
Transforming Health Care Delivery in Oregon Through Technology and Robust Health Information Exchange

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Today's Presentation

- Oregon's Priorities for Transforming Health Care: CCO 2.0 and HIT
- Results so far for HIT/HIE in Oregon
- Oregon's Meaningful Use of Certified EHR Technology
- Where we're going: HIT Efforts in Development

**OREGON'S PRIORITIES FOR
TRANSFORMING HEALTH CARE:
CCO 2.0 AND HIT**

Transformation Opportunities and HIT



Care coordination, support BH



Social Determinants of Health/Equity



Value based payment



Measure progress



Engage, align stakeholders

Health information technology

Overview

- Coordinated Care Organizations (CCOs) started in 2012 with the goal of achieving the Triple Aim:
 - Better care
 - Better health
 - Lower health care costs
- We have a lot of data about what is working and what needs more work over the next five years. We are calling this next phase “CCO 2.0”
- This is important because one in four Oregonians have Medicaid coverage, most through CCOs
- OHA and the Oregon Health Policy Board are leading this work



Governor Brown's vision

**CCO
2.0**

The Governor has asked the Oregon Health Policy Board to provide recommendations for CCO 2.0 in four areas:

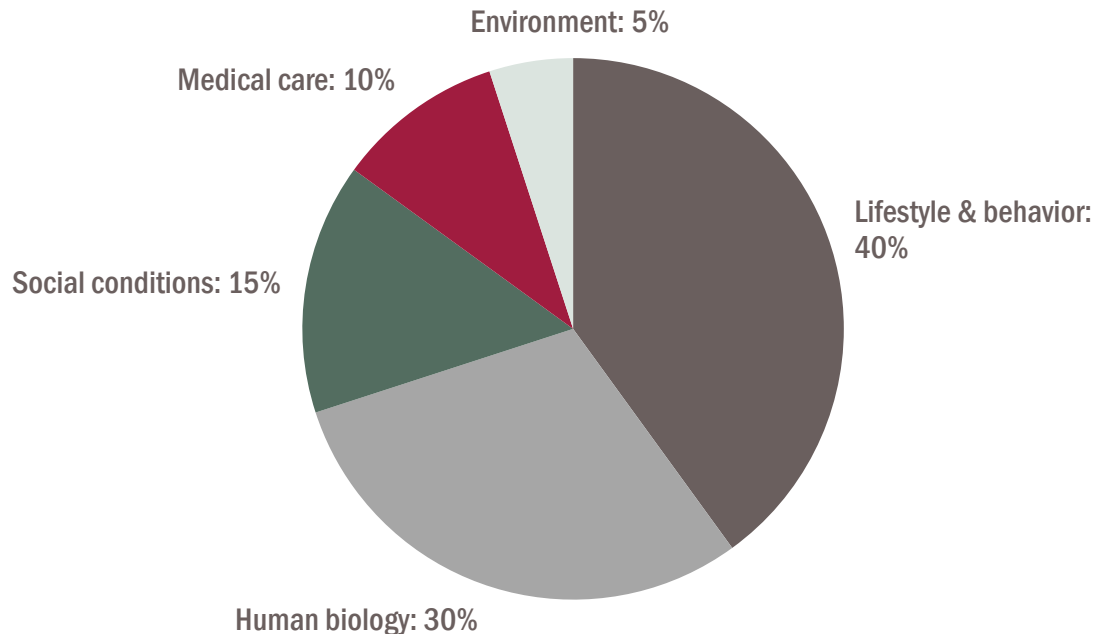
- Focus on social determinants of health and equity
- Increase value-based payments and pay for performance
- Improve the behavioral health system
- Maintain sustainable cost growth



Social Determinants of Health

CCO
2.0

The **medical care** we get only determines about 10% of our health. **Social and environmental conditions** – or the social determinants of health – actually make a much bigger difference in how healthy we are.



What are social determinants of health and health equity?



Health equity

Means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination

(RWJF)

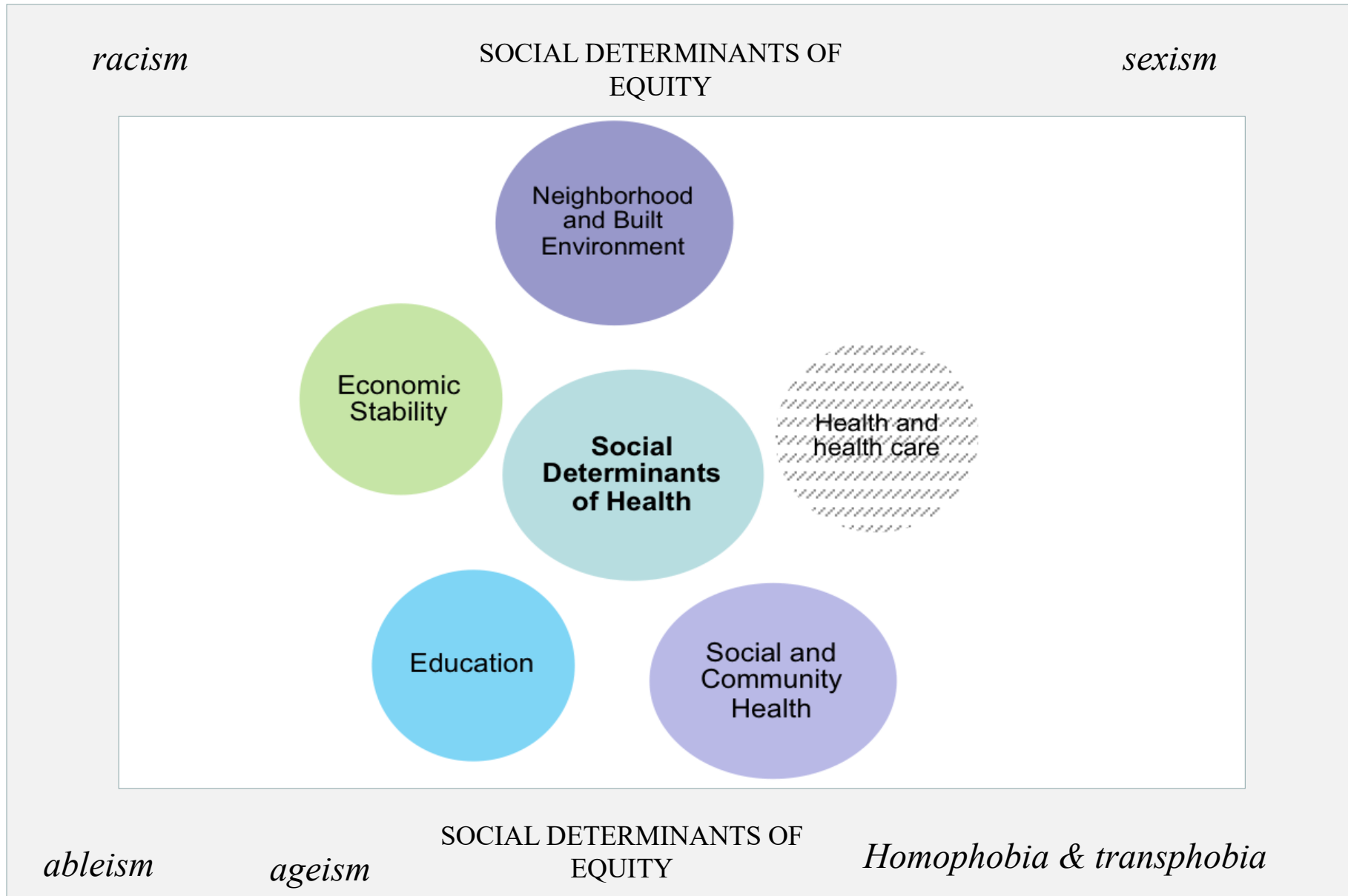
Social Determinants of Health (SDOH)

Are the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. (Oregon Medicaid Advisory Committee – “MAC”)

The Social Determinants of Equity

Are structural factors, such as racism, sexism, able-ism, and others, that determine how different groups of people experience Social Determinants of Health. (MAC)

Understanding how they are tied together: Social Determinants of Health & Equity Factors



CCO 2.0 and SDOH/E

- Increase strategic spending by CCOs
- Increase CCO financial support of non-clinical and public health providers
- Align community health assessment and community health improvement plans to increase impact
- Strengthen meaningful engagement of tribes, diverse OHP members, and community advisory councils (CACs)
- Build CCOs' organizational capacity to advance health equity, including health equity plans
- Increase the integration and use of traditional health workers

CCO 2.0 HIT: Use HIT to Engage Patients

Big idea: CCOs would use HIT to engage patients, including participation in their own care and access to their own health information. This would be linked to health equity plans.

What it might look like:

- CCOs could ensure members can access their health records electronically and work with contracted providers to improve education to patients, taking into consideration language and alternate formats.
- CCOs could offer evidence-based mobile health programs like Text4Baby

Value- Based Payments

VBP's are designed to incentivize changes that focus on **value** instead of volume of care delivered, **rewarding** providers for **high-quality care**, **positive member health outcomes** and **cost savings**.

Value-based payment and the triple aim

1 Better health

2 Better care

3 Lower costs

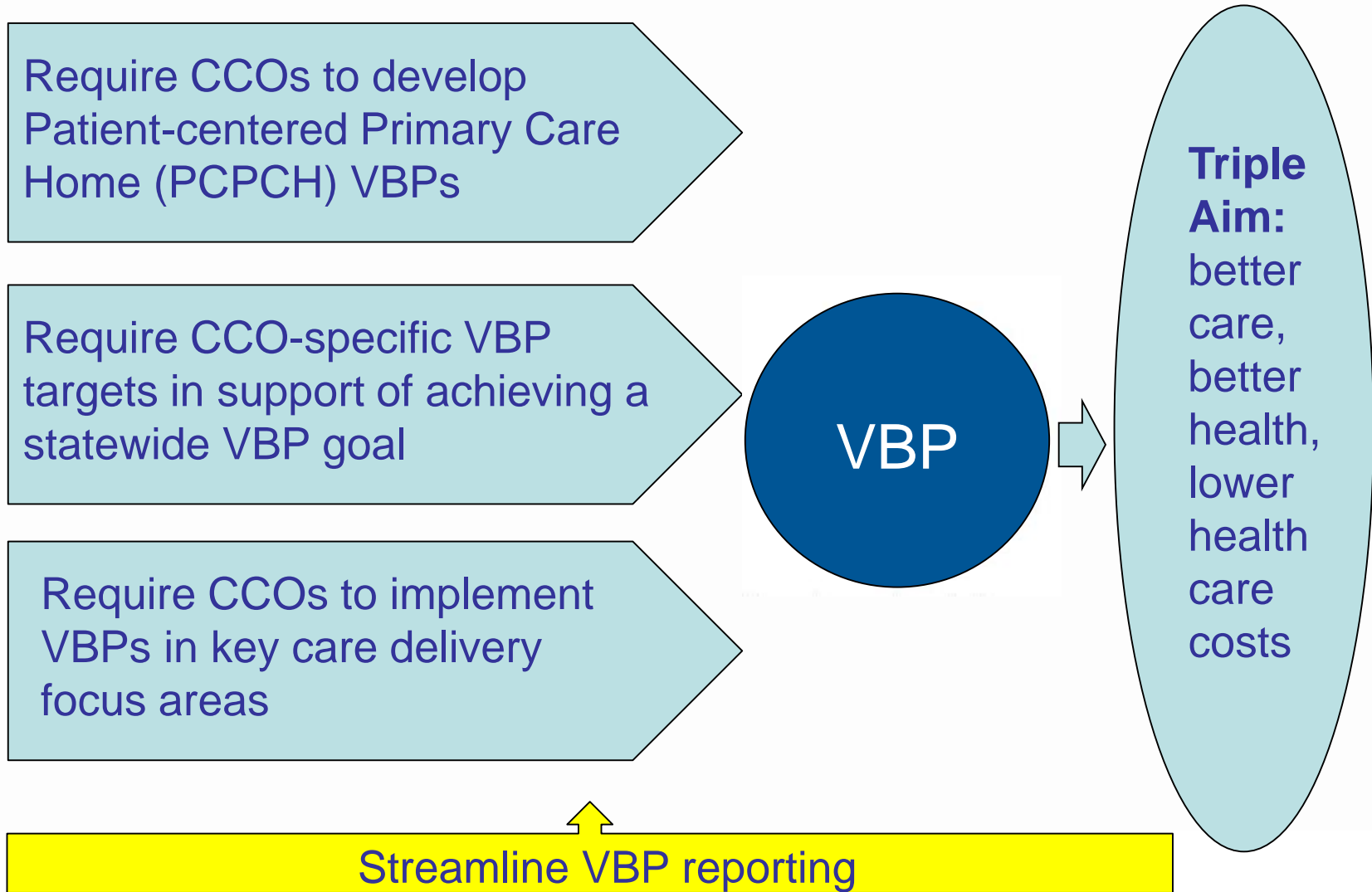


- Volume-driven care
- Focused on acute singular event
- Payer and provider incentives not aligned



- Value (not volume) of care
- Prevention and care coordination for improved quality and health outcomes
- Aligned incentives between payers and providers

CCO 2.0: VBP policy options



CCO 2.0 HIT: Use HIT for VBP

Big idea: CCOs would demonstrate they have sufficient HIT capabilities to manage value-based payment arrangements and population health.

