



Oregon

Theodore R. Kulongoski, Governor

**Health Information Infrastructure
Advisory Committee**

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November 12, 2008

Governor Ted Kulongoski
State Capitol Building
900 Court Street NE
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Dear Governor Kulongoski:

We are pleased to submit the attached the initial report and recommendations of the Health Information Infrastructure Advisory Committee (HIIAC).

Created by Executive Order 09-09, the HIIAC was charged 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, with recommendations to be considered as part of the Board's comprehensive reform plan. These recommendations of the HIIAC have been incorporated into the reform plan report of the Health Fund Board. 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.

The Committee is grateful for the opportunity to participate in these important deliberations and stand ready to continue our service in developing and implementing an effective and dynamic plan for the use of health information technology to support the transformation of our health care system.

We would like to acknowledge the many hours of work the committee members and staff have devoted to this effort, and their service to the citizens of Oregon.

Sincerely,

Dick Gibson, M.D., Co-Chair
Legacy Health System

Ree Sailors, Co-Chair
Governor's Office

Oregon Health Fund Board



Health Information Infrastructure Advisory Committee

Report to the Oregon Health Fund Board

October 2008

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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 <http://www.oregon.gov/OHPPR/HIIAC/ExecutiveOrder2008.pdf>) 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

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.

paper-based medical record, which often leads to duplicative services and inefficient care.⁶

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.

⁶ J. Marchibrota. 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>.

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.

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.
- 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

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>

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 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

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>.

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.

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 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.msp>.

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 (HITSPP) 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.hitspp.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/healthnetwok>.

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

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>

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 C 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, 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. Audience members were invited to participate in the small groups and the HIIAC would like to thank representatives from the ACLU, Regence Blue Cross Blue Shield, and Harkins Systems for their active participation in these discussions. 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:

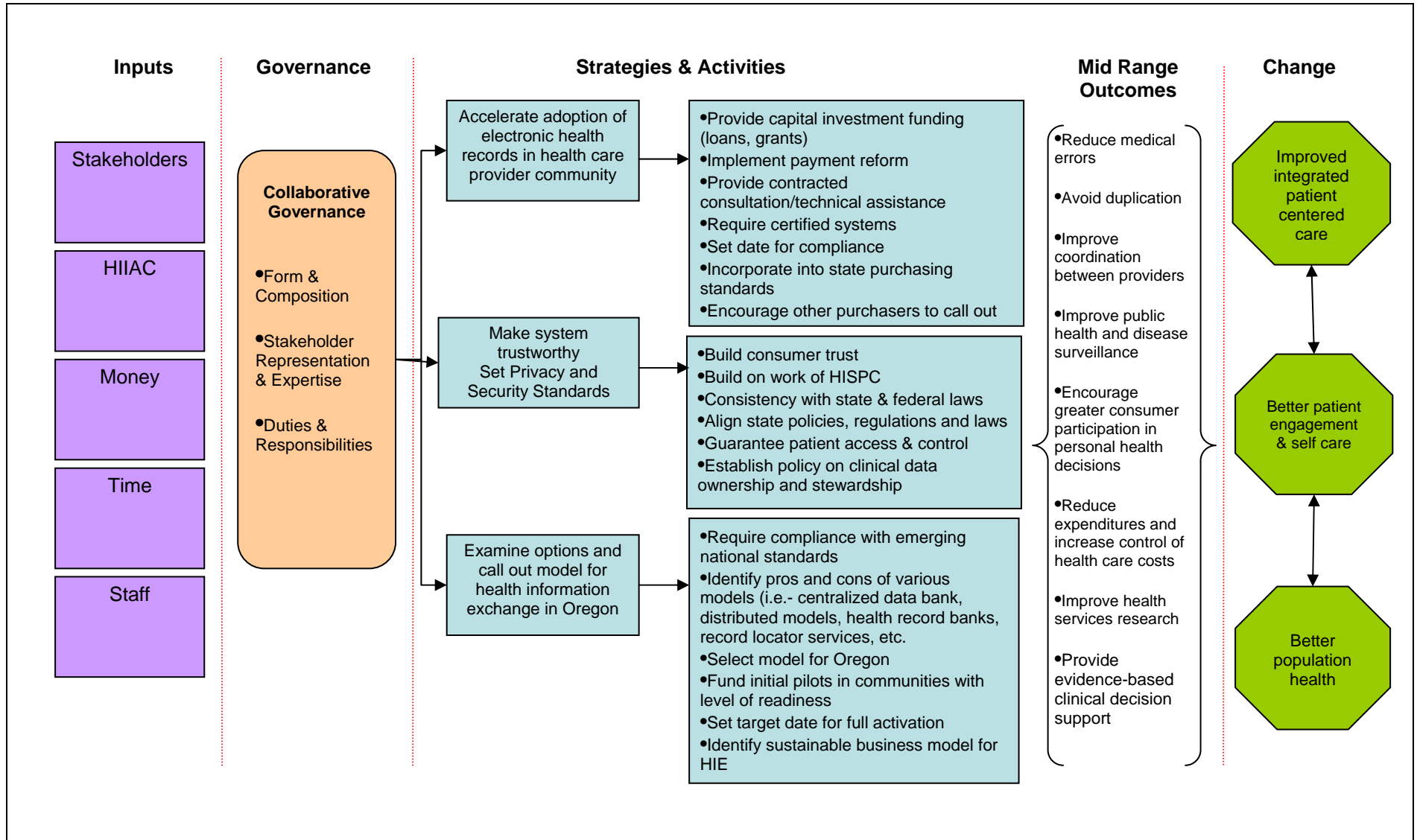
- Review and identify obstacles to the implementation of an effective health information exchange infrastructure in Oregon and provide policy recommendations to remove or minimize those obstacles;
- Outline the role of the State in developing, financing, promoting and implementing a health information 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.

