health care.
- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement.
- Align with recommendations of the Governor’s Health Information Infrastructure Advisory Committee (HIIAC) about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. Support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers.
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions.

Financial Transparency

There needs to be greater transparency about health care costs and provider operating and financial data. While there are a number of state-sponsored projects working to increase financial transparency in Oregon, access to this type of information remains limited.

Financial Transparency Recommendation 1: Require health care providers, including but not limited to hospitals, ambulatory surgery and imaging centers to be more transparent and public about fiscal information.

Accountable Care Districts

Accountable care districts will act as a vehicle to foster shared accountability for quality and cost among all of the providers (including physicians, other health care professionals, hospitals, and other centers where health care is delivered) serving a defined population across the continuum of care.

Accountable Care District (ACD) Recommendation 1: Define accountable care districts within Oregon’s delivery system. All health care quality and utilization data reported by the Oregon Quality Institute will be aggregated to

allow for meaningful comparisons of quality and utilization across the state and across ACDs.

ACD Recommendation 2: Engage and incentivize communities at the onset, to use ACD data to inform health planning and resource utilization discussions.

Payment Reform Models

The current healthcare delivery system relies heavily on a fee-for-service (FFS) payment method in which a provider is paid a fee for rendering a specific service. This system rewards providers based on the volume of care delivered, without including incentives that encourage high-quality care and efficient resource utilization. New reimbursement models are needed that incentivize health care providers to be accountable for quality, efficiency and care coordination.

Payment Reform Recommendation 1: Health care providers (physicians, other health care professionals, hospitals, and other centers delivering care) should be accountable for quality, efficiency, health outcomes and care coordination. Payment reform should be designed to incentivize these desired outcomes, while holding global Oregon health care costs to Consumer Price Index as measured over a five year period.

Payment Reform Recommendation 2: New payment models should be tested within the infrastructure established by delivery system reform.

Comparative Effectiveness and Medical Technology Assessment

Comparative effectiveness research provides valuable information about the relative effectiveness and cost-effectiveness of alternative treatment options. This information can be used to develop standard clinical guidelines and inform benefit design to ensure that health resources are utilized in a manner that maximizes health gains. There are currently a number of comparative effectiveness and medical technology assessment initiatives in place in Oregon and across the nation, but no mechanism to facilitate collaboration across efforts or to ensure that coverage decisions across the state are informed by the best available research and data.

Comparative Effectiveness Recommendation 1: Streamline and strengthen efforts to support comparative effectiveness research and ensure policy decisions are informed by the best available evidence.

Comparative Effectiveness Recommendation 2: Endorse patient decision aids shown to increase the use of cost-effective care.

Comparative Effectiveness Recommendation 3: Develop standard sets of evidence-based guidelines for Oregon based on comparative effectiveness research.

Comparative Effectiveness Recommendation 4: Develop common policies across public and private health plans regarding the coverage of new and existing treatments, procedures and services based on comparative effectiveness research.

Comparative Effectiveness Recommendation 5: Develop higher standards of immunity from litigation for providers who utilize evidence-based medicine, including evidence-based decision aids and standardized clinical guidelines.

Shared Decision Making

In a world class health system that delivers patient-centered care, providers work with patients and their families to make health care decisions aligned with their values and goals. Decision support processes can help patients understand the likely outcome of various care options, think about what is personally important about the risks and benefits of each option and make decisions with the support of their care team.

Shared Decision Making Recommendation 1: The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should develop or endorse evidence-based standardized decision support processes for integrated health homes and other care settings, which account for patients' cultural, ethnic, racial and language needs.

Shared Decision Making Recommendation 2: New payment methods should be used to encourage providers in state funded and private health programs to use decision making support processes and reimburse them for time spent engaged in tasks associated with these processes.

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Shared Decision Making Recommendation 4: A statewide electronic Physician Orders for Life Sustaining Treatment (POLST) Registry should be created to ensure the availability of the POLST form at the time of need.

Public Health, Prevention and Wellness

Three in five deaths in Oregon are from heart disease, stroke, cancer, diabetes and chronic lower respiratory diseases and these diseases cost the state more than \$1.4 billion every year. With better funded, evidence-based community efforts to detect and treat risk factors, a significant amount of chronic disease could be prevented, thus improving population health and reducing utilization of expensive and invasive acute treatments.

Public Health Recommendation 1: The state should partner with public and private stakeholders, employers, schools and community organizations to establish priorities and develop aggressive goals for the prevention of chronic disease and other physical, oral and behavioral health conditions and reduction of unhealthy behaviors that contribute most to the mortality of Oregonians.

Public Health Recommendation 2: The state should partner with local boards of health (including public and mental health), providers, employers, schools, community organizations and other stakeholders to develop a statewide strategic plan for achieving these goals and a process for evaluating progress toward these goals.

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Administrative Simplification and Standardization

Administrative expenses account for a large percent of total health care spending and there are significant opportunities to contain costs by increasing administrative efficiency.

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Reduced Pharmaceutical Spending

Pharmaceuticals account for eleven percent of total health care spending in Oregon.¹ Bulk purchasing arrangements established by purchasers and insurers can help reduce the cost of drugs and reduce overall health care spending.

Reduced Pharmaceutical Spending Recommendation 1: Utilize bulk purchasing arrangements to maximize savings in pharmaceutical spending.

DRAFT

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DRAFT

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**Oregon Health Policy
Commission**



**Report to the 73rd Legislative
Assembly: Electronic Health
Records & Data Connectivity**

March 2005

Report to the 73rd Legislative Assembly: Electronic Health Records & Data Connectivity

Prepared by:

The Electronic Health Records & Data Connectivity Subcommittee

Reviewed and endorsed by:

The Oregon Health Policy Commission

If you have any questions, or if you need this material in an alternate format, please call (503) 378-2422

Department of Administrative Services
Office for Oregon Health Policy and Research
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HISTORY

The 2003 Oregon Legislative Assembly passed House Bill 3653, creating the Oregon Health Policy Commission (OHPC) to develop and oversee health policy and planning for the state. The OHPC identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Oregon State Legislature and the state Office for Oregon Health Policy and Research. Additionally, the OHPC partners with health care experts and stakeholders around the state to develop projects focused on improving Oregonians' health status and access to effective and efficient health care services.

The OHPC Subcommittee on Electronic Health Records (EHR) and Data Connectivity was formed to develop recommendations for 1) fostering the adoption of EHR and 2) developing the infrastructure for the secure exchange of electronic health data in Oregon. The following report outlines the Subcommittee's recommendations on the appropriate role for government, in conjunction with the private sector, to further these efforts. It is the intent of the OHPC and the Subcommittee that these recommendations be used to further discussion with state legislatures, providers, and other stakeholders to move the state's health information technology forward.

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EXECUTIVE SUMMARY

Although the United States has one of the most technologically advanced health care systems in the world, it relies predominantly on a 19th century record keeping system.¹ This antiquated paper-based record keeping system and the barriers it imposes on appropriate data sharing is a source of harm and excess costs to Oregonians. The State of Oregon can assist substantially in transformation of the system by adopting electronic health records (EHRs) and health information exchange.

Electronic health records and health information exchange are part of the solution to improve quality and safety, and reduce the cost of care.¹¹ Fully functioning electronic health records make health data manageable, offer support for provider decisions at the point of care, such as reminders or drug-drug alerts, allow for input of orders by providers, and facilitate population-wide reporting and assessments.¹⁴ The electronic health record can reduce redundant, unnecessary medical tests as much as 15-20% within a hospital or outpatient setting. In all, electronic health records with the necessary functionality are estimated to save up to \$44 billion for the United States as a whole, a number confirmed in some early studies.¹⁷⁻¹⁹

Adoption of electronic health records is not enough. Even when computer systems are used, most of the information is stored in silos and is not easily available to other providers. Creating a system with widespread health information exchange and interoperability is necessary to transfer information in urgent situations quickly and easily and to further improve efficiency and reduce waste in health care. This does not mean a centralized database containing all data, but the ability to confidentially, privately, and securely share data between healthcare entities when appropriate.