What it might look like:

- CCOs would use HIT to risk stratify populations and target interventions to ensure patients and communities receive the care they need to stay healthy
- CCOs would use HIT to manage value-based payment (VBP) arrangements, including sharing with providers data on patient attribution, patient risk scoring, CCO claims or cost data, and provider performance
- CCOs would show they can use HIT to analyze and manage electronic clinical quality metric data (as a component of VBP arrangements)

Need to improve BH system

“The behavioral health system continues to include fragmented financing, carve-outs that prevent integration and efficiencies, siloed delivery systems, and services that fail to serve and exacerbate poor health outcomes.”

- The 2016 Behavioral Health Collaborative

CCO 2.0 – Improving Behavioral Health

- Require CCOs be fully accountable for the behavioral health benefit
- Address prior authorization and network adequacy issues that limit member choice and timely access to providers
- Use metrics to incentivize behavioral health and oral health integration
- Expand programs that integrate primary care into behavioral health settings
- Develop a diverse and culturally responsive workforce, and
- Ensure children have behavioral health needs met with access to appropriate services.

Behavioral Health HIT Scan Results

OHA conducted a survey of Oregon's 275 behavioral health agencies with at least one state licensed program; about half (48%) completed a survey

EHR Adoption among Responding BH Agencies



EHR challenges for those who have an EHR

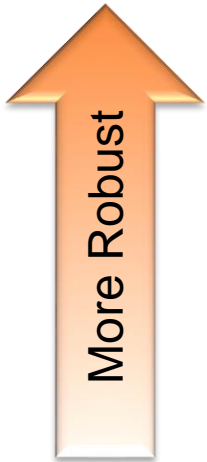
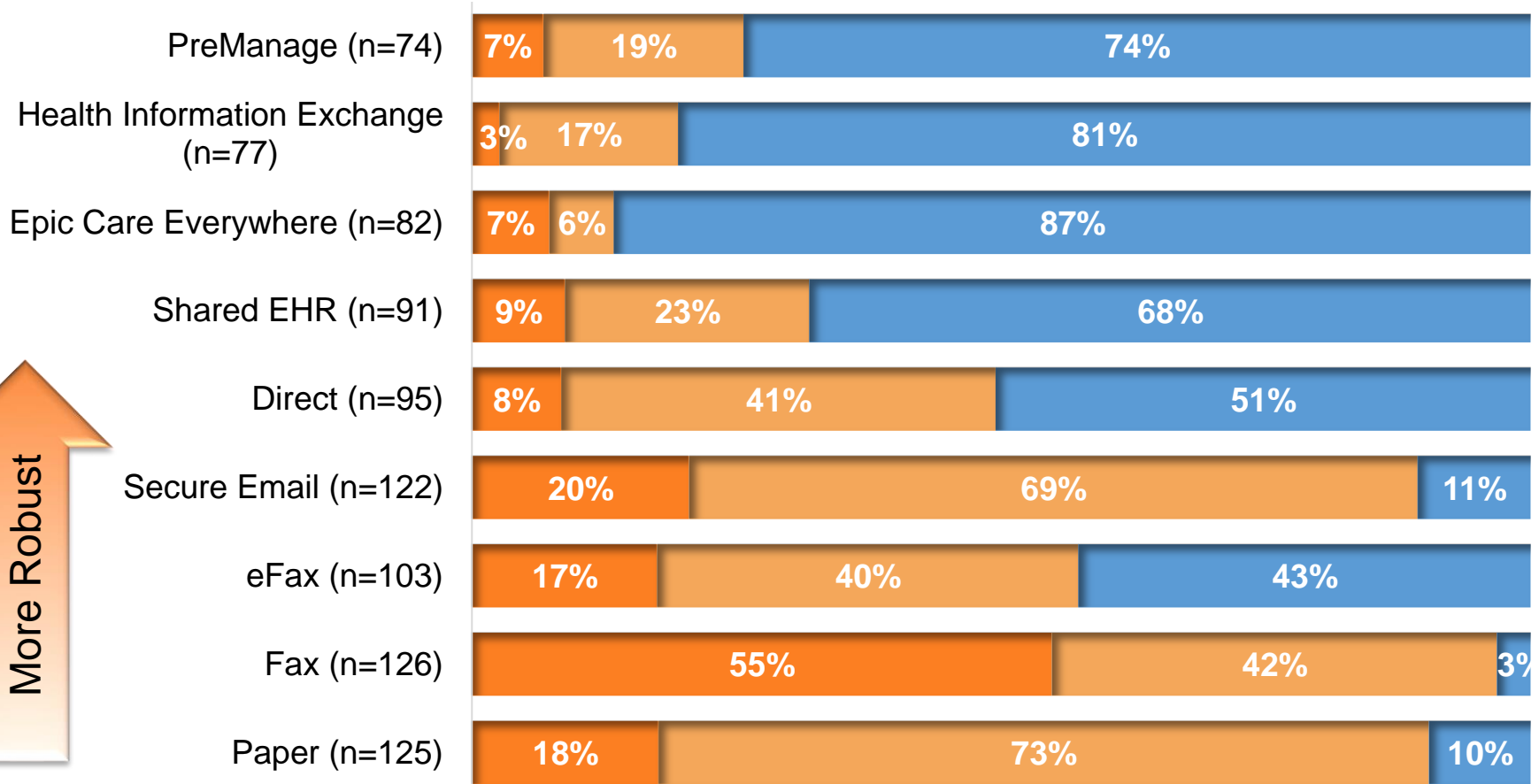
		Count	Response Rate
1	Financial costs	71	70%
2	Unable to exchange information with other systems	55	54%

EHR barriers for those who do not have an EHR

		Count	Response Rate
1	Financial cost	25	78%
2	Agency size is too small to justify the investment	21	66%
3	Lack of staff resources	15	48%
4	Lack of technical infrastructure	15	48%

Behavioral Health HIT Scan Results: Current Frequency of HIE Use

■ Most of the time
 ■ Some of the time
 ■ None of the time



CCO 2.0 HIT: Support EHR Adoption

Big idea: CCOs support EHR adoption among behavioral and oral health providers, helping to close the “digital divide” in health IT.

What it might look like:

- CCOs would establish targets for EHR adoption, focusing on each provider type (physical, behavioral, and oral health)
- CCOs would work with their key contracted providers to remove barriers to EHR adoption and use
- Patients would have better access to their health information electronically through an EHR’s patient portal

CCO 2.0 HIT: Support Health Information Exchange

Big idea: CCOs ensure that their contracted physical, behavioral and oral health providers can securely share patient health information electronically. CCOs will also use hospital event notifications internally and ensure contracted clinics have access to event notifications.

What it might look like:

- CCOs help connect disparate providers electronically for care coordination
- CCOs would ensure providers have timely hospital event information that can help manage populations and target interventions and follow up

CCO 2.0 RFA Timeline

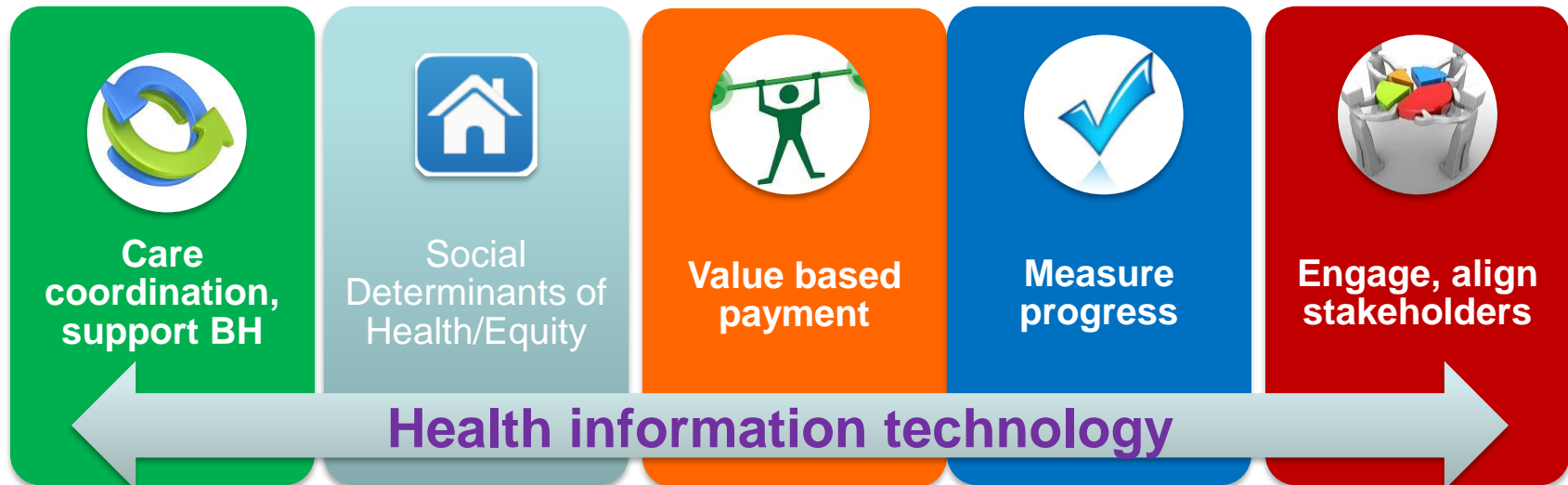


CCOs will be selected through a request for application (RFA) process

Only current CCOs and companies with an existing Oregon “footprint” can apply.

- January 2019: RFA released
- February 2019: Letters of intent due
- April to June 2019: Evaluation, CCO selection, and negotiations
- June 2019: Award CCO contracts
- September to December 2019: Readiness review
- January 2020: New CCO contracts implemented

HIT Supports for Transformation



Organizations and Individuals:

- Organizations invest in EHRs and HIT
- Patients engage thru HIT
- Local and national HIE efforts spread

Statewide efforts (in progress):

- Statewide HIE via coordinated networks
- Centralized core HIT
- Aligned payer expectations
- Shared HIT governance for long term sustainability

HITOC: strategic planning, monitor and adapt to changing environment, oversee progress, explore emerging areas

**RESULTS SO FAR:
CURRENT STATUS OF HIT/HIE IN
OREGON**

Oregon HIT/HIE Highlights in 2018

- Continued high adoption of electronic health records
- Health information exchange continues to spread:
 - Widespread use of EDIE/PreManage
 - Oregon footprint for national HIE efforts expanding
 - Spread and investment in regional HIEs
- Digital divide for behavioral health providers
- HIT Commons launched
 - New public/private partnership for implementing and accelerating HIT

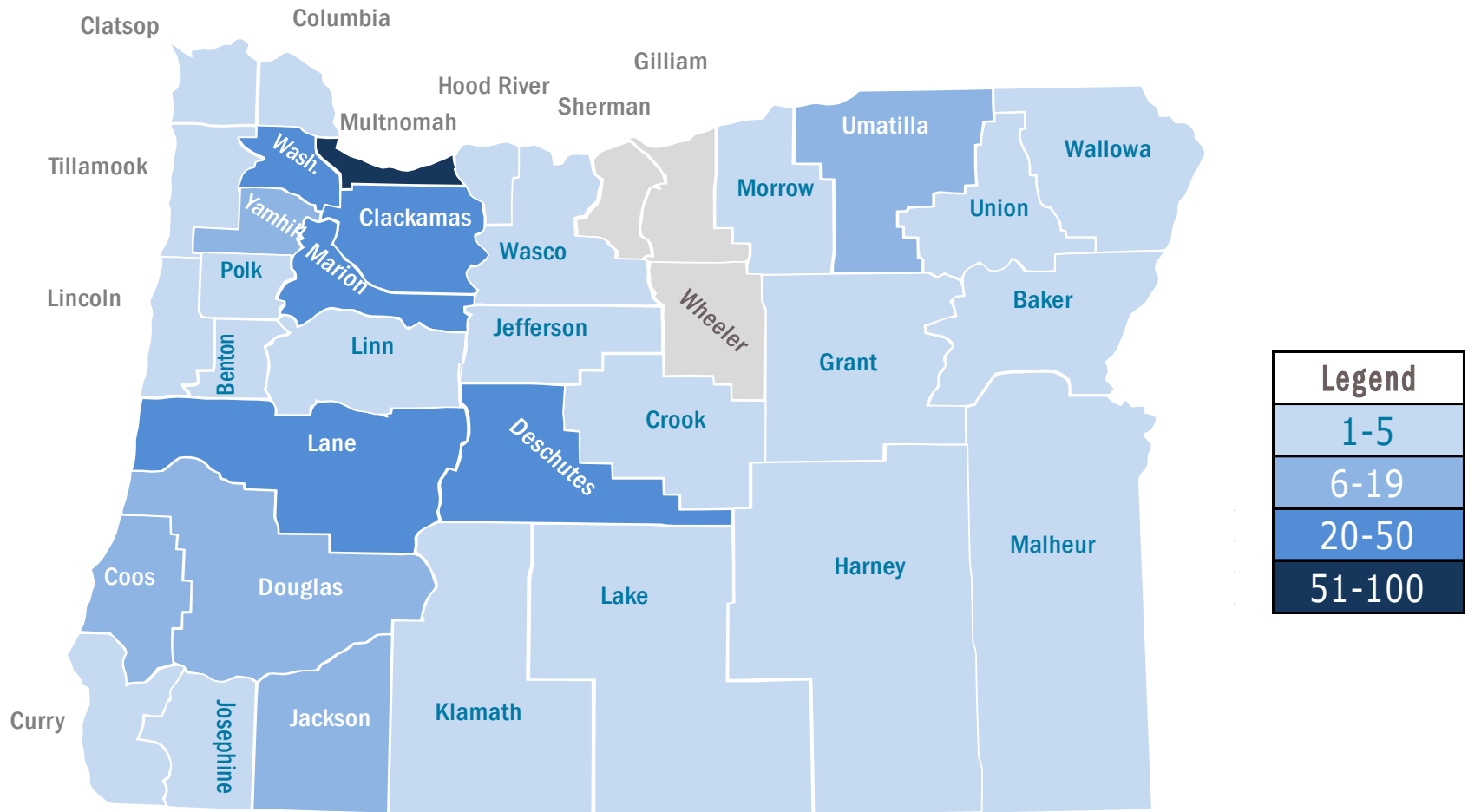
HIEs and National Efforts in Oregon

Network	Care Summary Exchange	Lab/ Radiology Results	Longitudinal Patient Record	Alerts and Notifications	E-Referrals	Analytics/ Advanced Data Services
EDIE/PreManage				X		
ADIN (Advantage Dental)	X				X	Planned
RHIC (Regional Health Information Collaborative – IHN CCO)	X	X	X	X	Planned	X
Reliance eHealth Collaborative	X	X	X	Planned	X	X
Carequality	X	X				
Commonwell	X	X				
eHealth Exchange	X	X				