C. Logic Model for Health Information Infrastructure Development



SECTION II: RECOMMENDATIONS AND NEXT STEPS

IV. HIIAC RECOMMENDATIONS

Objective 1: Stimulate, coordinate, and support as a priority statewide efforts to increase the utilization of interoperable health information technology.

Strategy A: Bring public and private stakeholders together to develop a strategic health information technology plan, provide oversight for the implementation of this plan, and maximize the impact of resources being spent on health information technology across the state.

ACTION STEP:

1.A.1 Authorize a health information technology oversight council charged with focusing state, federal and private sector resources and activities to accelerate the adoption of personal health records (PHR), electronic health records (EHR), and electronic data interchange among healthcare providers¹⁷, patients and consumers. The council membership must reflect the geographic diversity of Oregon and must include consumers, providers, and privacy and technology experts.

Rather than create a new council, the Governor could expand the authority of HIIAC to work in this capacity and in conjunction with the Oregon Health Fund Board to carry out a health information technology strategic plan for Oregon.

The council will:

- Be comprised of members from the private and public sector who are knowledgeable in the areas of HIT, health care delivery, public policy, and research;
- Serve as the oversight council for a purchasing collaborative designed to help providers obtain affordable rates for EHR, PHR, and interoperability infrastructure;
- Identify and select the industry standards required for all subsidized HIT promotion based, where available, on existing national standards and the current Certification Commission for Healthcare Information Technology certification requirements;

¹⁷ The term providers, as used throughout the HIIAC recommendations, refers to both behavioral and physical health providers.

- Select, support, and monitor HIT vendors contracting with the state purchasing pool for the provision of HIT hardware, software and support services;
- Enlist and leverage community resources to advance HIT adoption;
- Educate the public and providers on the benefits and risks of IT infrastructure investment;
- Educate providers and assist with pre-selection and implementation planning to assist in ensuring the value (cost savings and quality) is realized following EHR installation and EHRs remain interoperable so as to support the exchange of health information in Oregon;
- Coordinate healthcare sector activities that move HIT adoption forward and achieve HIT interoperability;
- Define, catalog and disseminate incentive-based participation strategies to be funded by the state and other payers;
- Guide resource use;
- Reasonably ensure that any endorsed vendors' applications include appropriate privacy and security controls and the data cannot be used for other than patient authorized health care activity as allowed by law;
- Support current state efforts to implement a personal health records bank for Oregon Health Plan enrollees;
- Develop a strategic plan for the development of a statewide health information exchange and closely monitor its implementation; and
- Incorporate the responsibilities as recommended by HIIAC for privacy and security (Objective 4 of this report).

Strategy B: Set specific goals for the adoption of electronic health records (EHRs), personal health records (PHRs), decision support tools, e-prescribing and other health information technology as well as the establishment of a system for state health information exchange.

The state must set ambitious goals for Oregon in all areas of health information technology that align with the statewide health information technology strategic plan and must monitor progress toward these goals.

ACTION STEPS:

1.B.1. Set health information technology goals for Oregon.