Most of the investment in EHR/Connectivity infrastructure will come from redirecting dollars already in the system but wasted on inefficient processes. Even the smallest of investment now by the State of Oregon to support collaboration and coordination will assure maximum benefit from the private sector investments currently underway.

Goals

- Oregonians' health record information is available to them and their healthcare provider anytime and anywhere that it is needed.
- Oregonians' health records are confidential and secure at all times.

These goals are best achieved through widespread adoption of robust, secure, interoperable electronic health records that support the delivery of high-quality efficient health care.

Recommendations

Standards: Endorse and encourage the use of national and federal standards for EHRs and adopt specific standards as they emerge.

Coordinated Regions: Embrace a partnership model with communities to foster a coordinated regional framework for sharing electronic health information.

Financing: Embrace a partnership model with business leaders in the health and information industries to better understand the costs and benefits of adopting EHRs that efficiently exchange information.

Regulations & Laws: With the assistance of pertinent stakeholders and professional liability experts, determine whether any Oregon laws or regulations create barriers to implementation of interoperable EHRs or are inadequate to protect privacy and remedy them.

Healthcare Purchaser: Coordinate with private sector healthcare purchasers to leverage resources that encourage investment in information technology, with particular attention to the Public Employees Benefit Board (PEBB) and the State of Oregon's Office of Medical Assistance Programs (OMAP)

Monitoring & Assurance: Commission a study, alone or with partners such as the Oregon Medical Peer Review Organization (OMPRO) and business leaders, that assesses the current state of adoption of interoperable EHR functionality in medical practices throughout Oregon. The State should be particularly attentive to rural communities and the safety net providers.

Engaging the Public and Public Expectations: Coordinate with the private sector to conduct communication campaigns that increase the public's understanding of the value of electronic health data that can be shared.

Public Health, Research, and Outcomes Reporting: Collaborate with the private sector to assure that interoperable EHRs are used to support good policy development, decision-making and planning through its public health infrastructure. Participate in research that evaluates successes and failures of interoperable EHRs.

Education and Training: Coordinate with health professions training institutions and health professions leadership groups to increase the workforce's understanding and skills in managing electronic health information and systems.

Pilot Projects: Participate in collaborative demonstration and pilot projects that accelerate the adoption of interoperable EHRs in Oregon and assure broad application to leverage public and private resources.

Leadership & Governance: The State of Oregon needs a high-level, visible, respected Health Information Technology Coordinator, a Health Information Technology Advisory Board of experts and appropriate staff dedicated to carrying out these recommendations, who are accountable to the Director of the Oregon of Health Policy & Research (OHPR) and the Oregon Health Policy Commission.

Although the State does NOT have a role in the governance of and actual operations of the regional networks that exchange information, the State should have a catalyst role in creating an environment in which such organizations can thrive.

REPORT ON ELECTRONIC HEALTH RECORDS AND DATA CONNECTIVITY

Introduction

Although the United States has one of the most technologically advanced health care systems in the world, it relies predominantly on a 19th century record keeping system.¹ This antiquated paper-based record keeping system and the barriers it imposes on appropriate data sharing is a source of harm and excess costs to Oregonians. The State of Oregon can assist substantially in transformation of the system by adopting electronic health records and health information exchange. This report explores the benefits and barriers to adoption of these information technologies.

Background

While the knowledge and technology in the United States health care system is unparalleled, there are serious questions about the quality and equity of care delivered. For instance, a patient with an illness where there is known treatment, such as life-saving medications after heart attack, only receives appropriate care 54.9% of the time.² Medical errors occur in at least 7% of hospital admissions, and lead to serious injury in about 3.7% of total hospitalizations.^{3,4} These quality and safety problems result in about 57,000 deaths, 41 million sick days, and \$11 billion in lost productivity annually.⁵ Rising costs have pushed the expenditures for health in the US to \$1.7 trillion, or 15% of GDP, in 2003; Oregonians spend approximately 1% (\$17 billion) of this amount. Inefficiencies in the system itself may lead to over \$100 billion worth of redundant, unnecessary, or inappropriate care, or \$1 billion in Oregon.⁶⁻⁹ A large portion of this – estimated at \$77.8 billion nationwide and approximately \$800 million in Oregon - comes from the fragmentation and gaps in the system.⁸

Although there are many factors underlying these problems, many (though not all) of them center around inadequate access to information, which in turn results in waste, fragmentation of care, poor quality, and errors. A recent study, for example, showed that missing information compromises as many as 13% of all clinical encounters, and while half of the time the needed information is available somewhere, the 5-10 minute penalty to obtain it is too burdensome for the busy physician.¹⁰ Thus, while computers and the Internet are virtually ubiquitous in our society, and most modern industries have used them to improve their processes and the quality of their products, the health care system remains mired in a world of paper-based transactions. There is considerable evidence this reliance on paper leads to waste and compromised quality of care.

Consider the typical Oregonian almost anywhere in the world. He or she may easily access bank records, obtain appropriate credit, and receive necessary documents electronically. That same person back home, who is acutely ill and sent to a emergency room in a different part of Portland, does not have a similar mechanism to get her medical records, leading to delays, confusion, and potentially deadly outcomes if given a normally appropriate drug cross-reactive to one of her listed allergies.

For these reasons, the Institute of Medicine, the Department of Health and Human Services and multiple others have called for a more connected, structured system of care to address these problems. Electronic health records and health information exchange are part of the solution to improve quality and safety, and reduce the cost of care.¹¹ However, the barriers to their adoption are

significant. Furthermore, public perception that electronic health records pose a threat to privacy remains strong, while financial models show misaligned incentives. Careful action by state government and other interested parties is required to catalyze these changes and lower the barriers.

What is an electronic health record and why promote it?

An electronic health record is not a computer or separate database about patients; rather, an electronic health record is a longitudinal collection of electronic health information for and about persons and the way to create, use, store and retrieve that information.^{12, 13} A fully functioning electronic health record provides the ability to make health data manageable, offer support for provider decisions at the point of care, such as reminders or drug-drug alerts, allow for input of orders by providers, and facilitate population-wide reporting and assessments, amongst other things.¹⁴ It must also provide security to ensure privacy and confidentiality of patients while enabling easy communication between the health care team.

These important functions have been shown to improve safety and reduce cost and the waste of health care dollars. Electronic health records make patient information immediately available to all who have access, reducing costs of transcription and time searching for charts. This is a major issue in the United States, which ranks the worst of several countries in redundant testing and availability of the medical record in a recent comparison.¹ The electronic health record can reduce redundant, unnecessary medical tests as much as 15-20% within a hospital or outpatient setting. Financially, systems can help reduce billing errors and prevent fraud through improved documentation and administrative checklists.