HIE Definitions

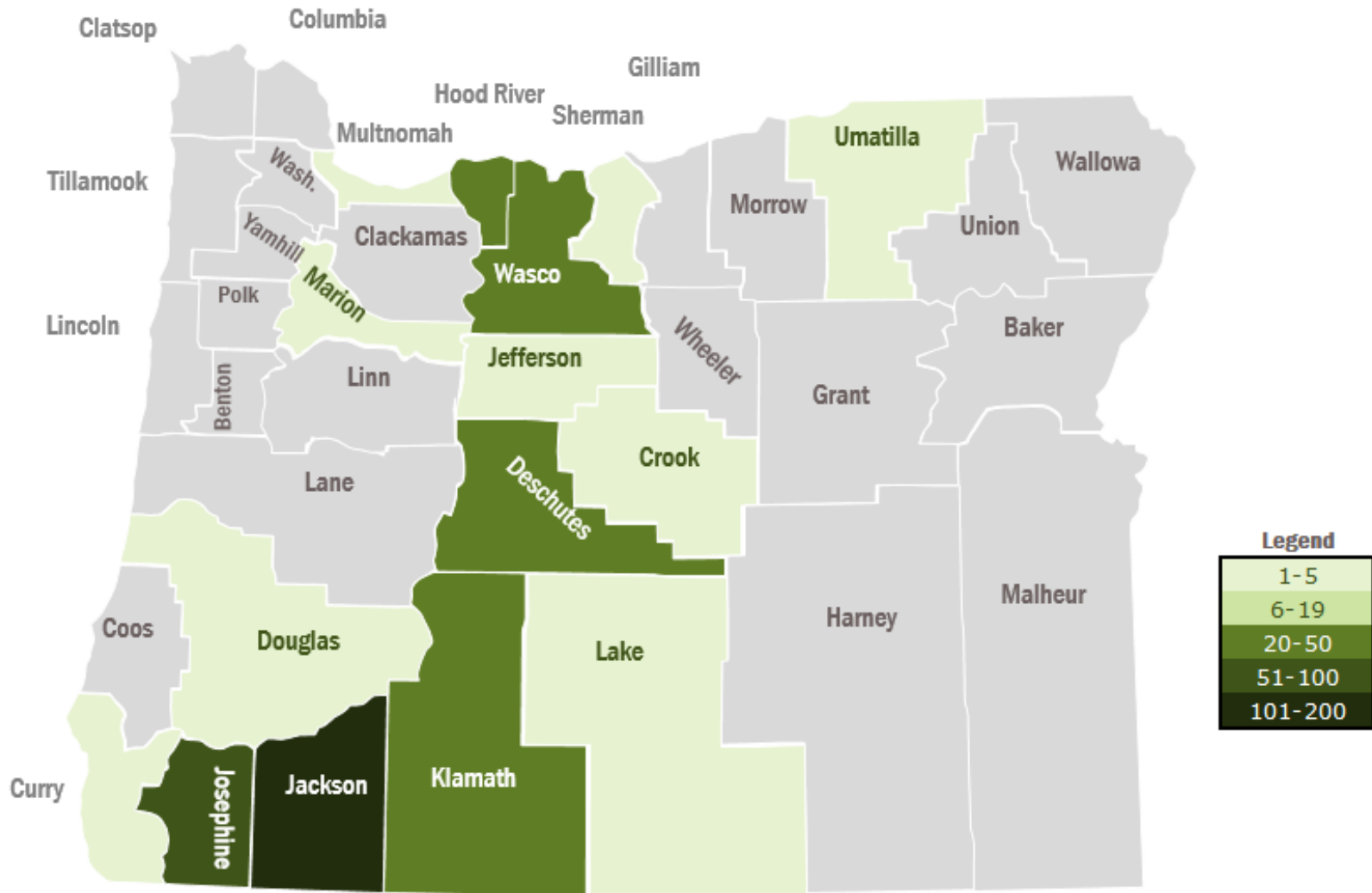
- **Care Summary Exchange** means the ability to transmit and receive CCDs in CCDA format.
- **Lab/Radiology Results** means the ability to transmit and receive, in ingestible form or other form, results from laboratories or radiology centers and may include a variety of data types including ingestible data and images, PDFs, and transcribed reports.
- **Longitudinal patient record** means collecting information from a variety of sources (CCD, ADT, lab/rad messages, etc.) and assembling it in a unified picture or “dashboard” for each patient.
- **Alerts and Notifications** means pushing information about a patient or set of patients to a certain provider or other entity (like a CCO). This can take many forms, from individual ADTs to mining back-end data to provide notifications about specific health issues.
- **e-Referrals** means an electronic closed-loop referral system in which the referring provider can confirm the referred-to provider accepted the referral and the ongoing status of the referral.
- **Analytics/Advanced Data Services** means tools that allow participants to view and analyze their data for reporting purposes and/or to improve care, improve health outcomes, and lower costs.

Collective Medical Technologies, PreManage & EDIE: Site Density



Source: 3/2018 data self-reported to OHA, parent entity and site-level mixed data.

Reliance eHealth Collaborative: Site Density



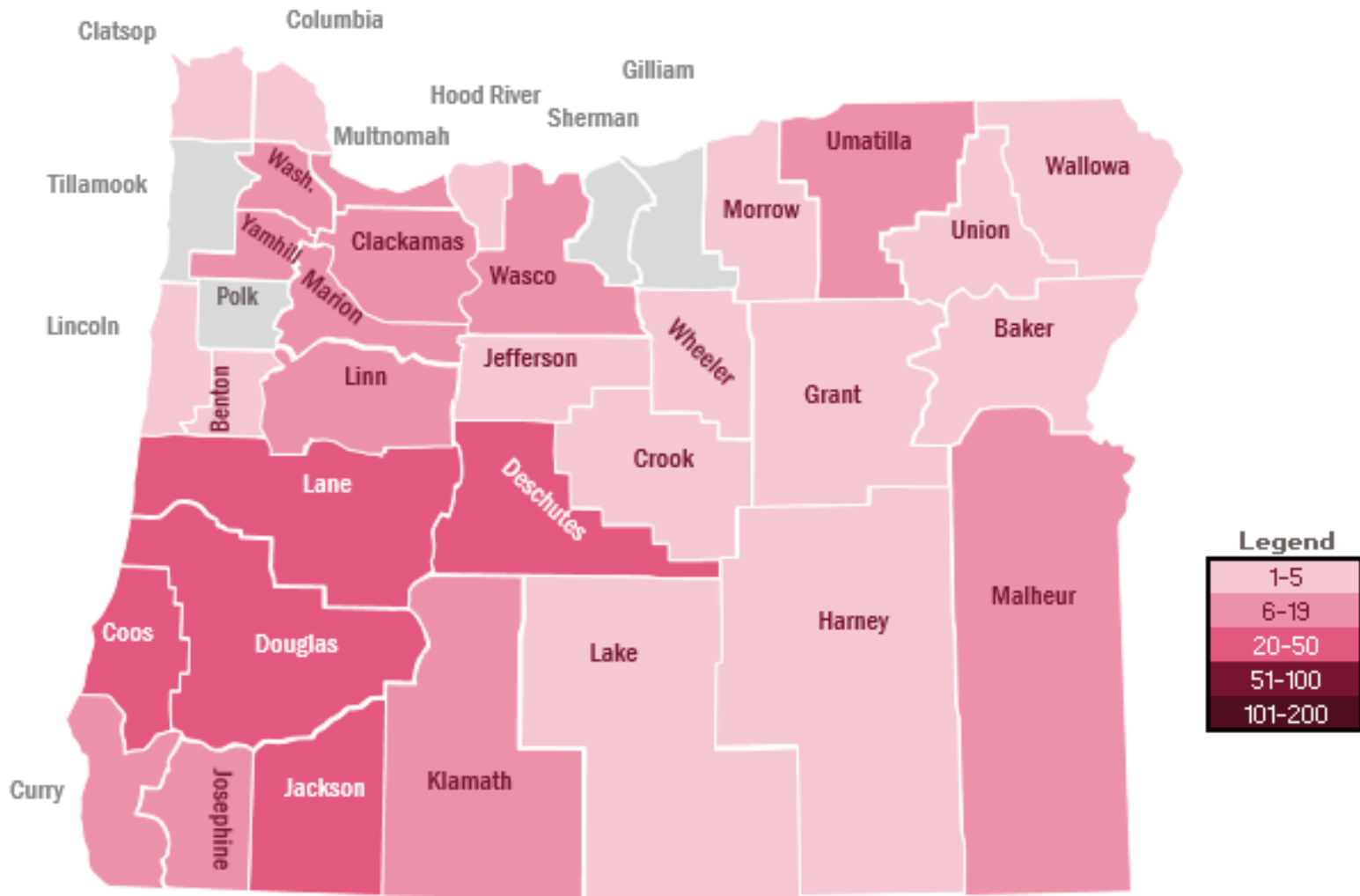
Source: 3/2018 data self-reported to OHA, physical site level data.

Regional Health Information Collaborative: Site Density



Source: 3/2018 data self-reported to OHA, physical site level data.

Advantage Dental Information Network: Site Density



Source: 11/2017 data self-reported to OHA, physical site level data.