The health information technology oversight council, acting in conjunction with the Health Fund Board should set ambitious goals for Oregon in all areas of health information technology, including: electronic health record and personal health record adoption; use of clinical decision making, evidence based practice support, and population management tools; and e-prescribing. While Oregon providers have adopted health information

technology more readily than providers across the nation, there are still over 40% of providers who do not utilize electronic health records (EHRs). The state should set ambitious goals to lead to full adoption of EHR systems and monitor progress toward these goals. In addition, incentives should be put in place to reward providers who are using EHRs in their practice to improve health outcomes and provide decision support consistent with the state's need to set goals for more widespread utilization of electronic prescribing, evidence based guidelines, and other decision support tools.

In addition, every Oregonian should have the opportunity to have a personal health record and the state should set and monitor goals to make personal health records available to and used by people across the state.

The state should also set ambitious goals for interoperability and health information exchange that would ensure the right information is available to the right people at the right time.

The goals should include, but not be limited to:

- Increase percent of Oregon practices with EHRs by 10% every year.
- All Oregonians have access to a personal health record by 2013.
- By 2013, 50% of Oregonians' health information will be included in systems that allow for electronic exchange. By 2014, 85% of Oregonians' health information will be in systems that allow for electronic exchange.

1.B.2 Evaluate progress toward these goals.

The health information technology oversight council, working in conjunction with the Health Fund Board and other state agencies, should monitor progress toward these goals. The Office for Oregon Health Policy and Research currently conducts a survey of Oregon's physicians to determine the rate of adoption of EHRs. This effort should be expanded to allow the survey to capture more detailed information about the utilization of HIT and health information exchange across a wider range of providers. In addition to measuring statewide adoption of health information technology, the council should analyze the impacts of health information technology on population health and quality of care, including: reduction in medical errors, increased consumer participation in their care, decreased costs, and the availability of appropriate information when and where it is needed.

Objective 2: Accelerate widespread, effective use of health information technology (HIT) by health care providers and patients/consumers to improve health outcomes and health care quality.

Strategy A: Restructure reimbursement systems to provide adequate incentives and compensate providers for utilizing health information technology to improve health outcomes.

The infrastructure and on-going maintenance costs associated with the use of health information technology is an enormous barrier to building an interoperable network of providers throughout Oregon. This barrier is felt at all levels of the delivery system but seems to have a profound effect on small practices and providers serving vulnerable populations, such as safety net and rural providers. Organizations that utilize health information technology to improve patient outcomes deserve the opportunity to recoup some of the added burden of these systems as many of the greater cost benefits are realized by other parts of the delivery system.

ACTION STEP:

2.A.1. Determine a fair and appropriate way to reimburse providers for their use of electronic health records (EHRs), starting with providers who serve a large percentage of Medicaid patients.

The health information technology oversight council, in conjunction with the Health Fund Board, will make recommendations on how to fairly and appropriately compensate providers for costs associated with using health information technology to improve patient care. Options that are considered should include, but not necessarily be limited to: setting aside money to fund increased fee-for-service rate adjustments in Medicaid; requiring Medicaid MCO contracts to reimburse higher rates for health information technology adoption; and building pay for performance into the Medicaid reimbursement methodology and similar options to be used by other payers across the state. The possibility of the state using its bonding authority to support the acceleration and adoption of health information technology should also be explored, especially with respect necessary capital for infrastructure development. Without these types of policy and administrative changes, organizations will continue to delay adoption, discontinue technology use, and/or carry the misaligned burden of these costs.

Strategy B: Create a public-private purchasing collaborative or another mechanism to help solo providers, primary care providers, small and rural practices, and those providers who serve a large percentage of Medicaid patients, obtain affordable rates for high-quality electronic health records (EHR) hardware, software and supporting services. Set quality, performance,

and service standards for the technology vendors that will contract with this collaborative.

A recent study conducted by the New England Journal of Medicine revealed that major barriers to adoption of EHRs include capitol costs, difficulties identifying a system that meets practice needs, uncertainty about the return on investment, and concern that a system would become obsolete.¹⁸

Capital cost is the barrier to EHR and other health information technology adoption most commonly cited by providers, especially those in small practices, rural settings or underserved areas. Small practices do not have the same purchasing power as large hospitals and health systems and thus are not able to negotiate with vendors for reduced prices. Even if they are able to pay for initial installation of an EHR system, many of these practices cannot pay to maintain systems or provide ongoing support to staff to effectively use the products to improve patient care.

There are a wide range of products on the market and it is often difficult for providers to determine the EHR functionalities that are needed to support improved patient care and which vendors will be able to provide them with a high-quality product and continued high-quality support and service. In addition, it is difficult for these practices to identify EHR service companies that will be able to provide ongoing support and technical assistance to practices as they integrate the use of EHR into their practice infrastructure. Where providers are using health information technology, different systems are often not interoperable, which limits opportunities to improve care coordination and ensure that complete health information is available to the patient when they want it and to the provider at the time of care.