Most significant, however, is the effect of decision support and computerized provider order entry (CPOE) on patient safety. Decision support through alerts about patient allergies and drug interactions has been shown to reduce adverse events, or preventable injuries to patients. Reminders about best practice, such as electronic guidelines or protocols, can help improve the delivery of appropriate care and reduce inappropriate care.¹⁵ CPOE – having physicians and other providers enter patient orders in a structured, electronic format – has been shown to have many benefits over written orders.¹⁶ Improved legibility and accountability due to CPOE can reduce some significant errors such as misreading the placement of a decimal point or confusing names of drugs (Lamisil[®] for fungal infections and Lamictal[®] for brain disorders, for instance). Improved adherence to guidelines for critical issues such as screening, corollary orders to ensure safety, and appropriate selection of antibiotics has clearly been proven to improve the quality and safety of care delivered. Safety also can be increased by preventing potentially injurious medication orders through drug-drug interaction and allergy checking at the time of ordering, benefits beyond those engendered by decision support alone. Such efforts reduce costs for the health system as a whole. In all, electronic health records with the necessary functionality are estimated to save up to \$44 billion for the United States as a whole, a number confirmed in some early studies.¹⁷⁻¹⁹

Barriers to electronic health records

Despite these potential benefits, no more than 15% of physicians nationwide use fully functional electronic health records.²⁰ In a recent poll, 47% percent of the public was concerned that privacy and confidentiality risks outweighed benefits in electronic health records.²¹ Although many assessments indicate electronic data – with appropriate security – can protect privacy well,²² the

perception of risk remains a significant barrier to adoption. Increased availability of data does carry with it increased responsibility for each participant in the health system. Audit trails and penalties for misuse can be used to enforce responsible data access and use; in fact, electronic record-keeping will allow patients to continually monitor who is accessing their health records, a thing which is impossible with a paper system.

In addition to the privacy and confidentiality concerns, other barriers exist to easy adoption. First and foremost is the financial barrier. Per provider, the initial costs are between \$10,000 and \$20,000 in the first year with substantial maintenance costs in the subsequent years; a medium-sized hospital's initial costs have been estimated at \$2.7 million. The cost problem is further exacerbated by misaligned financial incentives—research shows only 11% of the benefits go back to the provider, yet the vast majority of costs for effective systems are borne by providers or health systems.²³ Implementation of electronic health records in clinical settings can also be challenging, requiring practices to assess readiness and be prepared for temporary changes in productivity;²⁴ failure to consider these issues have led to significant system disappointments.^{23, 25} The complex legal and regulatory environment also poses a significant barrier, and these will need clarification prior to more widespread adoption.

Appropriate availability of health information: Health information exchange

Adoption of electronic health records is not enough. Even when computer systems are used, most of the information is stored in silos and is not easily available to other providers, leading to the problems outlined above. Creating a system with widespread health information exchange and interoperability is necessary to transfer information in urgent situations quickly and easily and to further improve efficiency and reduce waste in health care. Unlike many other industries, however, most communities and organizations do not possess the ability to transmit the important data easily even when needed urgently. Current systems rely on patient data faxed by humans, an unacceptably slow and error prone method. Digital information exchange, besides requiring electronic health records, requires interoperability, or the ability of disparate information systems to operate in conjunction with each other through shared or translated protocols and standards. Like other industries, however, this does not mean a centralized database containing all data, but the ability to confidentially, privately, and securely share data between healthcare entities when appropriate.

Those with experience in health information exchange have shown substantial benefits from its use. Consumers who switch physicians, insurers or simply seek emergent care will no longer suffer from delayed or lost medical records. Another benefit is the reduction of redundant laboratory tests for patients who seek care in different settings; between 8.6% and 20% of tests could be avoided if the information were available, saving up to \$31.8 billion per year in medical costs nationally.^{9, 15} Reduction in redundant radiology studies through digital transmission of reports and, eventually, the films themselves may save up to \$3.2 billion per year. Connections to pharmacies could help generate better medication lists, reduce adverse effects from drug interactions, and speed prescription filling. Referral processes could be improved, communication between providers would be more robust, and transitions of care (such as between clinic and hospital) would be safer for patients, saving up to \$31.2 billion. Connection to the public health system could provide more timely information about disease and bioterrorism outbreaks, allowing for more rapid response and the potential to save many lives. The focus on bioterrorism makes the ability to react quickly and

appropriately – using good information – to threats to safety and security is very important. Health information exchange can assist in that process, save lives, and reduce costs. In all, \$77.8 billion might be saved if the highest level of information exchange is adopted in the United States.⁸

Barriers to health information exchange

Barriers to health information exchange exist. Costs are substantial and especially in smaller communities, may outweigh the benefits accruing directly to them in the short term, despite the significant societal benefits. Creation of connections to share data requires expensive, specialized technical interfaces. The variability of the system plays a role here – few common standards or frameworks are in place to allow the sharing of data.⁸ This has two implications beyond cost – one, gaining interoperability of systems will require time and effort in the development of standards or frameworks, and two, standards cannot be created externally (for example, by states) without seriously impairing the efforts of purchasers of electronic health records and those striving for health information exchange. Rather, frameworks that allow interoperability must be created through the collaboration of stakeholders. Concerns for privacy, security, confidentiality, and appropriate use are paramount in health information exchange as a whole, since the information will be more easily accessed; these risks currently require careful legal assessment and the formation of robust agreements between sharing entities. Infrastructure issues such as the accessibility of reliable, fast electronic connections plague many rural areas. Like electronic health records, the long-term benefits of health information exchange extend primarily to the payers (such as private insurers) and purchasers as a whole. Thus, those asked to make a substantial initial investment in the system – the providers – would *not* be the primary recipients of the benefits in the long run. In the short term, the system must be created – at significant cost – prior to any benefits being realized; the barrier of obtaining start-up funding must be addressed at every level of the health care system.

Current efforts

In light of the proven benefits of electronic health records and health information exchange, a myriad of federal, state and private efforts have been launched. These efforts take many forms, but generally attempt to reduce barriers through financial or regulatory means. External to Oregon, purchasing collaboratives such as the Leapfrog Group²⁶ and Bridges to Excellence²⁷ have launched campaigns to increase adoption of electronic health record and health information exchange through the creation of specifications for high quality care (e.g. presence of CPOE) and future financial incentives for doing so. Payers such as Massachusetts Blue Cross / Blue Shield have contributed \$50 million to enable sharing between providers in the hopes of recouping their expenditures through reduced future costs. In addition, the multiple organizations concerned with the quality and safety of health care such as the National Quality Forum, the Agency for Healthcare Quality, and others recognize the benefits of electronic health records and health information exchange in achieving higher quality care and have funded a variety of projects related to barrier reductions. The 'pay for performance' initiatives – altering payment strategies based on adherence to quality measures - began by the Centers for Medicare and Medicaid Services (CMS) and other payers all have need of standardized, appropriately shared electronic information. Similarly, the Doctor's Office Quality – Information Technology (DOQ-IT) initiative from CMS recognized the need for electronic health records to ensure high quality care in the outpatient settings, changing its initial aims from performance reporting to electronic health record deployment. California and other

states have analyzed local and state laws to determine what liability exists and to limit liability wherever possible.

A key federal action was the appointment of a Health Information Technology Coordinator, Dr. David Brailer, and the creation of a special office within the federal government to facilitate the adoption of electronic health record and health information exchange. Dr. Brailer has had private and public experience, providing quality information through technology to hospitals through a private venture and spearheading the public health information exchange efforts in Santa Barbara. Federal regulations such as those outlined in the Health Information Portability and Accountability Act of 1996 (HIPAA) have helped move standards for exchange forward by formally adopting appropriate standards for payer-provider electronic claims. The infrastructure created as a result of HIPAA to protect privacy, confidentiality, and security of data will be useful to form health information exchange agreements and keep the public informed. In addition, a number of states have adopted or are considering adoption of legislation that would attempt to further the integration of information technology into the practice of medicine. These activities range from formation of centers to study health information exchange to financial incentives for exchange (such as tax credits) to creations of actual networks for health information sharing.