National Networks Spread

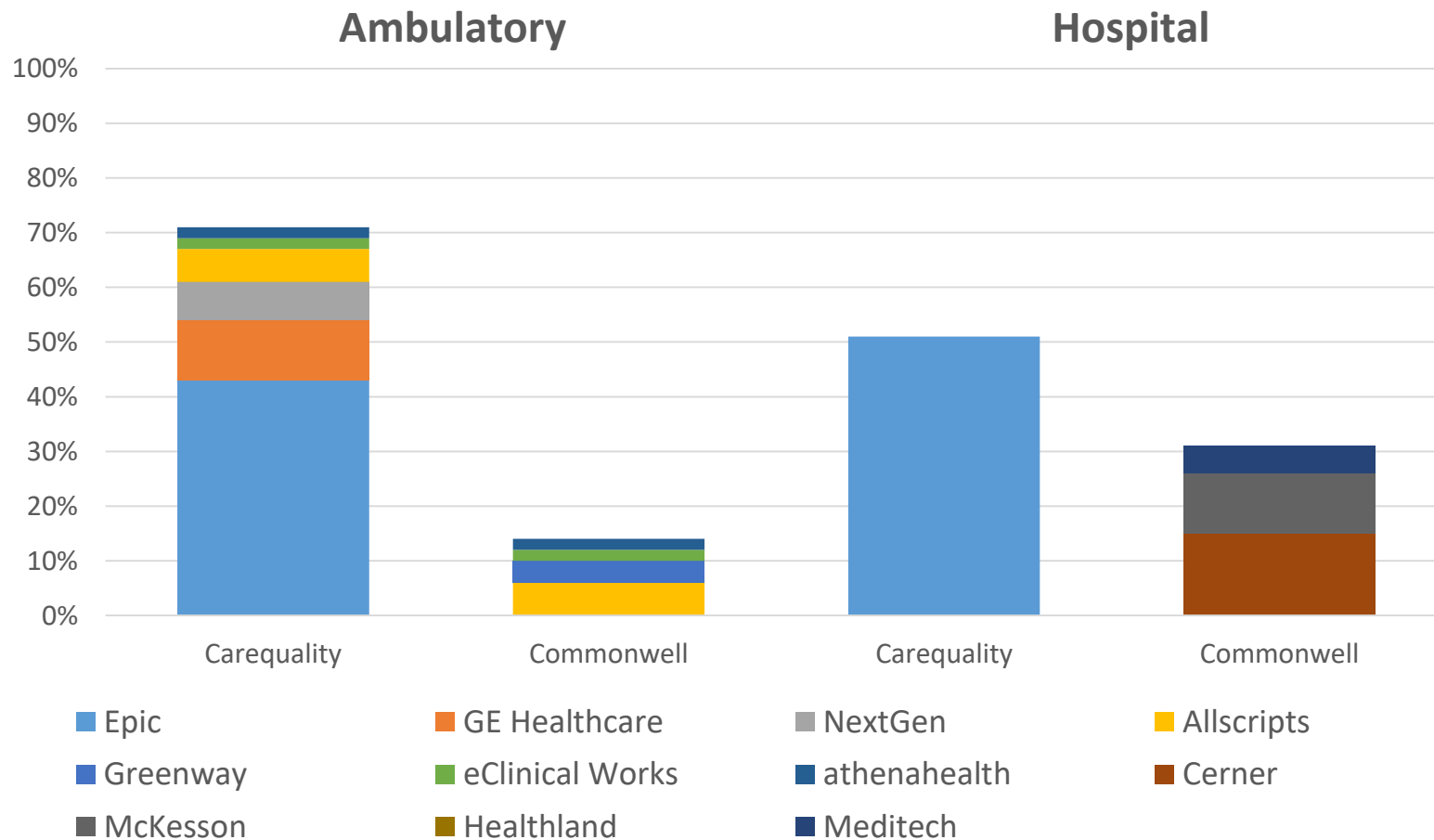
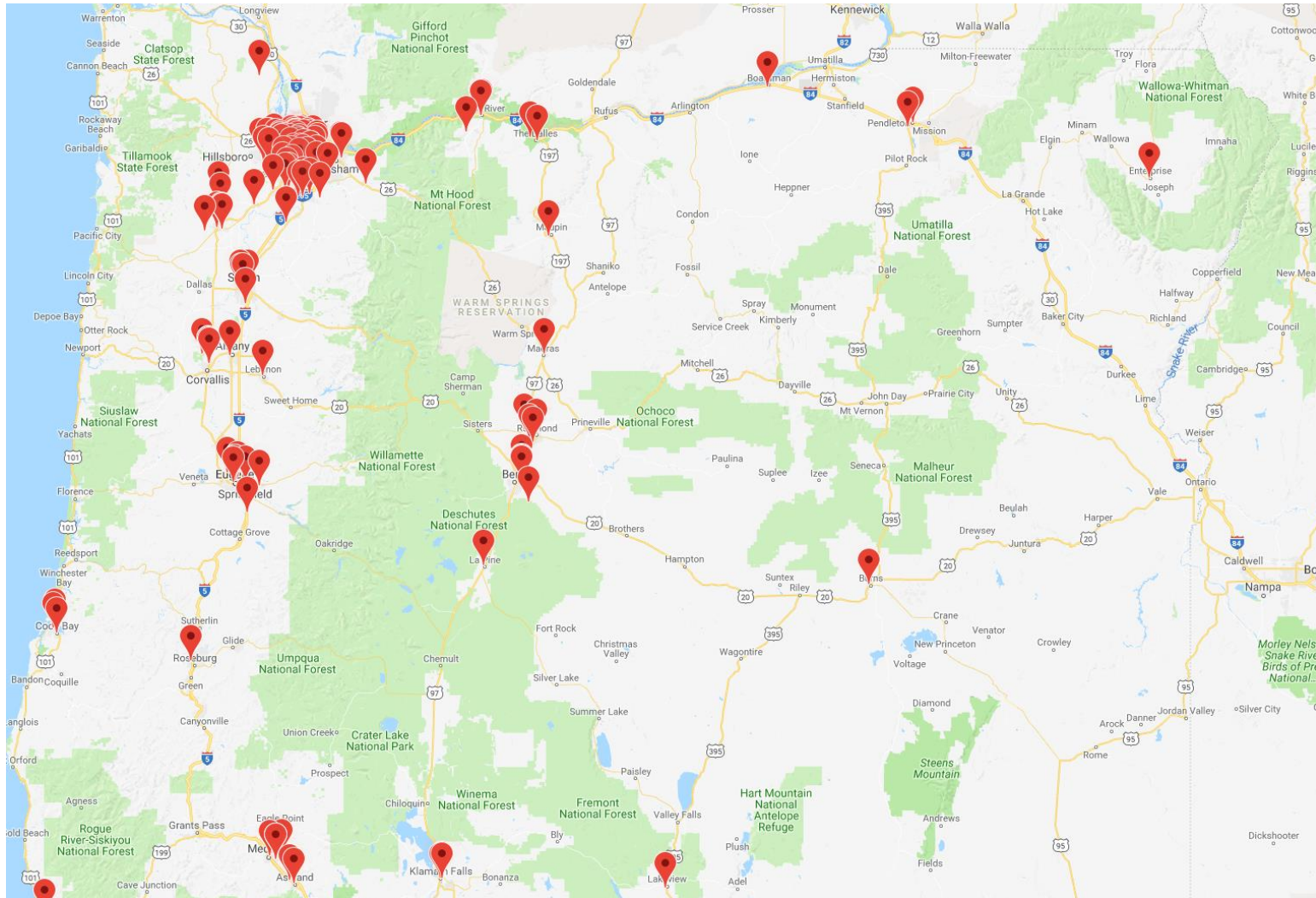


Chart indicates % of EPs/ EHs using a vendor that has implemented Carequality or joined Commonwell; data is from Medicare/ Medicaid EHR incentive programs, and does not represent actual Carequality users (presented 4/2018).

Carequality



Map depicts administrative home of organizations participating in Carequality as of April 2018

Commonwell



4/2018: <http://www.commonwellalliance.org/providers/>

eHealth Exchange Oregon Participants

- Adventist Health System
- Asante Health System
- InterCommunity Health Network CCO
- Kaiser Permanente
- Legacy Health System
- Mercy Health
- OCHIN
- Oregon Health and Science University (OHSU)
- Providence Health System
- The Portland Clinic
- Reliance eHealth Collaborative
- Salem Health
- Samaritan Health Services
- Department of Defense (DOD)
- Veterans Health Administration (VHA)
- SSA

Progress on HIE to HIE Connections

- Many efforts are already connecting with each other
 - ADIN is connected with RHIC and Reliance
 - PreManage is connected with Reliance and ADIN
 - Reliance is connected with several HIEs outside of Oregon through the Patient Centered Data Home model
 - Many healthcare entities/networks have connected to eHealth Exchange
 - Commonwell is becoming a Carequality Implementer
- Trusted Exchange Framework and Common Agreement (TEFCA) meant to accelerate inter-HIE network connectivity

Statewide HIE and “Network of Networks”

- HITOC – Strategic Plan for HIT/HIE (2017-2020)
 - Goal: Oregonians’ data available wherever they receive care or services across the state
- HITOC Strategic direction: “Network of Networks”:
 - Build upon existing HIE investments and connect HIE “networks”
 - Coordinate stakeholders to develop the necessary framework
 - Common rules of the road, technical and legal frameworks
 - Technology infrastructure necessary centrally
 - Ensure interoperability to improve value of exchanged data
 - Ensure privacy and security practices are in place
 - Provide neutral issue resolution
- Statewide efforts and shared governance needed

HIT Commons launched January 2018

Public-private partnership to support and spread statewide HIT efforts in Oregon

- OHA and Oregon Health Leadership Council co-sponsored development of an HIT Commons Business Plan
- Building off the success of the EDIE public/private partnership
- Endorsed by OHA, OHLC, HITOC, and other stakeholders

Key objectives:

- Establish neutral governing and decision-making process for investing in HIT efforts
- Leverage opportunities for shared funding of HIT
- Coordinate efforts for the adoption and spread of HIT initiatives

EDIE Utility 2017 Evaluation

- Initial EDIE Utility goals were not realized, however recent trends suggest efforts are beginning to show reductions in utilization
 - ED high utilizers with a care recommendation developed in EDIE/PreManage had a subsequent 10% reduction in ED visits
- EDIE and PreManage users consistently report real time information has greatly improved the efficiency and effectiveness of their care
- EDIE Utility model has been a successful public private partnership
 - Public private partnership and inclusion of broad stakeholder representation has contributed to success

Oregon's PDMP Integration Initiative

- Integration of the Prescription Drug Monitoring Program (PDMP) with health IT systems
 - Authorized prescribers, pharmacists can query the Oregon PDMP within their workflow
 - Oregon's PDMP contains controlled substance prescriptions filled in Oregon retail pharmacies, managed by Public Health
 - Ensures providers have accurate, relevant and timely PDMP information at the point of care to make better informed clinical decisions
- Launched statewide “gateway” subscription in 2018 In 2018,
 - HIT Commons jointly funded between OHA, hospitals, health plans
 - Phased approach with rollout expected over 3 years

PDMP Integration – Fall 2018

- EDIE Alerts include PDMP data in 25 hospitals, for 600+ ED providers
- Prescribers: Lane County Public Health and Rogue Valley Physicians are the first live clinics, with several large health systems and provider groups in process
- Retail pharmacies: Walmart, Providence

PDMP thru EDIE Alerts Live:

- Adventist Medical Center
- Asante (3)
- Grande Ronde Hospital
- Kaiser (2)
- Legacy (3)
- OHSU Hospital
- PeaceHealth (3)
- Providence (8)
- Salem Hospital
- Sky Lakes Medical Center
- Wallowa Memorial Hospital

PDMP via Regional HIE:

Both IHN-CCO's RHIC and Reliance eHealth Collaborative integrations will allow prescribers one-click access

OREGON PROVIDERS' MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY

Jessi Wilson, RHIA, MAT
MU Programs Manager, OHA



Where It All Started

2009 – America Reinvestment & Recovery Act (ARRA)

- Health Information Technology for Economic and Clinical Health (HITECH) Act

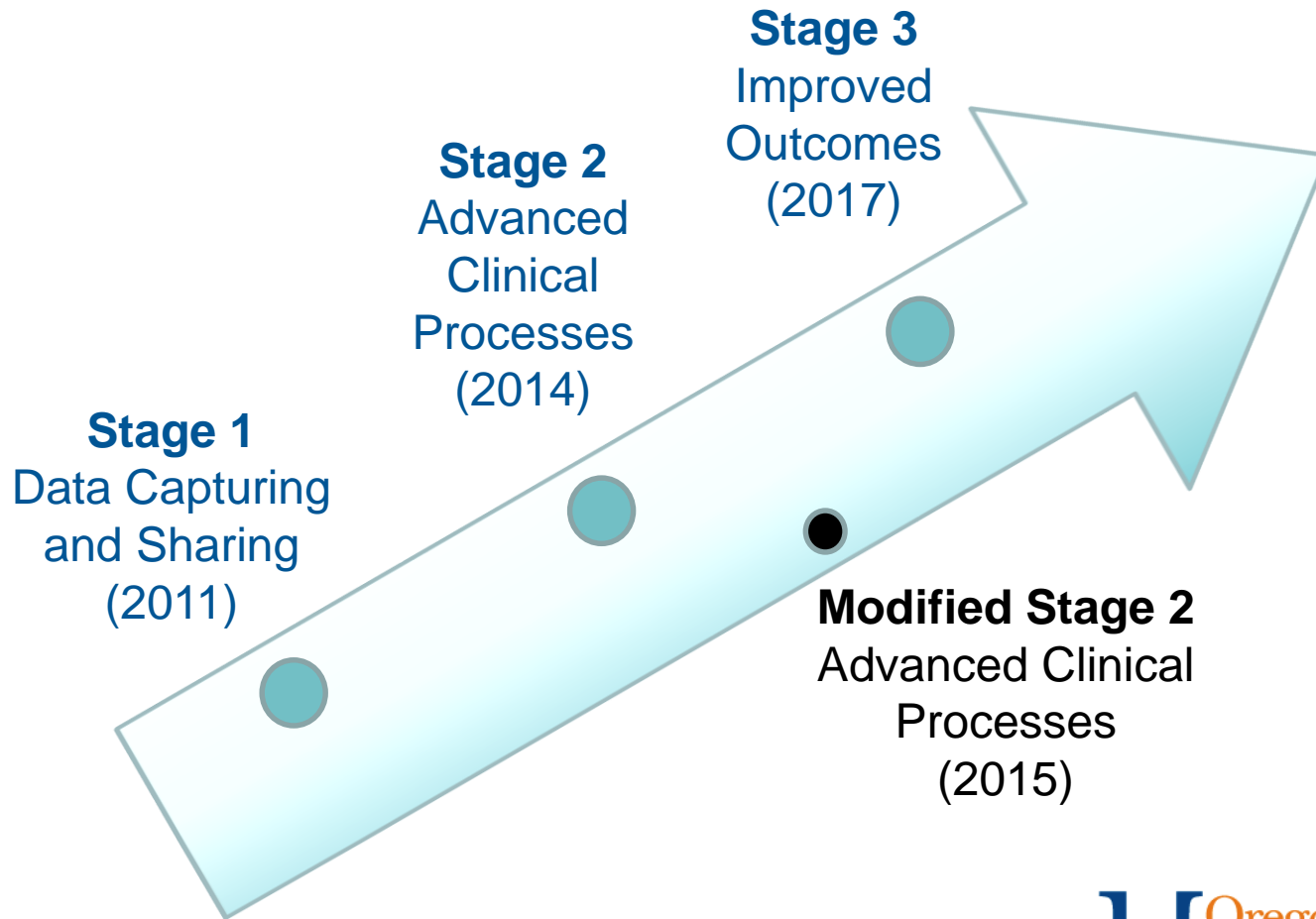


Meaningful Use (MU) of Certified EHR Technology (CEHRT)



Medicare and Medicaid EHR Incentive Programs
(aka Promoting Interoperability Programs)

Meaningful Use



First Year Demonstrating Meaningful Use	Stage of Promoting Interoperability Programs								2019 and Future Years*
	2011	2012	2013	2014	2015	2016	2017	2018	
2011	Stage 1	Stage 1	Stage 1	Stage 1 or Stage 2	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2012	N/A	Stage 1	Stage 1	Stage 1 or Stage 2	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2013	N/A	N/A	Stage 1	Stage 1	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2014	N/A	N/A	N/A	Stage 1	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2015	N/A	N/A	N/A	N/A	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2016	N/A	N/A	N/A	N/A	NA	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2017	N/A	N/A	N/A	N/A	NA	NA	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2018	N/A	N/A	N/A	N/A	NA	NA	NA	Modified Stage 2 or Stage 3	Stage 3
2019 and Future Years	N/A	N/A	N/A	N/A	NA	NA	NA	NA	Stage 3

What is CEHRT?