The state can help practices overcome these barriers by leveraging the knowledge of the health information technology oversight council in identifying a small number of EHR vendors and service companies who meet quality, performance, and service standards set out by the state. In addition, the state could create a purchasing collaborative or participate in a public-private purchasing pool that utilizes bulk purchasing power to negotiate more affordable rates. In order to maximize the utility of these systems for providers and patients, it is important for the state to select systems which are interoperable with one another following implementation and with other systems used around the state.

¹⁸ DesRoches C. 2008. Electronic Health Records in Ambulatory Care – A National Survey of Physicians. The New England Journal of Medicine. 359: 50-60.

Strategy C: Encourage and support providers in utilizing technology that supports clinical decision making (CDM), evidence-based practice (EBP), population-based management and quality improvement.

It is vital for providers to have access to health information technology that will maximize their ability to measure and report on quality metrics and take advantage of interoperable EHR chart information, clinical guidelines and other evidence that can improve the quality of care patients receive. In addition, while some of these tools have been developed, there is more work that needs to be done to ensure that the tools are easily integrated into practice workflow. In addition, electronic health records and other technology utilized by providers must allow for easy reporting of important quality and outcomes information so that it can be used for regional, statewide and practice-based improvement efforts. When providers, health plans, and other stakeholder groups invest in the installation and utilization of health information technology systems, it is vital that these systems include useful CDM, EBP and population-based management components to support high-quality patient care.

ACTION STEP:

2.C.1. Create a purchasing collaborative to help small practices afford a small number of state-supported electronic health record (EHR) vendors and service companies that meet quality, performance, privacy (add to all) and service standards and offer the most aggressive price.

The health information technology oversight council, acting in conjunction with the Health Fund Board, should establish a public purchasing collaborative or collaborate with private partners to create a public-private purchasing pool. The collaborative should use the contracting process to select a small number of EHR vendors and a small number of EHR service companies able to support providers using the selected EHR products that will be offered through the collaborative. The contracting process should be built on quality, performance, privacy, and service criteria, as well as cost and value, and selected vendors must have a proven track record of providing good products and services to customers. In addition, the contracting process must establish a mechanism for monitoring vendors' performance and remedying noncompliance with contract specifications.

Standards to be considered for inclusion in the contracting for *electronic health record vendors* should include, but not be limited to:

- Meeting or exceeding current Certification Commission for Healthcare Information Technology standards
- Valuable clinical decision support, evidence-based medicine, population management and quality improvement tools to be used by providers at the point of care and the ability to report on key quality metrics

- Interoperable data exchange with other EHRs, personal health records, and the Oregon Health Records Bank
- Adherence to HIIAC privacy and security principles (Objective 4 of this report)
- Ability to record, store, and report quality of care and health outcomes measures
- Ability to be utilized in a range of care settings
- Other standards as determined by HIIAC in conjunction with the Health Fund Board

Requirements to be considered for state contracting with electronic health record *service companies* should include, but not be limited to:

- Ongoing support of the EHR systems selected by the EHR *vendor* contracting process
- Implementation support
- Conversion from paper records or another EHR to one of the state-selected EHRs
- Interface support
- Support practices in optimizing use of EHR
- Support quality reporting
- Support participation in health information exchange
- Adherence to HIIAC privacy and security principles (Objective 4 of this report)
- Other standards as determined by HIIAC and through public forums

The contracting RFP process should be completed by January 1, 2010.

Strategy D: Subsidize installation and ongoing management of health information technology in small and rural practices.

Even with reduced prices negotiated by the state or a purchasing collaborative, many practices need financial support to purchase and/or maintain an EHR system. The state should first focus financial assistance on primary care solo and small practices serving underserved and Medicaid populations. The state should only provide support for the adoption of EHR vendors and service companies that meet quality, performance, privacy, and service standards as determined by the state and should be careful not to undermine related community efforts. Grants to support the purchase and installation should be matched by community foundations and other private partners to leverage public dollars.

ACTION STEP:**2.D.1. Establish a program to subsidize provider use of state-selected electronic health record (EHR) vendors and service companies.**

Establish a program through legislation to provide subsidies, in the form of grants or low-interest loans, for providers who cannot afford to purchase and/or maintain an EHR system. Priority should be given to small, rural and/or primary care practices and providers serving a large percentage of Medicaid patients. The health information technology oversight council, acting in conjunction with the Health Fund Board, should be responsible for designing the subsidy programs and the program will be administered by the Department for Human Services. Subsidies must be used to purchase EHRs from state-selected EHR vendors or support services from state-selected EHR service companies available through the purchasing collaborative. Amounts of subsidies will be determined on a sliding scale, based on service to underserved populations and service to Oregon's Medicaid population, as well as other factors such as size of practice and practice location. The subsidy program should be designed to maximize federal match, community matching funds, and other private funds. The technology oversight committee should also explore opportunities to use the state's bond authority to finance the subsidy program.