Opportunities for Oregon in electronic health records and health information exchange

Oregon possesses many potential advantages, but does not escape from the barriers. Advantages include a number of innovative groups who seek quality and a rational health system. The state itself, through the Public Employees' Benefit Board (PEBB) and the Oregon Medical Assistance Program, has long explored new avenues to improve access, cost, and quality. Recently, the work that PEBB is doing in exploring new incentives for quality and cost-effective care was commended on a national level.

The efficiencies in the health care system gained by adoption of electronic health records and health information exchange would improve the competitiveness of Oregon's economy. Rapidly increasing health care costs create burdens on business, increasing their costs and narrowing their margins. By aggressively pursuing health information technology and achieving the gains denoted above, the State of Oregon can reduce this burden on business, making Oregon more attractive for future investors. Since multiple other states are already engaged in this process, Oregon stands to benefit from their example by carefully examining their work and avoiding their costly mistakes. The time to act is now.

Health care purchasers are organized and eager to see a transition take place. Many of the large health systems in Oregon, such as Kaiser Permanente Northwest, Providence, PeaceHealth, and OHSU, are recognized for their significant contributions to changing health care delivery for the better, including innovations in medical informatics and electronic health record use. Provider groups from the Mid-Valley IPA and around Roseburg are actively seeking to adopt electronic health records and trying to reduce the barriers to connectivity agreements.

The infrastructure and capacity to deploy in Oregon should be put to use. An innovative group of independent telephone companies, cooperatives, cable companies, wireless companies and competitive access service providers offering an extensive mix of voice, video and data services

serves Oregon communities. Catalyzed by SB 622, multiple optical fiber networks were created and deliver reliable but underutilized high capacity digital services throughout the state. These are valuable assets for healthcare delivery (especially in rural Oregon), but infrastructure only adds value when it is put to use.

The State of Oregon can play an extremely important role as a catalyst in this process. Many barriers remain. Cost is a pre-eminent concern in Oregon, and collaboration between all manner of stakeholders will be needed to address the significant cost of starting and maintaining electronic health records and health information exchange. Legal and privacy uncertainties in the state still hinder efforts. Lack of public awareness of the benefits of information technology in health care slows progress. This report contains specific recommendations for how the State of Oregon can act to speed this process and benefit all its constituents.

RECOMMENDATIONS

States including Maryland, Florida, Wisconsin, and Tennessee are investing funds to build infrastructure for interoperable electronic health records. Oregon should too, although the Subcommittee recognizes the serious state budget constraints during this biennium. The Subcommittee also recognizes that the most fruitful recommendations at this time are those that set a long-term direction and seek to do the most with current available funding. Most of the investment in EHR/Connectivity infrastructure will come from redirecting the dollars already in the system and wasted on inefficient processes. Even the smallest of investment now by the State of Oregon to support collaboration and coordination will assure maximum benefit from the private sector investments currently underway. Following are the subcommittee's recommendations for the State to provide leadership in the development of Oregon's health information infrastructure.

Goals

Adopt the following goals to support high quality health care:

Oregonians' health record information is available to them and their healthcare provider anytime and anywhere that it is needed.

Oregonians' health records are confidential and secure at all times.

These goals are best achieved through widespread adoption of robust, secure, interoperable electronic health records that support the delivery of high-quality efficient health care.

Principles for Recommending the State Role

Standards

Endorse and encourage the use of national and federal standards for EHRs and adopt specific standards as they emerge. In this rapidly evolving field, it is vital that state government NOT independently pursue standard setting. The State has an essential role in helping Oregon's innovators contribute to the creation of, and be knowledgeable about, emerging federal standards, industry standards and leading-edge efforts by innovators outside of Oregon. In the absence of standards, the State's primary role is to embrace a partnership model with the private sector to facilitate cooperation and common approaches to interoperability.

Coordinated Regions

Embrace a partnership model with communities to foster a coordinated regional framework for sharing electronic health information. Developing too many regions will waste resources in duplicative efforts; developing too few regions will inhibit creation of trusted partnerships of stakeholders across the care spectrum. Community-based initiatives are rapidly emerging. The State must make a substantial investment in bringing these community-based projects together for coordination, efficiency and consolidation. Without State involvement, too many local information exchanges will be created, they will not be interoperable across the state, and they will waste resources in duplicative efforts.

Financing

Embrace a partnership model with business leaders in the health and information industries to better understand the costs and benefits of adopting EHRs that efficiently exchange information. The State should track emerging national cost-benefit data, apply the models using Oregon data, and identify principles and strategies that redirect existing funds to invest in EHR infrastructure. As the financial picture emerges, the State should coordinate development of, and possibly administer, financial incentives and sustainable financing for interoperable EHR implementation.

Regulations & Laws

With the assistance of pertinent stakeholders and professional liability experts, determine whether any Oregon laws or regulations create barriers to implementation of interoperable EHRs or are inadequate to protect privacy. If identified, recommendations for remedies should be addressed. Issues that may need action include (a) regulations of electronic prescribing, (b) assurances of patient record confidentiality and strengthening of penalties for misuse, and (c) protection for providers in the event of an unintentional good-faith disclosure of patient information.

Healthcare Purchaser

Coordinate with private sector healthcare purchasers to leverage resources that encourage investment in information technology. Possible strategies include direct subsidies for implementation of EHRs, pay-for-performance incentives to providers for adoption and use, transaction fees for information exchanged electronically, pilot projects to develop health information exchanges, and designated insurance premiums for information technology investment. The Public Employees Benefit Board (PEBB) should continue its excellent ground-breaking work and should seek partners to use its purchasing power to foster investments in interoperable EHRs and to require demonstrable progress in using, sharing and reporting health information.

The State of Oregon's Office of Medical Assistance Programs (OMAP) should coordinate with the pilot projects of the federal Centers for Medicare & Medicaid Services (CMS) that encourage implementation of EHRs and emerging community health information exchanges so that Oregon can improve service and decrease costs to the program. OMAP should continue its investment in modernizing its information systems, and with private sector partners aggressively provide technical assistance to health care providers in order to achieve the long-range financial benefits of electronic data exchange.

Monitoring & Assurance

Commission a study, alone or with partners such as OMPRO and business leaders, that assesses the current state of adoption of interoperable EHR functionality in medical practices throughout Oregon. The study is essential if Oregon is to focus activities with high potential return on investment and to participate in emerging financial incentive programs.

Identify markets in which adoption of EHRs and development of regional information infrastructure lag. State leadership as a catalyst may be particularly important for small provider practices, in some rural communities and in communities with highly competitive markets. The State should be particularly attentive to the role of the Oregon Community Health Information Network (OCHIN)

and technical support for safety net providers to assure their participation in health information exchange.

Engaging the Public and Public Expectations

Coordinate with the private sector to conduct communication campaigns that increase the public's understanding of the value of electronic health data that can be shared and that increases public demand for access to their personal health records. The campaign should center on helping the public use personal and population information to improve their own health. The State should specifically address the privacy and security concerns of the public and engage them in developing guidelines for practice.

Public Health, Research, and Outcomes Reporting

Collaborate with the private sector to identify opportunities to assure that interoperable EHRs are used to support good policy development, decision-making and planning through its public health infrastructure. Systems should be developed in a way that supports compatibility with the emerging Public Health Information Network built to monitor, promote and protect population health. Where possible, the state should support electronic systems that help providers report legally-mandated public health conditions. Collaborative programs to determine best practice for standards and ease of use will have the greatest improvement in reporting frequency.

Identify opportunities to participate in research that evaluates successes and failures of interoperable EHRs and to disseminate results to broad audiences.