- An EHR that meets the standards and criteria established by the ONC and CMS for the EHR Incentive Programs
- Is able to...
 - Store data in a structured format
 - Maintain data securely and confidentially
 - Work with other systems to share information
- There have been three CEHRT editions
 - 2011
 - 2014
 - 2015

EHR Incentive Program Basics

Medicaid EHR Incentive Program

- Administered by states
- \$63,750 maximum incentive amount over six years
- Runs 2011 – 2021
- Last year to begin participation was 2016

Medicare EHR Incentive Program

- Administered federally
- \$44,000 maximum incentive amount over five years
- Runs 2011 – 2018
- Replaced by the Quality Payment Program (QPP)

Where We Are Now – Medicaid

Medicaid EHR Incentive Program

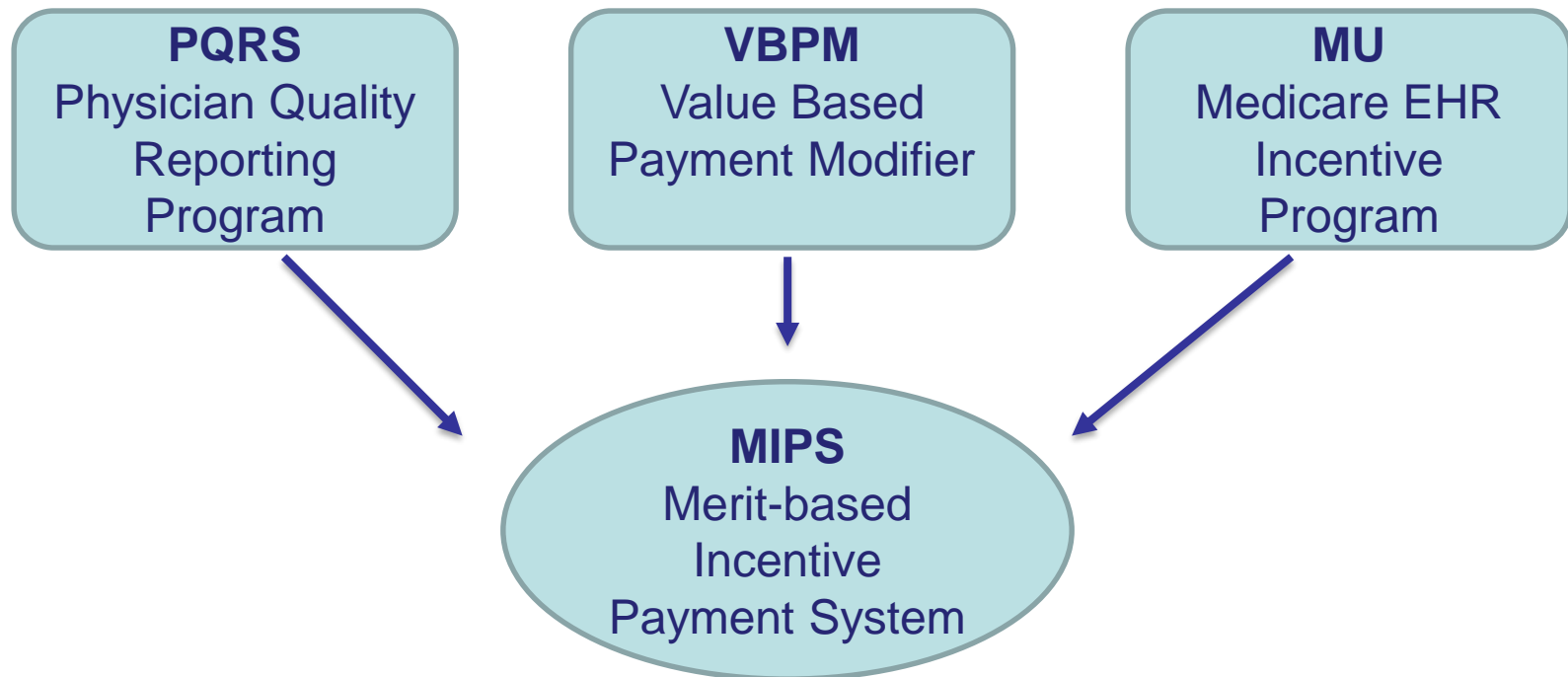
- Currently processing 2017 attestations
 - Last year paying Eligible Hospitals
- Program Year 2018 attestations accepted January 2019
 - Last year for 2014 CEHRT and Modified Stage 2
 - First year for the Clinical Quality Metrics Registry (CQMR)



Where We Are Now – Medicare

Medicare EHR Incentive Program

- Ends in 2018
- Replaced by the Merit-based Incentive Payment System - part of the Quality Payment Program (QPP)



Oregon Program Participation and Stats

	Provider Type (unique count)	Total paid (million)
Medicaid EHR Incentive Program	Eligible Professionals (3,404)	\$116.5
	Hospitals (60)	\$74.8
Medicare EHR Incentive Program	Eligible Professionals (4,831)	\$144.6
	Hospitals (59)	\$182.7
Total		\$518.6

Based on most recent payment/attestation data from the National-Level Repository (CMS) 9/2011- 9/2018

How is Oregon Doing?

Overall EHR payment counts (Medicare and Medicaid), since inception

- Oregon ranks 30th out of 59 programs
- California, Texas, and New York are the top 3; Washington is 18th
- Oregon's population is 27th highest out of 51 states²

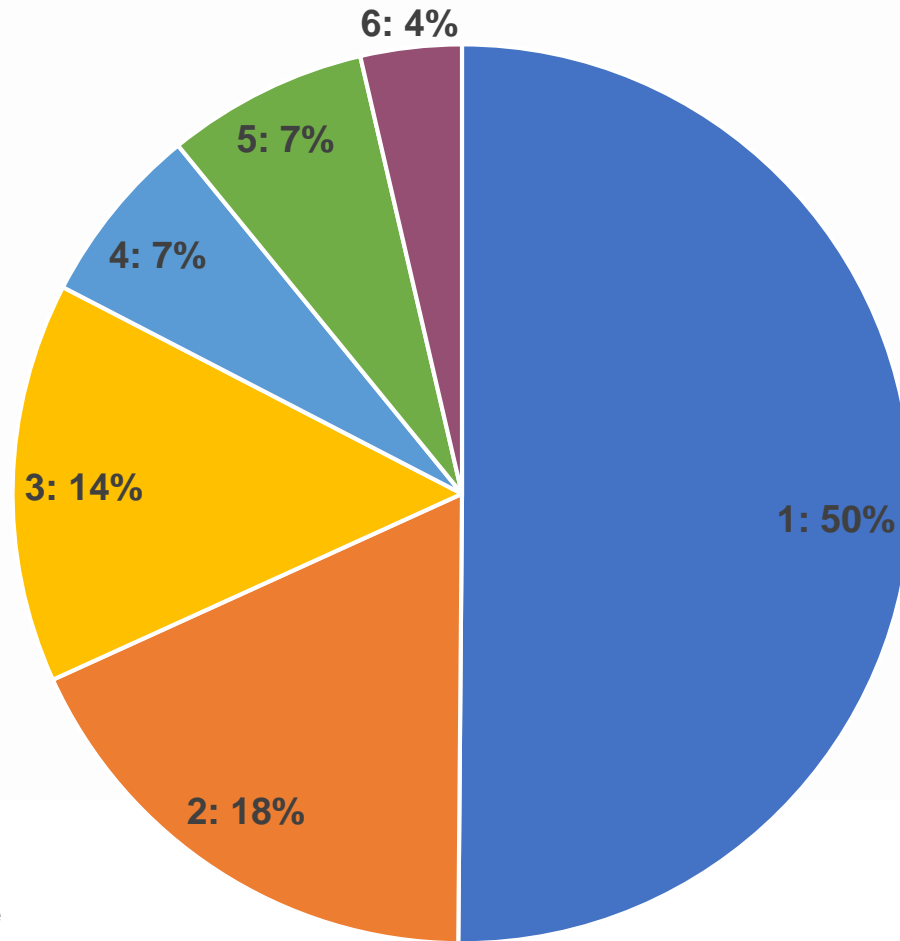
Proportion of Meaningful Use payments paid under the Medicaid EHR Incentive Program

- Oregon ranks 9th overall with 64% of total Medicaid EHR incentive payments made for meaningful use¹
- Delaware (69%), Minnesota (69%), and Maine (68%) are the top 3

1 – State Breakdown of Payments to Medicare and Medicaid Providers through June 30, 2018;
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html>

2 - <http://www.ipl.org/div/stateknow/popchart.html>

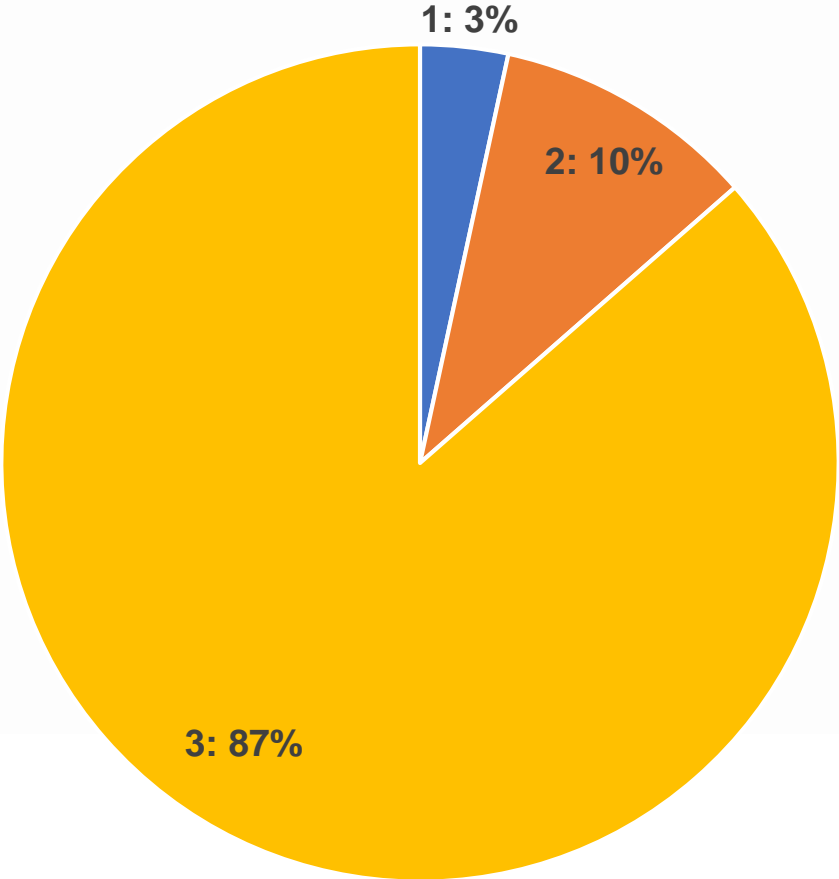
Number of Payments Received by Oregon Eligible Professionals Under Medicaid EHR Incentive Program



Based on most recent payment/attestation data from the Medicaid EHR Incentive Program, 9/2011-10/2018

(n = 3,794)

Number of Payments Received by Oregon Eligible Hospitals Under Medicaid EHR Incentive Program



Based on most recent payment/attestation data from the Medicaid EHR Incentive Program, 9/2011-10/2018

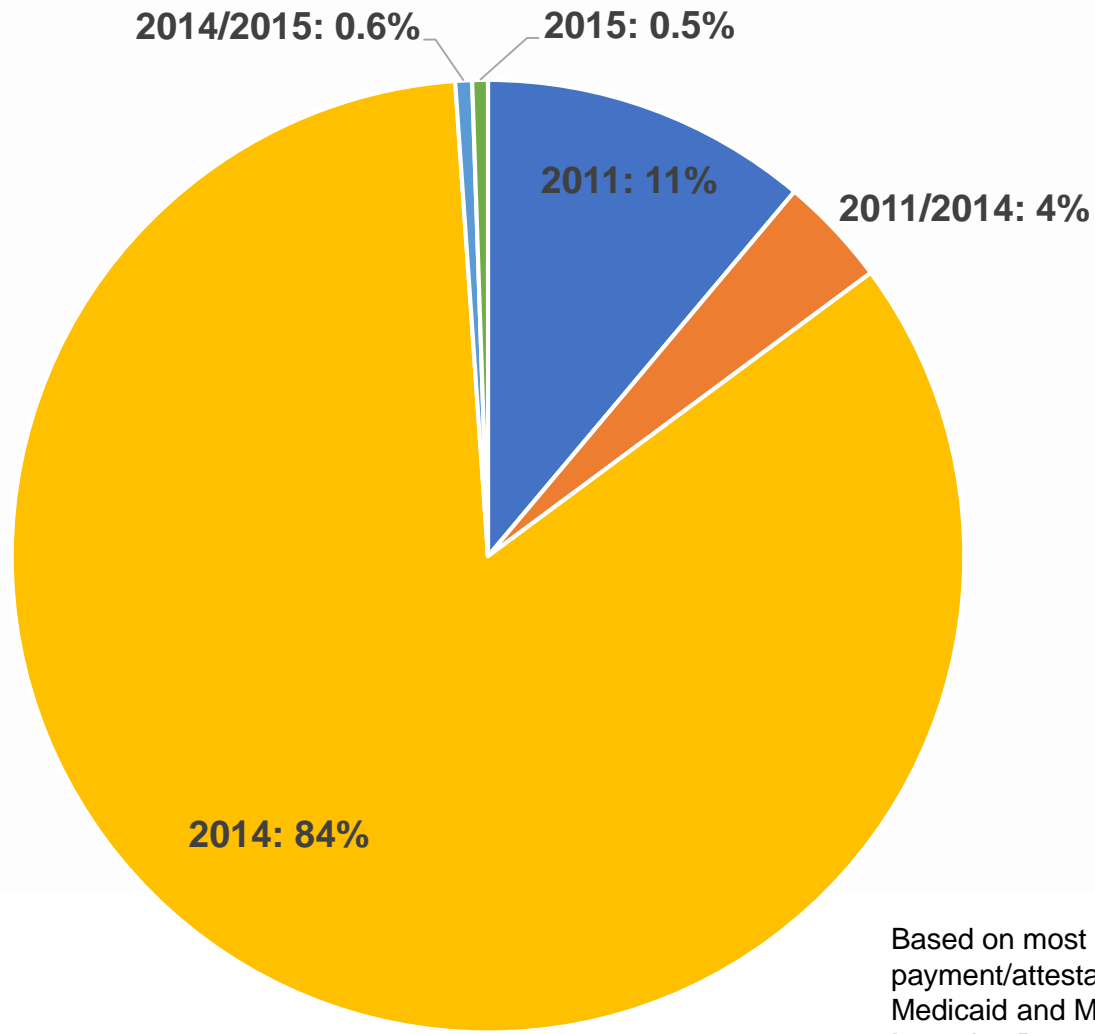
(n = 59)

Where We Are Headed

- 2019 and beyond
 - 2015 Edition CEHRT
 - Stage 3
- Sunset of Medicaid EHR Incentive Program 12/31/2021
- MIPs (for the Medicare providers)
 - No end in sight
 - See qpp.cms.gov for more information

What Does CEHRT Adoption Look Like for Oregon's Eligible Providers?