Objective 3: Have by 2012 a statewide system for electronic exchange of health information.

Strategy A: Support the use of DMAP's (Division of Medical Assistance, Department of Human Services) Health Record Bank (HRB) as a fundamental building block for a statewide system for health information exchange which ensures that patients' health information is available and accessible when and where they need it.

Health information exchange facilitates the electronic movement of health-related information among patients and authorized providers and organizations.

DMAP's Health Record Bank project provides an opportunity for the state to build upon the investment and work that is already being done in the area of health information exchange. The HRB 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.

The input of the private sector will be a key to ensuring the HRB will be interoperable with those outside Medicaid. Ensuring the DMAP Health Record Bank is built to be interoperable with the electronic health records used by providers serving enrollees in health plans through the Public Employees' Benefits Board, Oregon Educators' Benefits Board, and the Department of Corrections will lay the ground work for eventual health information exchange throughout the state.

The HRB should also encompass strong privacy and security protections and resolve the issues of patients' rights with respect to the use and ownership of their personal health information. A public education program targeted at both providers and patients will be necessary to allow patients and providers to have trust and confidence in the system, thereby increasing participation.

ACTION STEP:

3.A.1. The health information technology oversight council ensures support of the Health Record Bank project and requires that the system be built with interoperability as a main focus.

The health information technology oversight council works with DMAP to ensure that the Health Record Bank is developed in line with the overall

strategic goals for statewide health information exchange and that will allow it to interoperate with other systems used across the state.

Strategy B: Facilitate ongoing planning for the development of a statewide system for exchange of health information.

The Health Record Bank is only the first step in creating a system that allows for health information to be effectively, efficiently, and securely exchanged between patients and their providers. The state should coordinate efforts across the public and private sectors to build capacity for health information exchange, promote the development of interoperable technology, and leverage available resources to support a system for statewide exchange. Over time, the state should consider opportunities to partner with private sector and other partners to develop a self-sustaining model for health information exchange.

ACTION STEPS:

3.B.1. The state designates the health information technology oversight council as the oversight entity for promoting a statewide system for exchange of health information technology.

The health information technology oversight council should develop a strategic plan for the development of a statewide system for the exchange of health information technology. This includes setting the goal of having a statewide system for health information exchange in place by 2012 and monitoring progress toward this goal. By 2013, 50% of Oregonians' health information should be able to be exchanged through this system and by 2014, 85% of Oregonians should be included.

3.B.2. The state allocates the appropriate funding to create a statewide system for health information exchange.

Over time, the state should consider working with private and other partners to develop a self-sustaining model for health information exchange.

Objective 4: Ensure the highest level of privacy and security protections for Oregonians' personal health information in an electronic exchange environment to promote widespread participation by providers and patients in these systems.

Strategy A: Any policy developed related to health information exchange must reasonably ensure that systems are in place that protect people's security and privacy and provide for meaningful remedy if these policies are violated.

The federal Health Information Portability and Accountability Act (HIPAA) and current Oregon law offer strong protections for the security and privacy of people's health information. While additional safeguards will be needed over time, strict enforcement of current policies and the existence of penalties for the misuse – including negligent misuse – of information will result in more secure systems being adopted and more privacy and security safeguards being instituted from the beginning.

Strategy B: Utilize an opt-in policy for health information exchange to give individuals' control over their information and who has access to it.

Ensuring clear law and rules for patients and providers involved in electronic health information exchange will increase the use and effectiveness of these systems. Requiring that consumers actively opt-in to a health exchange system will ensure that they know their information will be exchanged electronically.

Strategy C: Ensure that required administrative, physical, and technical safeguards are in place to protect individuals' health information that is specially protected under federal and Oregon state law . Require patients to provide authorization for every instance of exchange of health information that falls within these specially protected categories.

ACTION STEPS:

4.1.The health information technology oversight council will analyze the policies and programs it develops to ensure that the privacy and security of health information is maintained, especially as health information exchange systems are established and expanded.

4.2.The HIIAC will continue to work on privacy and security issues and identify opportunities for Oregon to strengthen state law to protect the privacy and security of Oregonians' health information (See Next Steps).