Education and Training

Coordinate with health professions training institutions and health professions leadership groups to increase the workforce's understanding and skills in managing electronic health information and systems. Low interest loans for informatics education may be useful for increasing the availability of health professionals with the needed technical skills for implementation.

Pilot Projects

Participate in collaborative demonstration and pilot projects that accelerate the adoption of interoperable EHRs in Oregon and assure broad application to leverage public and private resources.

Leadership & Governance

The State of Oregon needs a high-level, visible, respected, Health Information Technology Coordinator, comparable to the federal-level position held by David Brailer at the Department of Health and Human Services. This person and appropriate staff should be dedicated to carrying out these recommendations, and should be accountable to the Administrator of the Office for Oregon Health Policy & Research (OHPR) and the Oregon Health Policy Commission.

Convene a high-level Health Information Technology Advisory Board of experts broadly representing constituencies to guide its work. Although the State does NOT have a role in the governance of and actual operations of the regional networks that exchange information, the State should have a catalyst role in creating an environment in which such organizations can thrive.

The State of Oregon Action Plan

In order to promote electronic health records (EHR) and health information exchange (HIE) that leads to improved quality of care and reduced costs, this committee recommends the following actions:

1. The Governor should direct the Administrator of the Office for Oregon Health Policy and Research (OHPR) to:
 - Appoint a state Health Information Technology leader and provide staffing within OHPR to encourage coordination and cooperation in public and private sector activities for electronic health record implementation and health information exchange
 - Appoint a high level advisory committee to provide state leadership and coordination for electronic health record implementation and development of health information exchange

OHPR would be responsible for seeking state and federal resources to fund the costs associated with the new position and the advisory committee.

2. Provide seed funding, to be matched by private sector funds, for a pilot project to demonstrate how Oregon's health care providers can cooperatively build a secure system to find and access patients' records across boundaries
3. Use Oregon's purchasing power through PEBB and OMAP to encourage adoption of electronic health record and health information exchange
4. The Committee recommends the following activities be conducted by the Health Information Technology leader and staff:
 - Convene a quarterly working session for the community-based projects for coordination and cooperation
 - Prepare and disseminate information to help the public understand the electronic health record and health information exchange issues
 - Prepare a report that applies known techniques to clearly identify how benefits and costs may accrue to various stakeholders for implementing electronic health records and health information exchange, and foster a public discussion of results
 - Conduct a systematic assessment of Oregon's current status in electronic health record adoption and creation of health information exchange systems. Publish results, monitor change and identify gaps in progress
 - Help sponsor statewide meetings to promote EHR/Connectivity and encourage cooperation on important topics such as architecture, governance and sustainability
 - Coordinate with existing and emerging public health information reporting systems to assure compatibility
 - Conduct a systematic assessment of Oregon laws to identify and then remedy barriers to electronic health record and health information exchange

REFERENCES

1. Hussey PS, Anderson GF, Osborn R, Feek C, McLaughlin V, Millar J, et al. How does the quality of care compare in five countries? *Health Aff (Millwood)* 2004;23(3):89-99.
2. McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003;348(26):2635-45.
3. Institute of Medicine. *To Err is Human*. Washington, DC: National Academy Press; 1998.
4. Leape LL, Brennan TA, Laird N, Lawthers AG, Localio AR, Barnes BA, et al. The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II. *N Engl J Med* 1991;324(6):377-84.
5. Anonymous. *The State of Health Care Quality: 2003*. Washington, DC: NCQA; 2003 September 18, 2003.
6. Wang SJ, Middleton B, Prosser LA, Bardon CG, Spurr CD, Carchidi PJ, et al. A cost-benefit analysis of electronic medical records in primary care. *Am J Med* 2003;114(5):397-403.
7. Johnston D, Pan E, Walker J, Bates D, Middleton B. *The Value of Computerized Provider Order Entry in Ambulatory Settings*. Boston, MA: Center for Information Technology Leadership; 2003.
8. Walker J, Pan E, Johnston D, Adler-Milstein J, Bates DW, Middleton B. *The Value Of Health Care Information Exchange And Interoperability*. *Health Aff (Millwood)* 2005.
9. Brailer DJ, Augustinos N, Evans L, Karp S. *Moving toward electronic health information exchange*. Santa Barbara: SBCCDE; 2003 July.
10. Smith PC, Araya-Guerra R, Bublitz C, Parnes B, Dickinson LM, Van Vorst R, et al. Missing clinical information during primary care visits. *Jama* 2005;293(5):565-71.
11. Institute of Medicine. *Crossing the Quality Chasm: A new health system for the 21st century*. Washington, DC: National Academy Press; 2001.
12. Institute of Medicine. *Computer-based patient record*. Washington, DC: National Academies Press; 1991.
13. Institute of Medicine. *Patient safety: Achieving a new standard for care*. Washington, DC: National Academy Press; 2003.
14. HL7 EHR group. *Electronic health record functional descriptors*. 2004 [cited 2005 Jan 30]; Available from: <http://www.hl7.org/ehr/documents/Documents.asp>
15. Bates DW, Kuperman GJ, Rittenberg E, Teich JM, Fiskio J, Ma'luf N, et al. A randomized trial of a computer-based intervention to reduce utilization of redundant laboratory tests. *Am J Med* 1999;106(2):144-50.
16. Kuperman GJ, Gibson RF. Computer physician order entry: benefits, costs, and issues. *Ann Intern Med* 2003;139(1):31-9.
17. Teich JM, Glaser JP, Beckley RF, al. e. *Toward cost-effective, quality care: the Brigham Integrated Computing System*. In: Steen E, editor. *the Second Annual Nicholas E. Davies CPR Recognition Symposium*; 1996; Washington, DC: CPRI; 1996.
18. *Physician order entry system cuts error rate, improves path compliance, tracks data*. *Health Care Cost Reengineering Rep* 1997;2(10):152-7.
19. Park WS, Kim JS, Chae YM, Yu SH, Kim CY, Kim SA, et al. Does the physician order-entry system increase the revenue of a general hospital? *Int J Med Inf* 2003;71(1):25-32.

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20. Terry K. Exclusive Survey: Doctors and EHRs. 2005 [cited 2005 Feb 4]; Available from: <http://www.memag.com/memag/article/articleDetail.jsp?id=143144>
 21. McGee MK. Americans Split On Privacy Risks Vs. Benefits Of E-Health Records. 2005 [cited 2005 March 5]; Available from: <http://informationweek.com/story/showArticle.jhtml?articleID=60403005>
 22. Stanton J. HIPAA: the critical role of identity and access management. *J Healthc Inf Manag* 2004;18(2):38-43.
 23. Center for Information Technology Leadership. CPOE in ambulatory care. 2003 [cited 2005 Jan 30]; Available from: <http://www.citl.org/research/ACPOE.htm>
 24. Mekhjian HS, Kumar RR, Kuehn L, Bentley TD, Teater P, Thomas A, et al. Immediate benefits realized following implementation of physician order entry at an academic medical center. *J Am Med Inform Assoc* 2002;9(5):529-39.
 25. Jiang J, Klein G. Risks to different aspects of system success. *Information and Management* 1999;36:263-272.
 26. The Leapfrog Group. The Leapfrog Group. 2004 [cited 2004 March 10]; Available from: <http://www.leapfroggroup.org/>
 27. Bridges to Excellence. Overview. [cited 2005 Jan 31]; Available from: <http://www.bridgestoexcellence.org/bte/index.html>

		Recommendations															
#			Evaluation Criteria														
1	Adoption- CDS	Collaborate with private industry to provide low cost alternatives to control chronic disease utilizing existing assistive technology and a web-based database of resources (prescription medication, etc.)															
2	Adoption- CDS	Require Medicaid contractors (such as MCOs) provide web based wellness tools to assist with chronic disease management															
3	Adoption- CDS	State could encourage use of clinical decision support (CDS) tools with evidence based medicine (EBM) in contracting decisions															
4	Adoption- CDS	Work with private industry to expand the use of assistive technology that allows the use of a less skilled workforce to provide appropriate care, especially in the rural areas of Oregon.															
5	Adoption- EBM	Change reimbursement systems to reward providers that use EBM															
6	Adoption- EBM	State as a purchaser require contractors (MCOs and providers) adhere to appropriate evidence based medicine practices															
7	Adoption- EBM	Work with public health and safety net clinics to implement appropriate evidence based practices and provide appropriate clinical support through web based education and related resources															
8	Adoption- EMR	a legislative fund for clinics that have recently purchased a great EMR system but now through potential statewide system design changes they acquire mental health as a book of business and their EMR system they just purchased isn't integration friendly.															