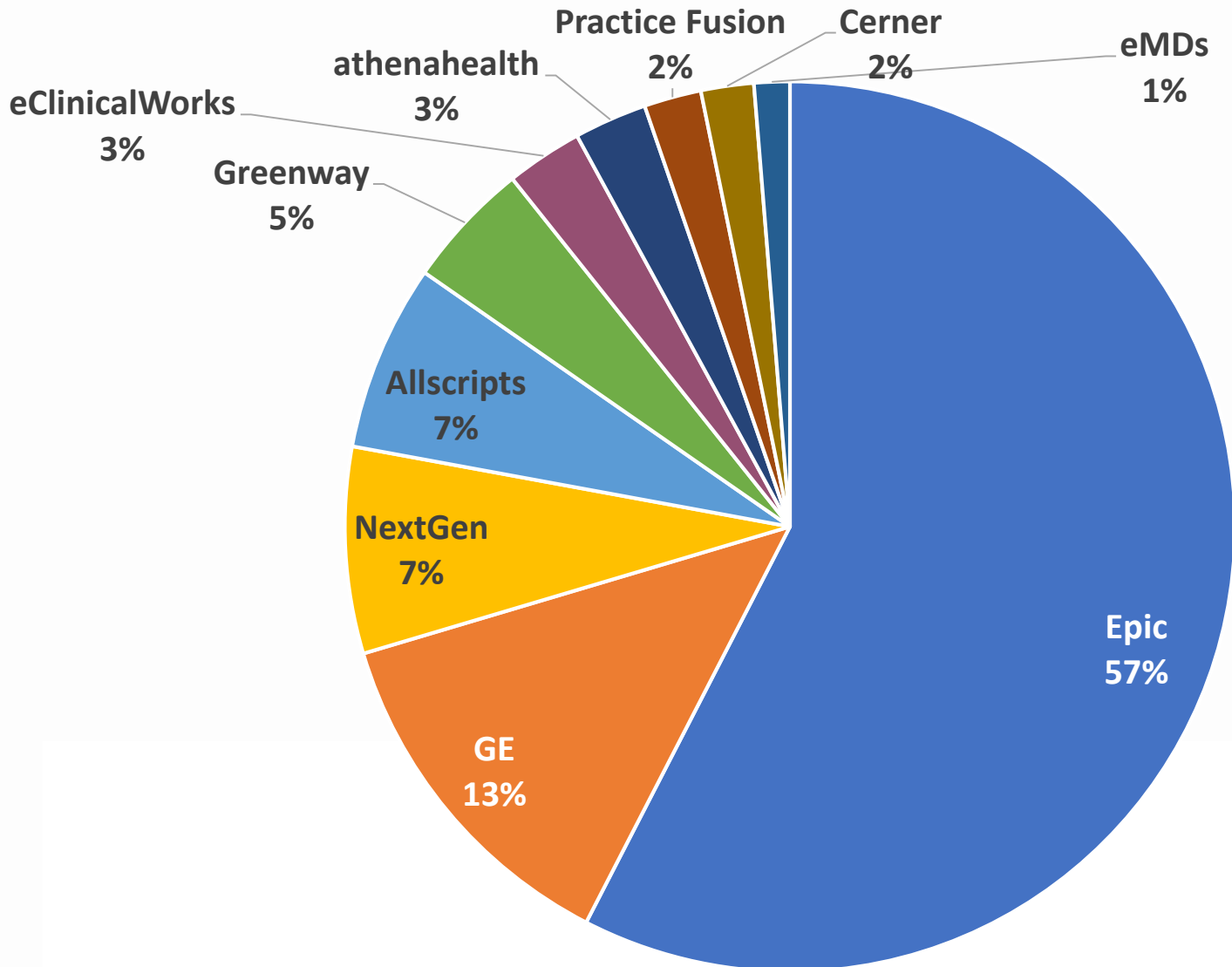
CEHRT Year of Oregon Eligible Professionals in Most Recent EHR Incentive Program Participation Year



Based on most recent payment/attestation data from the Medicaid and Medicare EHR Incentive Programs, 1/2013-10/2018

(n=8,090)

Top 10 EHR Vendor Systems Purchased by Oregon Eligible Professionals

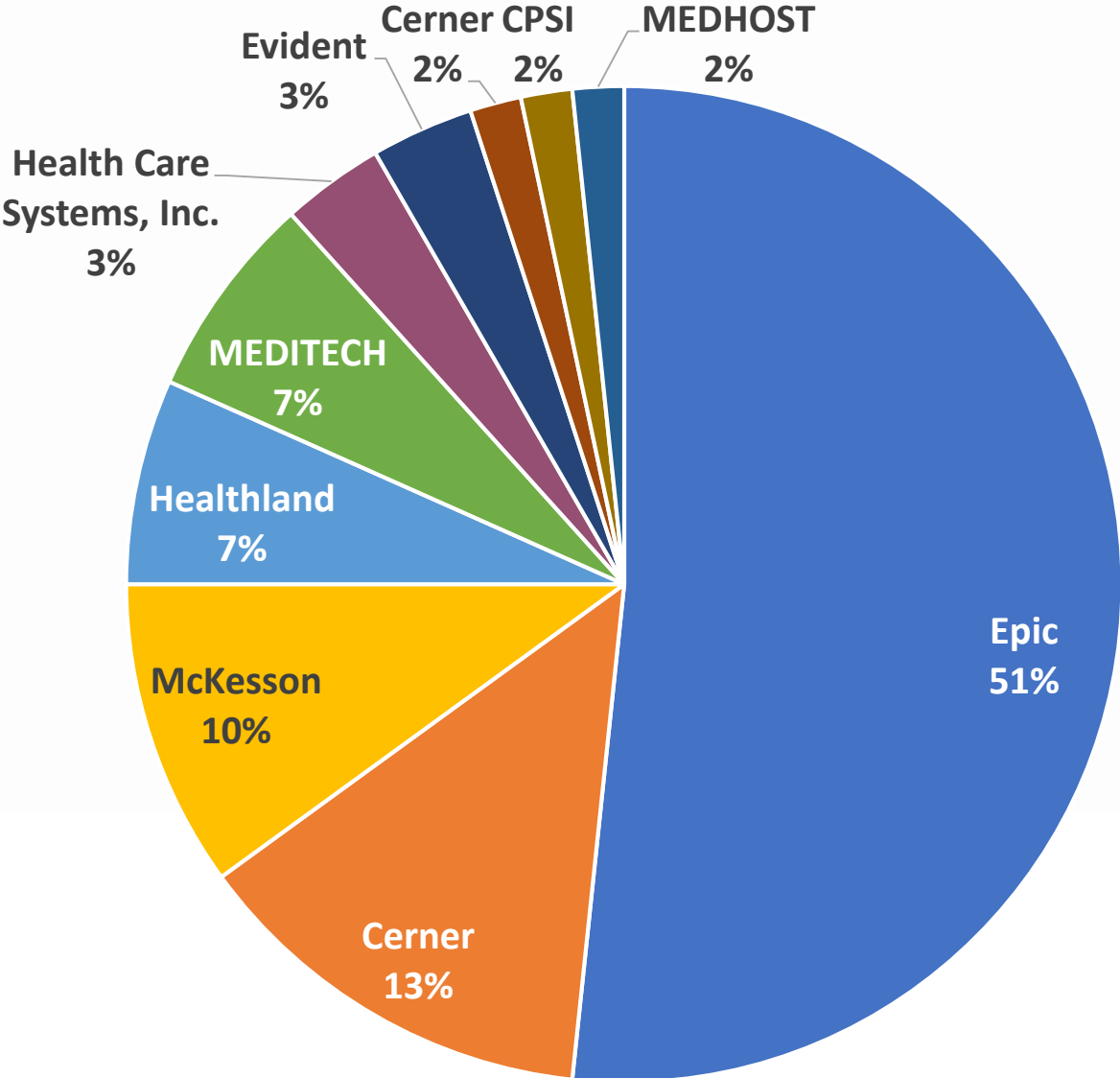


There are 145 unique vendors

Based on most recent payment/attestation data from the Medicaid and Medicare EHR Incentive Programs, 1/2013-10/2018

(n = 6,726 out of 8,090, 83%)

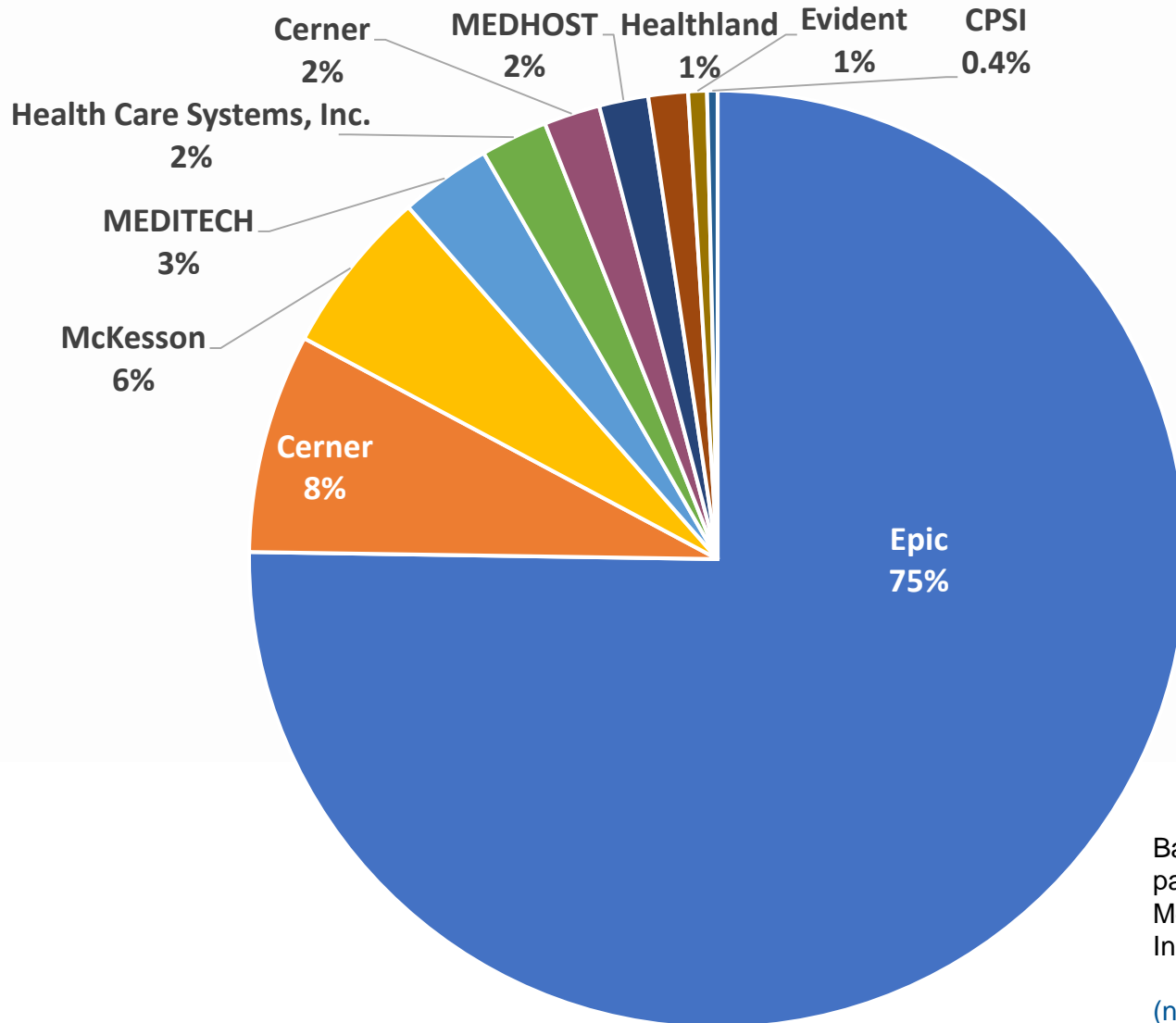
EHR Vendor Systems in use by Oregon Hospitals