V. NEXT STEPS

Although the HIIAC members spent significant time discussing privacy and security issues over the last few months, the group was unable to reach consensus on a number of specific focus areas. The group will focus their discussion over the next few months on developing more detailed privacy and security recommendations and will report to the Legislature during the 2009 Legislative session.

Some of the areas the group has identified for further discussion include:

- Patient control of records
- Authorization for individual instances of exchange
- Protection of providers if patient does not allow their information to be fully exchanged
- Right of the patient to keep parts of their record from being exchanged
- Specific penalties and remedies for security breaches
- Ability for patient to correct errors in their record
- Emergency allowances for exchange
- Third party access to information
- Policies that allow for research and public health monitoring while protecting patient privacy

Appendix A: Health Information Technology Glossary

Definitions from:

The National Alliance for Health Information Technology, Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms, April 28, 2008.

Available:

http://www.hhs.gov/healthit/documents/m20080603/10_2_hit_terms.pdf

Electronic Health Record – an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Personal Health Record - an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

Electronic Health Exchange – The electronic movement of health-related information among organizations according to nationally recognized standards.

Appendix B: HISPC Values and Principles

From the HISPC Final State Implementation Report:

HISPC 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.

Appendix C: Specially Protected Health Information and Oregon Law

Oregon HISPIC Project Specially Protected Health Information & Oregon Law March 30, 2007

**Gwen Dayton, JD
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A. Introduction:

Oregon law provides special protections for limited classes of health information. Such protections preempt the HIPAA privacy rule because they are more stringent than HIPAA. More stringent is defined as providing greater protections for the patient/health plan member or providing the patient/health plan member greater access to his/her individually identifiable health information (IIHI). The purpose of this document is to identify the different classes of specially protected health information given current Oregon law.

It should be noted that there have been no significant changes to classes of information considered specially protected for some time with two exceptions. The Oregon Legislature provided greater protections for genetic information during the 2005 legislative session. Also, the Oregon Department of Human Services (DHS) recently promulgated rules that allowed freer access to HIV/AIDS test information (keeping in mind that this does not provide any less protection than afforded by the HIPAA privacy rule).

Legislation was passed during the 2003 session that was considered HIPAA conforming legislation. This legislation did not change what was already considered specially protected health information under Oregon law. It merely made sure Oregon law conformed to federal regulations. The only additions to Oregon law, over and above HIPAA, were to establish a maximum amount providers could charge patients for a copy of their medical record and established in statute a model authorization form.

B. Classes of Specially Protected Health Information:

Oregon law, like most other states, provides special protections for certain classes of health information. While laws differ from state to state, generally the categories of health information afforded additional protections are relatively similar. In a number of cases, the primary difference between states is the level of protections found in statute or rule. As an example, Oregon probably has the most stringent genetic privacy law in the nation. Another good example is California – overall California provides greater privacy protections than any other state and has been a leader in enacting consumer-focused legislation that enhances the privacy of the individual.

The different classes of information afforded special protections under Oregon law include:

- Genetics
- Mental health
- Alcohol and chemical dependency (also specially protected under federal law, 42 CFR pt. 2)
- HIV/AIDS
- Health information about a minor (generally a minor 14 years of age or older and specific to alcohol and chemical dependency, birth control, mental health and sexually transmitted diseases)

When health care information is specifically protected, it generally requires a specific authorization from the patient/health plan member for any release, including for treatment, payment and healthcare operations. The authorization to release information needs to be specific, event driven or time limited and can be valid for no more than 18 months. Also, authorization forms need to indicate that no protections are guaranteed after initial release; that the information can be re-released and, at that point, not necessarily protected by the provisions of Oregon law. The exception to this is information about alcohol and chemical dependency. This exception, mandated by 42 CFR pt. 2, requires all authorizations include language indicating that the information cannot be re-released without specific authorization from the patient/health plan member.

C. Legal Specifics:

The following includes the specific legal information regarding specially protected health information under Oregon law.

- a. **HIV/AIDS - Authorization required:** No person may be compelled to disclose the identity of a person upon whom an HIV-related test is performed, or the results of such test in a manner which permits identification of the subject of the test except as required or permitted by law or authorized by the person whose blood is tested. ORS 433.045(3).
 - i. Authorization requirement includes third party payers. OAR 333-012-0170(8)(a)
 - ii. Authorization to release HIV test results must contain:
 1. The statement that HIV test information is to be released
 2. The purpose for which the information may be released
 3. The identity of those to whom the information may be released
 4. The time period during which the release may occur
 5. The date of the authorization and the signature of the person giving authorization. OAR 333-012-0270(8)(a).