Oregon Health Policy Commission Road Map for Health Care Reform

Creating a High-Value, Affordable Health Care System



**Please direct questions on this report or about the OHPC
to Gretchen Morley, OHPC Director, at 503-373-1641**

July 2007



**Office for Oregon Health
Policy & Research**

Road Map for Health Care Reform
Recommendations

printing of this report, this idea is under discussion by the Oregon Health Services Commission, the group that oversees the Prioritized List.

- **Expand disease management programs under the Oregon Health Plan.** Currently the OHP disease management program targets five key chronic conditions: asthma; chronic obstructive pulmonary disease; coronary artery disease; diabetes; and heart failure. This program helps individuals with chronic conditions manage their care by providing patients with the most cost effective services and health practices for their conditions.
- **Continue to maximize efforts to increase access to prescription drugs by the uninsured.** The state is currently seeking to access the power of bulk purchasing through the Oregon Prescription Drug Program (OPDP). The OPDP increases the uninsured's access to prescription drugs, and lowers state and city government costs while helping them stay within budgeted goals. The program can leverage the best prices on the most effective medicines by pooling prescription drug purchasing power, using evidence-based research to develop a preferred list of lowest cost drugs, and negotiating competitive discounts with pharmacies. In 2006, the OPDP and Washington's Prescription Drug Program formed the Northwest Prescription Drug Consortium. The Consortium has a potential enrollment pool of over five million members. That negotiating strength helped negotiate a new administrative contract with The ODS Companies that brings greater economic value, auditable transparency and financially guaranteed service levels for both group and uninsured members. This contract makes the OPDP and WPDP competitive in their markets for group participation and brings unprecedented value for their uninsured populations.

■ Develop widespread and shared electronic health records (EHR)

- **Increase coordination.** The state should fund a state coordinator of Health Information on a continuing basis with sufficient staff and funding support to carry out the assigned functions. The coordinator provides a strong state leadership role for health information exchange and EHR adoption, assures coordination of community efforts throughout Oregon, and assures that Oregon health records are compatible with emerging national standards and infrastructure. Among other things, the coordinator should conduct an ongoing assessment of the costs and benefits of implementing electronic health records and health information exchange for Oregon as a whole.
- **Create pilot programs for health information exchange.** The state should solicit CMS and other funding to support pilot projects that encourage health information exchange and reduce silos of personal health information. Examples of such projects are: (a) an Oregon Business Council funded Oregon Health Care Quality Corporation effort to develop a Portland metropolitan area pilot project for viewing and retrieval of lab results, image reports and hospital and emergency department summaries; and (b) a statewide master patient index to enhance the potential for information sharing.

- **Support efforts to improve privacy and security of electronic health records.** The state should support implementation and dissemination of the Health Information Security and Privacy Collaborative recommendations released in Spring 2007.³² These recommendations outline several steps that foster the protection of patients' health information especially in an electronic exchange. The plan looks at the public and private sector roles with regard to identification, authentication and authorization of users, addressing medical identity theft, reviewing specially protected information laws, educating consumers, protecting health information held by non-covered entities, ensuring appropriate access for secondary use, and enforcing current law. The report suggests the need for funded coordination at the state level through a Health Information Privacy Coordinator, as well as technical assistance to organizations for comprehensive adoption of appropriate privacy and security practices. In phase two of the project, the Collaborative intends to develop a "communication toolkit" to improve consumer education on health information exchange.
- **Monitor and promote widespread adoption of electronic health records.** The state should perform an annual assessment of EHR adoption to guide policy and identify areas where targeted assistance is needed. To the extent that small practices and safety net clinics are unable to finance timely EHR implementation, the state should help them secure other funding to do so, including federal sources such as CMS. Coordinated value-based purchasing activities should promote the creation of incentives for EHR adoption, including payment scenarios that allow some financial benefit to accrue to a provider investing in EHR.
- **Promote claims processing efficiencies.** The state should continue its efforts to create a simplified and standardized claims processing system throughout Oregon, using its influence as a purchaser and as the regulator of many of the key players. This would reduce the impact of inefficient claims processing and high transaction costs on the costs of health care, allowing funds to be better spent elsewhere. It is likely that this claims processing system can be integrated over time with EHRs and HIEs, such that health information is fully integrated.

Assure a workforce that can capitalize on health information technology

Sufficient provider capacity is necessary for successful system reform. Creative efforts will have to be undertaken to expand capacity and increase provider education in order to meet a range of patient needs and to successfully use information technology in health care settings.

It is important to train current and new providers in electronic record keeping. The OHPC recommends the Workforce Institute train practitioners who can capitalize on new information technology. Increased use of technology will result in improved, better coordinated care that will minimize duplication and errors. For advances in health information technology to be meaningfully translated into improved patient care, providers must both understand the value of

³² The implementation plan of the Health Information Security and Privacy Collaborative *Privacy and Security Solutions for Interoperable Health Information Exchange* can be found at: http://www.q-corp.org/q-corp/images/public/pdfs/final_implementation_plan_report.pdf

Road Map for Health Care Reform Recommendations

The state can and should take a strong lead in pushing health care purchasers to develop value-based purchasing strategies statewide. The Public Employees Benefit Board (PEBB) is a leader in value-based purchasing in Oregon. PEBB designs, contracts and administers a range of insurance products and flexible spending accounts for state employees and their dependents. It also offers health insurance options to retirees not yet eligible for Medicare and individuals in other participating groups. PEBB's total membership is approximately 120,000 individuals.

There is great potential for value-based purchasing strategies within Oregon's Medicaid program, which has over 270,000 enrollees in managed care and approximately 70,000 others in fee-for-service or primary care case management. This enrollment gives Medicaid both leverage and opportunity to influence the quality of care for its enrollees and the broader community. It also represents a large portion of the state's budget, giving efforts to improve service efficiency and quality broad implications.

Widespread, Shared Electronic Health Records Will Improve Care Quality and Efficiency

Good health information is key to the development of a high-value health care system. Reliable health information exchange (HIE) makes patient information available when and where it is needed to all who are authorized to access it. A recent study by the Commonwealth Fund ranked the United States last compared to four other developed countries with regard to the availability of health records when needed and regarding redundant medical testing. A robust system of interoperable electronic health records (EHR) can reduce duplicative medical tests by 15-20%. Evidence shows that EHRs that include tools such as clinical decision support, reminders and registries helps better manage patient care and improves quality.

Investments in EHR and HIE have substantial economic benefits to society as a whole, measured by improved outcomes, fewer mistakes, more effective, efficient and timely treatment, and reduced transaction costs. Among other things, EHRs can reduce billing errors and prevent fraud through improved documentation and administrative checklists, benefiting both providers and society.