Based on most recent payment/attestation data from the Medicaid and Medicare EHR Incentive Programs, 1/2013-10/2018

(n = 60)

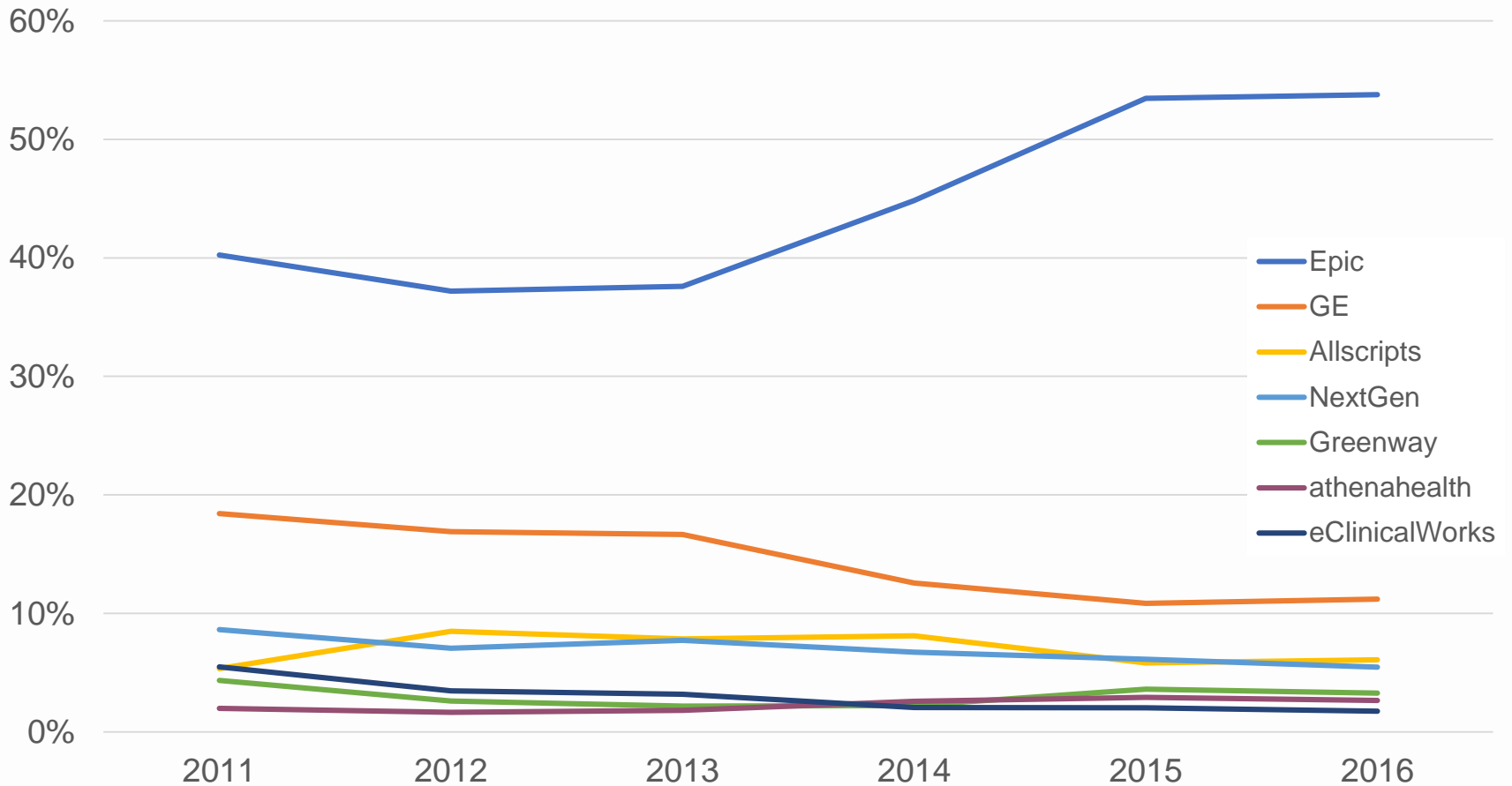
Oregon Hospitals' EHR Vendor Systems Weighted by Number of Beds



Based on most recent payment/attestation data from the Medicaid and Medicare EHR Incentive Programs, 1/2013-10/2018

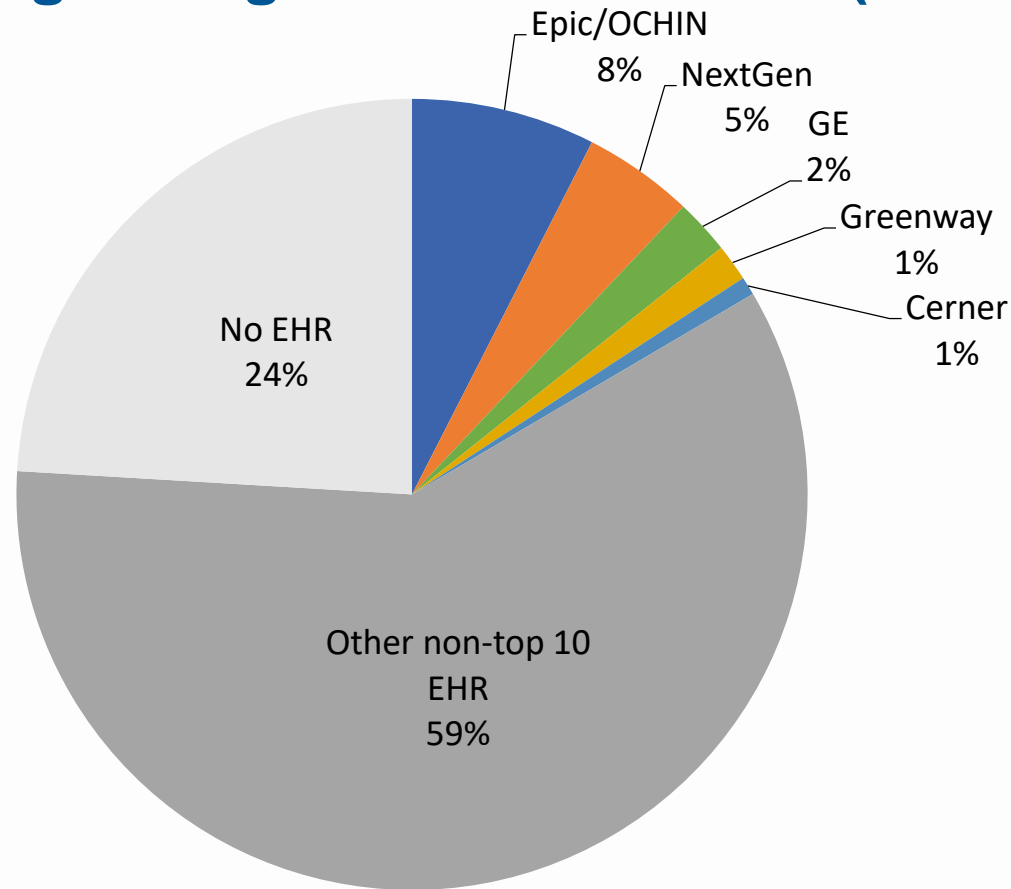
(n=6,660)

EHR Market Share by Year Among Oregon Eligible Professionals in Medicare and Medicaid EHR Incentive Programs



Based on most recent payment/attestation data from the Medicaid and Medicare EHR Incentive Programs, 1/2011-10/2018

Behavioral Health Agencies with EHR in Top 10 of Oregon Eligible Professionals (n=133)



Among agencies responding to 2017 survey by Oregon Office of Health IT

Successes

- \$518.6 million paid to Oregon eligible providers (Medicare and Medicaid)
- Approval of additional Medicaid EP types
 - Pediatric Optometrists
 - Naturopathic Physicians
- Improved
 - Care Coordination
 - Patient Engagement

Challenges

- Provider burden
- Interoperability
- Privacy and Security
- Creating digital divide for non-participating providers (e.g. BH)

Questions?

Oregon
Health
Authority

WHERE WE'RE GOING: HIT EFFORTS IN DEVELOPMENT

HIT/HIE Ongoing Efforts (2018-2020)

- Health information exchange
 - Develop “Network of Networks” for HIE
 - Bring Medicaid providers onto robust network of HIEs
 - Seek opportunities to support national networks
 - Provide access to high-value data (e.g., PDMP)
 - Improve consent and privacy practices
- Infrastructure and statewide HIT
- Shared governance for Oregon HIT
- HITOC strategy, policy, oversight

HIT Oversight Council (HITOC): Strategic Plan for HIT/HIE (2017-2020)

healthit.Oregon.gov

Clinical Quality Metrics Registry

- Consolidates reporting across programs:
 - Medicaid EHR Incentive Program
 - CCO incentive measures
 - Comprehensive Primary Care Plus (CPC+) (supported)
 - Merit-based Incentive Payment System (MIPS) (supported)
 - TBD – additional programs over time
- Collects common electronic CQMs specified for CMS programs per national standards
 - Also collects state-specific EHR-based CCO incentive measures (smoking prevalence, SBIRT)
- Uses capabilities of certified EHRs
- Offers flexible dashboards

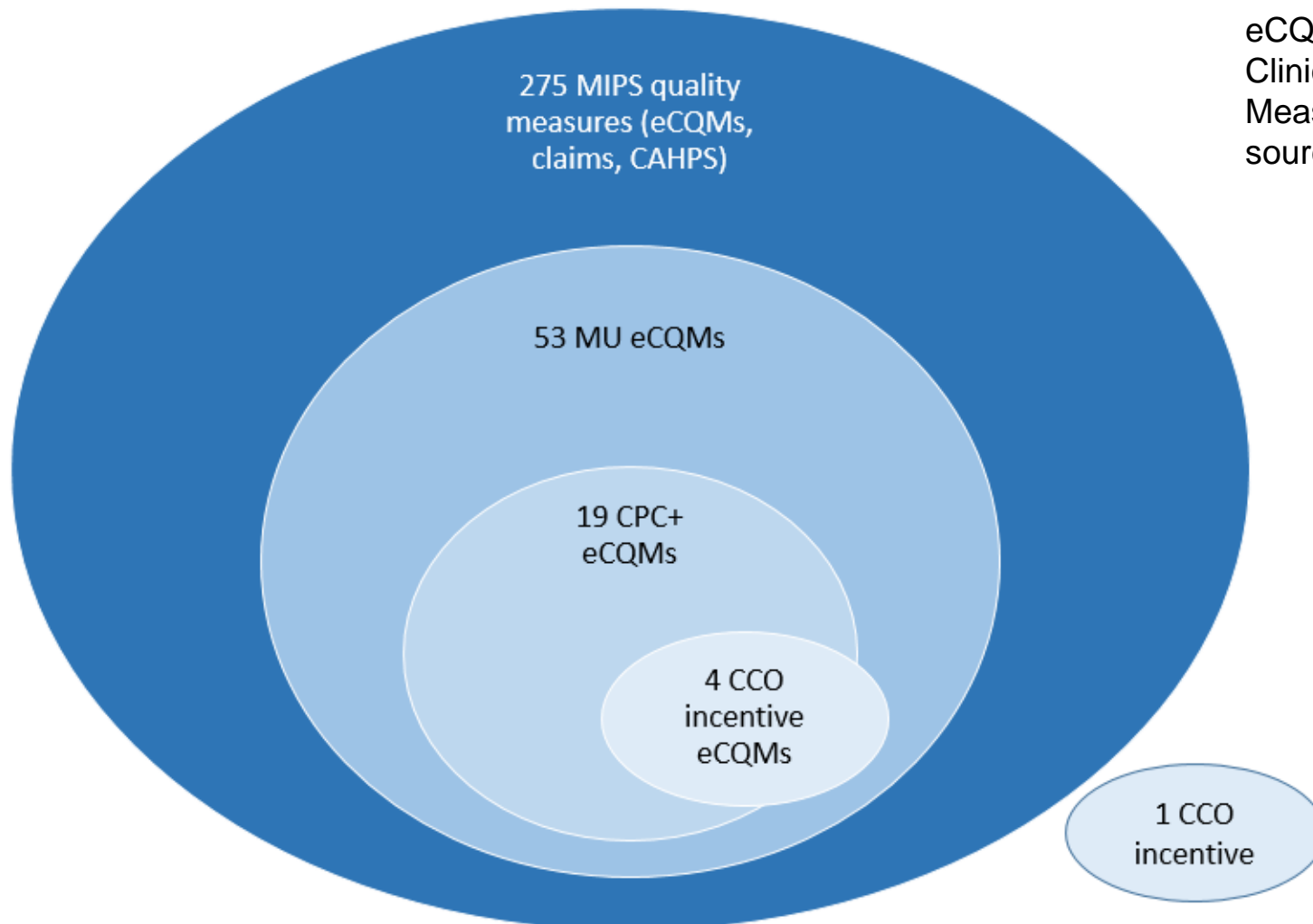
Benefits for Providers and Clinics

Providers and clinics get...