Exceptions: The following disclosures do not require authorization:

- iii. Emergency treatment
- iv. To those who “must review the record for the purpose of delivering health care to the individual or for routine administrative procedures”.

- v. Notification in cases of substantial exposure, without disclosing identity of person who is source of exposure
- vi. Reporting to public health authorities
- vii. Notification related to anatomical gifts. OAR 333-012-0270
- viii. But, ORS 430.045(3) prohibits disclosure “except as required or permitted by federal law, the law of this state or any rule...”

NOTE: Recent changed in Oregon Administrative Rule (OAR) allow disclosure of a positive HIV test result or positive diagnosis for purposes of treatment, payment or health care operations without authorization. Negative test results are no longer subject to special protection but such information is still considered protected health information (PHI) under the HIPAA privacy rule and all requirements regarding the sharing of PHI continue to apply.

- b. **Alcohol and Chemical Dependency** – (Oregon Law: ORS 430.399; 430.306)
Treatment Facility: Written records for patient in a drug and alcohol “treatment facility” may not be disclosed without authorization. “Treatment facility” means:
 - i. Outpatient facilities, inpatient facilities and other facilities the Department of Human Services deems suitable, which may provide diagnosis and evaluation, medical care, detoxification, social services or rehabilitation for alcoholics or drug-dependent persons and which operate as a general hospital or state hospital, hostel, foster home, clinic or other suitable form. ORS 430.399(5); ORS 430.306(9)

Minors: Fact of admission to treatment facility must be disclosed to parents or guardian. ORS 430.397

Public Provider: Written records held by a “public provider“ also require authorization unless an exception applies. (ORS 179.505) “Public provider” includes:

- i. Public and private entities that are licensed, approved, established, maintained, operated, or under contract with community mental health programs or with the Department of Human Services for care of substance abuse, mental illness or developmental disabilities. ORS 179.505(1)(g).

Exceptions:

- i. Medical emergency
- ii. Scientific research
- iii. Audit and evaluation
- iv. To State to defend legal action
- v. By a treating provider to officers or employees of that provider, its agents or cooperating health care services providers who are currently acting within the official scope of their duties to evaluate treatment programs, to diagnose or treat or to assist in diagnosing or treating an individual when the written account is to be used in the course of diagnosing or treating the individual.
- vi. Government payers

But...

ORS 179.505(2) says “or unless otherwise permitted or required by state or federal law...” HIPAA permits disclosure of protected health information without authorization in a number of circumstances. It does not specially protect drug/alcohol records. In this case, federal law preempts state law that is more permissive or allows freer exchange of patient information.

Federal Law: (42 CFR sec. 2.12 – 2.67) Patient authorization is required for disclosure of records by a federally assisted drug abuse program, whether or not recorded, unless the patient is incompetent. This applies to information that:

- i. Would identify a patient as an alcohol or drug abuser;
- ii. Is drug abuse information obtained by a federally assisted drug abuse program for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment. (42 CFR sec. 2.12(a)(1))

Program means:

- i. An individual or program (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or
- ii. An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment.
- iii. Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers. 42 CFR sec. 2.11
- iv. Does not apply to a hospital emergency room (ER) unless the primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral or the ER holds itself out as providing services. 42 CFR sec. 2.12(e)(1); United States v. Eide, 875 F.2d 1429 (9th Cir. 1989)

Federally Assisted means:

- i. Conducted by a U.S. department or agency, either directly or by contract
- ii. Licensed, certified registered or given authorization by a U.S. department or agency
- iii. Supported by funds of any department or agency of the U.S. 42 CFR sec. 2.12(b)

Exceptions: (42 CFR sec 2.51- 2.53, 2.61, 2.63)

- i. Medical emergency
- ii. Communication between a program and an entity providing services to a program such as data processing, bill collecting, laboratory analyses, legal or other professional services
- iii. Research
- iv. Audit and evaluation

- v. Reports of suspected child abuse and neglect, but only reports
- vi. Crime on premises or against program personnel
- vii. Court order but only if:
 - 1. Is necessary to protect against an existing threat to life or of serious bodily injury;
 - 2. Is necessary for investigation or prosecution of an extremely serious crime;
 - 3. If the patient offers testimony in an administrative or a litigation proceeding.

Notable non-exceptions:

- a. Continuing medical care
- b. Subpoena

No Re-disclosure: A disclosure made with patient consent must be accompanied by a written statement prohibiting re-disclosure. 42 CFR 2.32

- c. **Mental Health - Authorization Required:** Written authorization required for disclosure of records held by “public provider.” (ORS 179.505) It should be noted that there is some ambiguity in the law that has resulted in the industry practice of requiring authorization from the patient/health plan member prior to release of any mental health information.