The costs are sometimes cited as a reason providers are hesitant to invest in EHR, but recent research suggests that the costs of implementation are quickly recovered. Researchers at the University of California, San Francisco conducted case studies of solo and small primary care practices using EHR.³³ They found average start up costs of \$44,000 per provider, with practices recouping the investment costs in two and a half years. The average annual efficiency savings and benefits of increased provider productivity was \$15,800 per provider per year.

In a March 2005 Report to the 73rd Oregon Legislative Assembly, a subcommittee of the Oregon Health Policy Commission recommended that the state take reasonable steps to promote the rapid and widespread adoption of health information technology including electronic health records and health information exchanges. It is now 2007, and the reasons for bringing modern information technology to Oregon health care are still compelling. While some progress has been made since the 2005 report, there is much yet to be done.

³³ "The Value of Electronic Health records in Solo or Small Group Practices" Robert. H. Miller, et al., *Health Affairs*, September/October 2005, 24 (5): 1127-3.

Road Map for Health Care Reform Recommendations

Widespread adoption of compatible and shareable information technology is essential for improving the quality and safety of care and reducing waste and costs. A functioning EHR system:

- Provides improved manageability of health data;
- Offers support for provider decisions at the point of care, such as reminders and alerts about drug interactions;
- Allows for electronic prescribing and order entry by providers, thus reducing mistakes secondary to legibility, improving communication, providing interaction checking and increasing efficiency of the refill process and formulary adherence
- Facilitates patient population reporting and management;
- Can improve the productivity of health care staff over time;
- Facilitates the delivery of evidence-based health care; and
- Improves the coordination of care for the chronically ill (the highest users of health care.)

Oregon Needs a Well-Trained Health Care Workforce

The OHPC sees the newly formed Oregon Health Care Workforce Institute as an integral component of health care system reform. The Institute is a private-public partnership charged with developing a coordinated statewide response to critical needs in the health care workforce. The Institute will provide consistent and reliable research about health care workforce shortages and develop policies and resources to resolve the shortage. To minimize duplication and errors, it is critical that workforce training focus on building the understanding and skills to capitalize on new information technology that will result in improved, better coordinated care.

Improving Health Care Safety Will Decrease Costs and Improve Health Outcomes

Health care leaders agree that medical errors represent an epidemic that is beatable. The Institute of Medicine found that 44,000 to 98,000 people die in hospitals each year as the result of such events. The federal Veterans Administration system reports that about 180,000 deaths occur each year in the United States from “errors in medical care” across all health care settings. Other studies place the number of deaths even higher. In addition to deaths, many adverse events lead to serious, but non-fatal injuries. A recent survey of physicians and of the public offers a different perspective but with similar intent—35 percent of practicing physicians and 42 percent of the public have experienced a preventable medical error either personally or within their families. In Oregon, even with a health care system continually working to improve quality, more people probably die as the result of adverse events than from diabetes, Alzheimer’s, or pneumonia. Research findings consistently indicate that 50 to 70 percent of errors are preventable—if systems issues are identified and corrected.

The Oregon Patient Safety Commission was created during the 2003 legislative session to reduce the risk of adverse events and to encourage a culture of safety in Oregon’s health care system. The Commission brings a much needed independent view to quality issues and patient safety remedies. And while this Commission has made great strides in 2006 – 52 hospitals in Oregon are voluntarily reporting adverse events – currently the Commission is funded solely through fees from the hospitals. State financial support is needed in order to expand the Commission’s role and impact.

Health Information Infrastructure Advisory Committee (HIIAC) Meeting

Friday, April 25, 2008

1:00 – 5:00 pm

Portland State Office Building, Portland, OR

Committee Members Present:

Dick Gibson, Ree Sailors, Chris Apgar, Ken Carlson, Homer Chin, Andy Davidson, Joyce DeMonnin, Laura Etherton, Grant Higginson, Denise Honzel, Bart McMullan, Andi Miller, Andrew Perry, Barbara Prowe, Nan Robertson, Abby Sears, Sally Sparling, Greg Wenneson, Dave Widen,

Committee Members Absent:

Nancy Clarke, Paul Gorman, Gina Nikkel, Laureen O'Brien

Staff:

Jody Pettit, Dawn Bonder

Welcome and Introductions	HIIAC co-chairs Ree Sailors, Governor Kulongoski's Health Care Policy Advisor, and Dick Gibson, Chief Information Officer, Legacy Health Systems, called the meeting to order and welcomed HIIAC members and guests. HIIAC members and staff introduced themselves.
Logistics	Ree Sailors covered logistical details and asked all committee members to please sign and have their oaths notarized and returned to the Governor's Office.
Oregon Health Fund Board Overview	Ree Sailors gave a brief overview of the Oregon Health Fund Board, created by SB 329 during the 2007 Legislative Session. Ree also covered the expectation that the HIIAC will provide key facts on HIT and recommendations to the Oregon Health Fund Board, by August, 2008, for inclusion in the HFB's reform plan.
Discussion of DRAFT Vision Statement:	Jody Pettit, Oregon's Health Information Technology Coordinator, asked the HIIAC members to consider a DRAFT Vision Statement: Oregonians health information is: Available when and where it is needed for our care Is Private and Secure and under the control of the

**Individual
Is used for public health, research and
population-based care**

HIIAC members had an open discussion about the points contained in the DRAFT Vision Statement with the following comments:

Concern with the terms “under the control” and “research”.

Include more of the theory embodied in the California Healthcare Foundation Issue Brief, *Who’s Data is it Anyway*, dated February, 2008 and included in the pre-meeting reading packet. Emphasis was placed on defining what is meant by “ownership.”

Should “high-quality” modify “care”?

Add: “Improve, or move to, safe, high-quality care” as a fourth bullet, or as an addition to the first bullet.

Add: Measurable difference in health outcomes and administrative costs

Concern regarding the legality of the use of research; add appropriate and legal or permissible

Concern regarding the assumption that “people have access to their entire medical record” gave rise to a question about whether this needs to be specified: Are we talking about people having access to their entire medical record or just certain parts of that record? How would physicians be affected if patients have access to everything? It was pointed out that patients can have that info if they want to get it today.

In response to a question about whether the HIIAC will look only at Personal Health Record models (PHRs) or if other models will be up for consideration, Sailors responded that all options are open to the HIIAC for consideration.

HIIAC Members were invited to send comments and suggestions to the Vision Statement for

	inclusion before the next meeting.
<p>Reports on Previous and Current Work:</p>	<p>The HIIAC received reports on previous and current work on Health Information Technology:</p> <p>Pettit reviewed the Electronic Health Record (EHR) and Healthcare Connectivity Report from 2005.</p> <p>Jeanene Smith, Director of the Office of Oregon’s Health Policy and Research spoke about the work of the Oregon Health Policy Commission with respect to health information technology. Smith also noted that the Health Fund Board Committee on Delivery Systems keeps bumping into HIT as a tool for improvement and that the committee is looking forward to receiving recommendations from the HIIAC. Smith also discussed the Quality Institute report that was prepared for the Health Fund Board.</p> <p>Dave Witter of Witter & Associates presented, <i>Potential Impact of Widespread Adoption of Advanced Health Information Technologies (HIT) on Oregon Health Expenditures</i>. The slides from this presentation are attached to, and made part of these meeting minutes.</p> <p>Denise Honzel, Healthcare Consultant to the Oregon Business Plan, reviewed the Metro Area HIT project.</p> <p>Pettit reviewed Oregon’s Health Information Security and Privacy Collaborative (HISPC) work.</p>
<p>Privacy Discussion:</p>	<p>Chris Apgar, President of Apgar & Associates, reviewed the privacy rule arising from HIPAA and US 402(c) and how this legislation may affect electronic transfer. He pointed out that we will need to look at information exchange over state lines where the laws may differ.</p> <p>There was a question about who HIPAA covers: Health Plans (including Medicaid and Medicare) ? Providers</p> <p>Vendors of PHRs are currently not covered by HIPAA.</p>