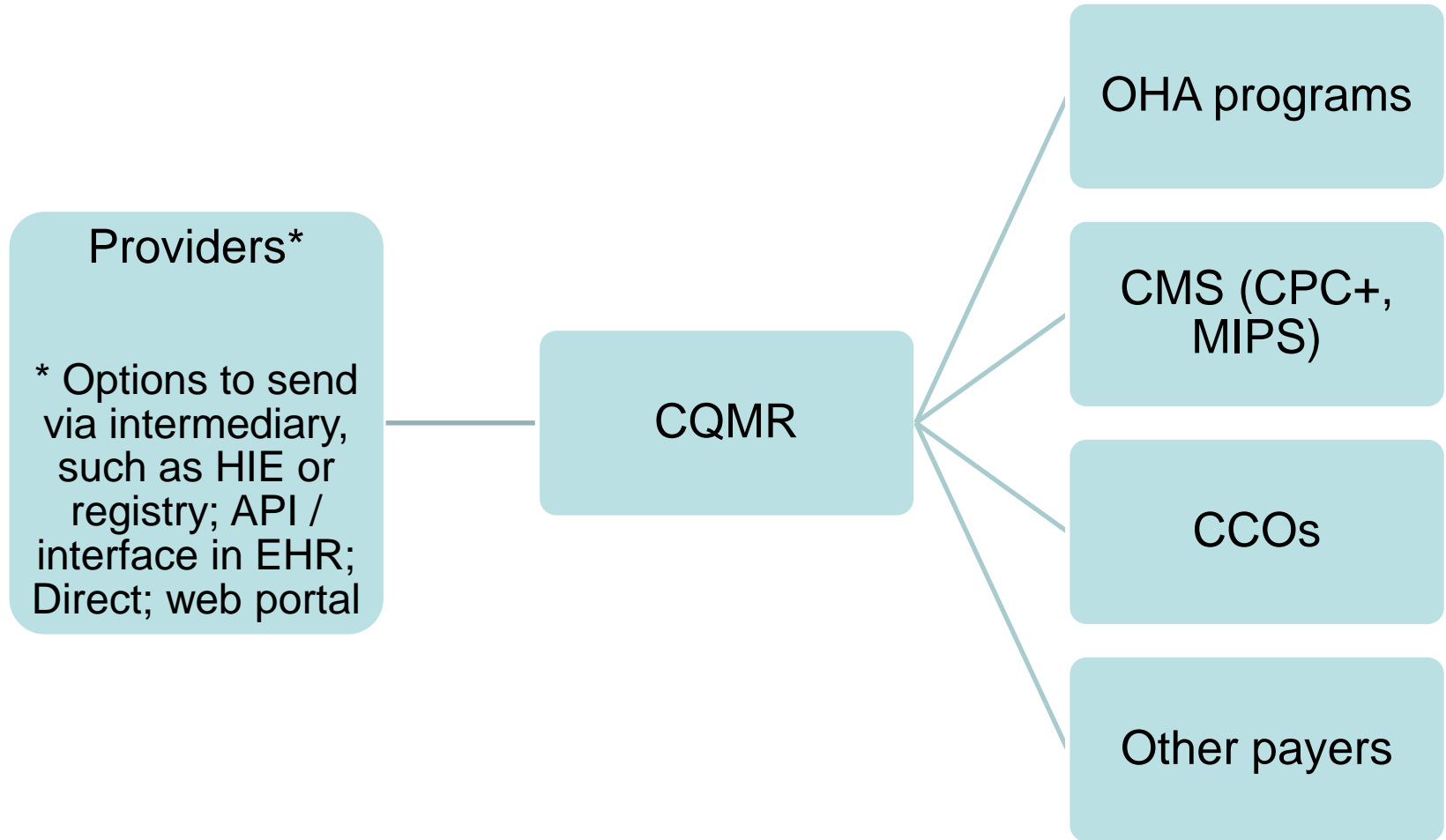
- *Single, streamlined tool* with multiple submission options
- *EHR alignment* to reduce need for custom reports and manual data entry
- *Glide path to robust data:*
 - As providers are ready to send patient-level data, system is ready to support drill-down views
 - Shows how clinics perform against benchmarks
 - Offers customizable dashboard views

2018 Measure Set Alignment

eQMs: electronic
Clinical Quality
Measures (EHR-
sourced measures)

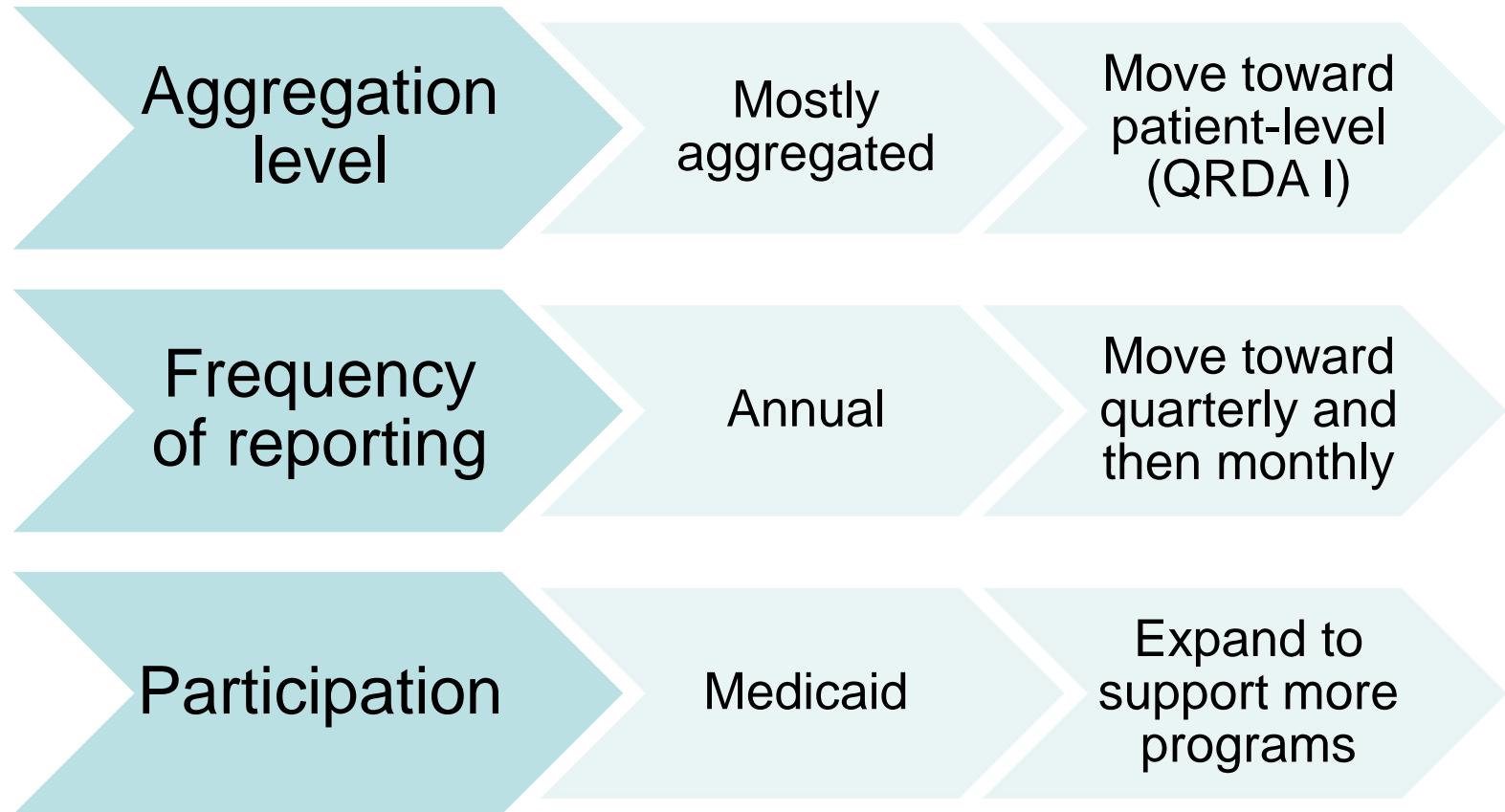


Data collection efficiency opportunities



Roadmap

Today and desired future state

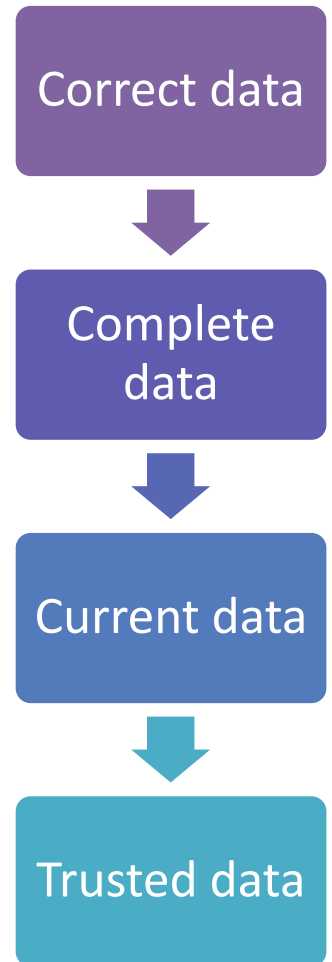


Related areas of work:

- Metrics alignment – measures and reporting parameters
- Pilots to combine clinical and claims data

Oregon's Statewide Provider Directory

- ✓ Up-to-date listing of healthcare providers, their demographic/contact information and affiliations
- ✓ Helps manage organizations, providers and multiple complex relationships between them
- ✓ Can contain electronic addresses used to route information to providers and organizations, or other functional data points
- ✓ Ongoing management of the data is handled by data stewards who ensure data displayed in the Provider Directory is accurate



Provider Directory uses

Use Cases

- **Operations:**

- Validate local directory information
- Find contact information
- Meet regulations

- **Health Information Exchange:**

- Access to addresses to enable sending patient information electronically
- Meet Meaningful Use/Advancing Care Information measures

- **Analytics:**

- Support research, analysis of claims, and quality improvement efforts

High-level Provider Directory Data Types

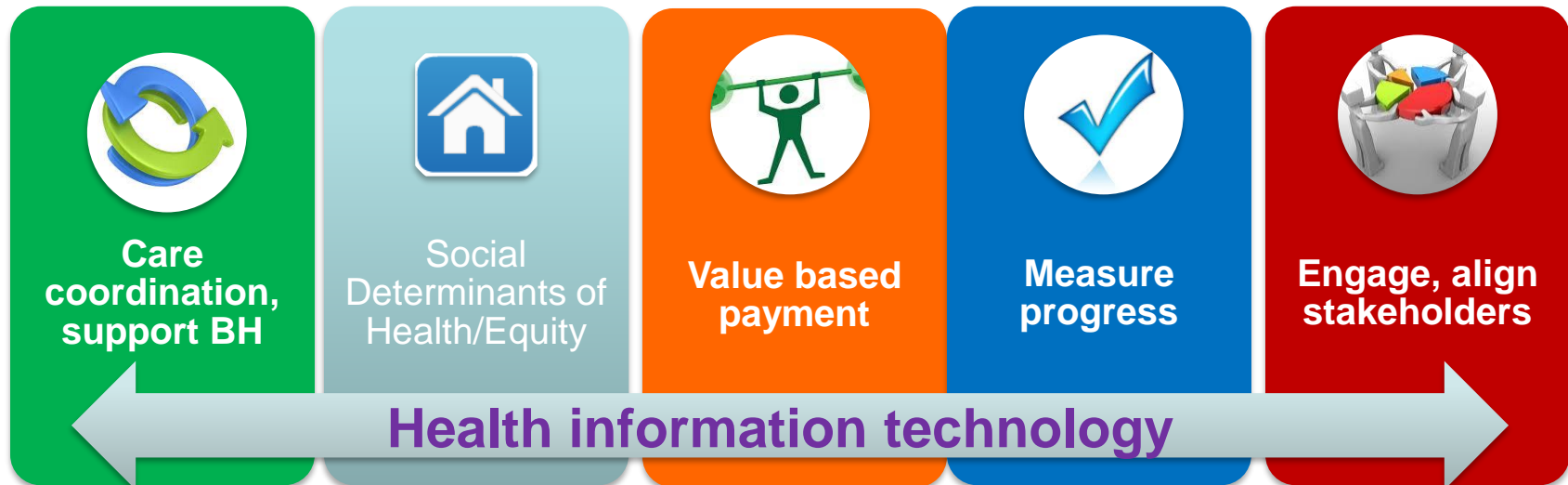
Data Type (includes Medicaid and non-Medicaid providers)

- ✓ Provider/Organization name
- ✓ Address (street, billing, practice, mailing)
- ✓ Contact info (Phone, fax, email(s), website)
- ✓ Demographics (gender, language)
- ✓ Provider type and specialty
- ✓ Provider affiliations (clinics, payers) with effective dates
- ✓ License and certifications (type, dates, renewals)
- ✓ Identifiers (NPI, Medicaid ID, etc.)
- ✓ Direct Secure Messaging Address information
- ✓ Other provider/practice information: Accepting new patients, office hours, ADA accessibility

Initial Sources: MMIS, Flat-File Directory, National Plan and Provider Enumeration System (NPPES)

Additional Sources: CCO network tables, EHR Incentive Programs, Patient Centered Primary Care Home, All Payer All Claims, Other

HIT Supports for Transformation



Organizations and Individuals:

- Organizations invested in EHRs and HIT
- Patients engaged thru HIT
- Local and national HIE efforts spread

Statewide efforts:

- Statewide HIE via coordinated networks
- Centralized core HIT
- Aligned payer expectations
- Shared HIT governance for long term sustainability

HITOC: strategic planning, monitor and adapt to changing environment, oversee progress, explore emerging areas

Questions?

Oregon
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Learn more about Oregon's HIT/HIE developments, get involved with HITOC, and Subscribe to our email list!

HealthIT.Oregon.gov

CCO 2.0 Efforts:

oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx

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