	<p>Pettit then reviewed a Notice of Privacy Practices.</p> <p>Covered entities can deny a request for information if disclosing the information will cause harm to themselves or another. A denial can be appealed to another healthcare provider. There can be no appeal if someone else is mentioned in the record or if the information was given in “confidence”.</p> <p>There was discussion about what is “useful data” to be included in the record.</p> <p>The group discussed OHSU’s open record where a provider can “attest” or “assert” that he or she has a right to view the record for treatment.</p> <p>There was some concern from a member that medical records are being at looked at every single minute of every single day, thereby creating no adequate way to audit the view of the record.</p> <p>A suggestion was made that as a starting point, we could separate out the non-sensitive information and begin exchange with this non-sensitive information. Clarification was made that it should be important and valuable, non-sensitive information.</p>
<p>Showing of the HISPC Privacy Documentary</p>	<p>Pettit screened the documentary film, <i>Sharing Health Information Nationwide . . .and Doing it Right</i>, produced during the second phase of Oregon’s HISPC project. The HISPC project team will be using this documentary film in town hall meetings throughout Oregon as a consumer education and engagement tool. More information will be presented to the HIIAC at subsequent meetings.</p>
<p>Committee Exercise</p>	<p>Notes were captured and incorporated into work product: please see notes below – but they will also be in the work product</p>
<p>Public Testimony:</p>	<p><u>Andrea Meyer of ACLU</u> – Who runs the systems? Public (government) vs. private sector. Informed consent – patients and consumers need to know risks and consumers. Opt in and Opt out.</p>

	<p>Prefers opt in. Process concerns – what happens with errors and mistakes? Remedy? Unique identifiers – how do you know you’ve got the right person? Request to go beyond current state and federal laws.</p> <p><u>Brad Hall from Acumentra Health</u> – Every Oregonians means we need to incent small and medium practices. We need to talk about the vehicle and what is going to be shared. Look to other countries like Taiwan in recent TV documentary.</p> <p><u>Tom Ricciardi</u> – Excited about meeting and made a request about administrative help. Help with set-up etc.</p> <p>Look at state AND private and combo</p> <p><u>Co-chair Dick Gibson</u> asked about feedback on the meeting today:</p> <ul style="list-style-type: none"> • Put documents on web site • Background and context helpful • Reports were succinct • Utilize experts on budget – cost/benefit • Audio options/webcasting <p><u>Juan Alaniz</u> - Washington State Visitor told us about their work over the past two years. Starting with the patients to build trust – patient is the paramount concern. What will be your legacy? – made it personal for folks involved. Doing consumer controlled health record banking.</p>
<p>Next Meeting:</p>	<p>Review adds to spreadsheets. Put out and get priority. Principles at next meeting? Sorting process. Maybe utilize Survey Monkey.</p>

Proposed Vision for discussion:

- Oregonians' health information is available anytime, anywhere it is needed.
- Oregonians' health information is private, secure and under the control of the individual.
- Oregonians' health information may be used to assure safe, high quality, cost effective personal and population-based health care.

Senate Bill 329: 'The Healthy Oregon Act' re: health information technology:

"Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable."

Oregon Health Fund Board Synopsis:

(placeholder document, more to come at meeting)

- Governor Kulongoski appointed Executive Director Barney Speight
- Develop a plan to provide affordable access to health care for all Oregonians.
- Staff of eight
- Budget of \$1.8 million
- Present a plan to reform Oregon health care system to the 2009 legislature

To provide guidance regarding laws, principles and best practices that assure the protection of the privacy and security of Oregonians' health information as it is shared electronically across organizations and with individuals in healthcare settings.

Values & Principles

The goal of this effort is to keep Oregonians health information private and secure. The following values frame Oregon's policy for assuring the privacy and security of electronic health information.

- Trust
- Privacy
- Autonomy

- Feasibility
- Balance
- Portability

- Equality
- Transparency
- Public Accountability

The Oregon HISPC project team carefully studied the research on privacy and security of health information exchange in search of a framework appropriate to guide solution recommendations for Oregon. The Markle Foundation's Connecting for Health principles regarding the individual and their health information provide such a framework that will allow Oregon to achieve all the solution recommendations detailed in this report. The Steering Committee recognized the importance of the principles in building trust among all parties in Oregon and embraced the principles as the foundation for health information exchange in Oregon.

1. Individuals should be guaranteed access to their own health information.
2. Individuals should be able to access their personally identifiable health information conveniently and affordably.
3. Individuals should have control over whether and how their personally identifiable health information is shared.
4. Individuals should know how their personally identifiable health information may be used and who has access to it.
5. Systems for health information exchange must protect the integrity, security, and confidentiality of an individual's information.
6. The governance and administration of health information exchange networks should be transparent and publicly accountable.

Definitions

To facilitate the policy discussion, definitions of some key terms, taken from the recent Institute of Medicine report, "Disposition of the Air Force Health Study" (2006), are provided below. These definitions were recently referenced in the report submitted to Secretary Michael Leavitt of the US Department of Health and Human Services by the National Committee on Vital and Health Statistics recommending actions regarding "Privacy and Confidentiality in the Nationwide Health Information Network."

Privacy: the right to control the acquisition, uses, or disclosures of his or her identifiable health data.

Confidentiality: the obligations of those who receive information to respect the privacy interests of those to whom the data relate.

Security: the physical, technological, or administrative safeguards or tools used to protect identifiable health data from unwarranted access or disclosure.

II. Summary of Analysis of Solutions Report

In order to ensure that evolving systems for community-wide exchange of electronic health information adequately protect the privacy and security of individuals, Oregon's public and private partners must work towards the following objectives.

1. Consumer Protection

Adopt the Markle Foundation's Connecting for Health principles regarding the individual and their health information as guiding principles for consumer protection.

- Individuals should be guaranteed access to their own health information.
- Individuals should be able to access their personally identifiable health information conveniently and affordably.
- Individuals should have control over whether and how their personally identifiable health information is shared.
- Individuals should know how their personally identifiable health information may be used and who has access to it.
- Systems for health information exchange must protect the integrity, security, and confidentiality of an individual's information.
- The governance and administration of health information exchange networks should be transparent and publicly accountable.

2. Provider Identification

A coordinated approach to identifying, authenticating and authorizing providers

3. Patient Identification

A coordinated approach to identifying, authenticating and authorizing patients

4. Public Engagement

An educated and engaged Oregon population regarding health information privacy rights and expectations

5. Specially Protected Information

An examination of state laws that define specially protected health information to determine the appropriateness of the protections and the feasibility of implementing these protections in an electronic environment

6. Medical Identity Theft

An examination of state laws regarding identity theft to determine if medical identity theft is appropriately and adequately addressed

7. Technical Assistance

Support to organizations for comprehensive adoption of appropriate privacy and security practices for HIPAA and other federal and state law compliance

8. Non-Covered Entities

Legal privacy and security requirements for entities handling personal health information that are not covered by HIPAA

9. Secondary Use

An examination of current practices for secondary use of data to determine an acceptable balance between ensuring that personal health information is protected and making de-identified data available for appropriate use

10. Enforcement

Legislative or regulatory measures to address inappropriate disclosures and mitigate potential harmful effects of personal health information disclosure