Exceptions: No authorization required for:

- i. Medical emergency
- ii. Scientific research
- iii. Audit and evaluation
- iv. To State to defend legal action
- v. By a treating provider to officers or employees of that provider, its agents or cooperating health care services providers who are currently acting within the official scope of their duties to evaluate treatment programs, to diagnose or treat or to assist in diagnosing or treating an individual when the written account is to be used in the course of diagnosing or treating the individual.
- vi. Government payers

Form of Authorization: ORS 179.505 specifies requirements. State model form likely qualifies.

“Private” Mental Health Record: Mental health records held by a non-public provider do not require authorization for disclosure, except:

- i. Authorization Required for “Psychotherapy Notes”: Psychotherapy notes are notes recorded by a mental health professional in the performance of the official duties of the professional that document or analyze the contents of conversation during a counseling session, and that are maintained separately from the rest of the individual’s medical record. (ORS 179.505(1)(e); 42 CFR sec. 164.501 - HIPAA Privacy Standards)

- d. **Genetic Information** – (Oregon Law: ORS 192.531 to 192.549; OAR 333-025-0105 to 333-025-0130) Authorization Required:
- i. "...a person may not disclose or be compelled, by subpoena or any other means, to disclose the identity of an individual upon whom a genetic test has been performed or the identity of a blood relative of the individual, or to disclose genetic information about the individual or a blood relative of the individual in a manner that permits identification of the individual..." (ORS 192.531)

Genetic Information is defined as: "Information about an individual or an individual's blood relative that is derived from a 'genetic test'." (ORS 192.531)

Genetic information does not include:

- i. Family history
- ii. Clinical diagnosis of a genetic or heritable condition, if not derived from a genetic test.

Exceptions:

- i. Law enforcement purposes (identification, investigation)
- ii. Court order
- iii. Medical diagnosis of relatives of decedent
- iv. Identification of body

Paternity Testing: Consent of individual not required to obtain genetic information for purposes of establishing paternity "as authorized by statute." (ORS 192.535)

Form of Authorization: Administrative rules incorporate State model form.

Notice of Use and Authorization Requirements: ORS 192. 538; OAR 333-025-0100-0165 :

Beginning July 1, 2006, health care providers other than "indirect providers" are required to provide a notice to patients explaining the possible use of their biological specimen or clinical information for coded genetic research now or at some point in the future and give the patient the right to opt of such use.

Individuals or Entities Required to Provide Notice: This applies to all providers whether or not the provider conducts genetic research. Covered health care providers include:

- i. Collect biological specimens or clinical individually identifiable information from patient;
- ii. Are HIPAA covered entities; and
- iii. Have a direct treatment relationship with an individual. OAR 333-025-0165

Individuals or Entities (health care providers) not required to provide the notice:

- i. A provider who is not a HIPAA covered entity. These providers may comply with the notice requirement but are not required to. An example of a person who is a health care provider but not necessarily a HIPAA covered entity is a publicly employed EMT who never bills for services or the increasingly rare physician who runs an entirely paper practice.
- ii. An indirect health care provider. An indirect care provider is defined as a health care provider having a relationship with an individual in which:

1. The health care provider delivers health care to the individual based on the orders of another health care provider; and
2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual. (OAR 333-025-0100(26))

Notifications Need to Include:

- i. The patient's biological specimen or clinical individually identifiable health information may be used for anonymous or coded genetic research;
- ii. Provide the patient or the personal representative an opportunity to opt out of such use.
- iii. Specifically, the notification must include:
 1. A place where the patient may mark to indicate the patient's opt-out statement;
 2. A general explanation of the meaning of anonymous and coded research;
 3. A statement describing the biological specimen or clinical individually identifiable health information may be used at some undetermined point in the future without further notice to the patient;
 4. A statement that a refusal to allow use of biological specimens or clinical individually identifiable health information will not affect access to or provision of health care by the provider originally providing notice;
 5. A statement specifying that the patient retains the right to make or revoke an opt-out statement by submitting in writing such a request to the health care provider originally providing notice;
 6. A statement indicating that an opt-out statement will be valid from the date received by the health care provider;
 7. A prominent heading indicating the purpose of the notice; and
 8. The name or title and telephone number or other contact information of a person or office to contact for further information. (OAR 333-025-0165(7))

Notice Must be Provided no later than the time required for federal privacy notices by the Federal Privacy Rule for services rendered on or after July 1, 2006. (OAR 333-025-0165(3))

Frequency of Notice Provision: The notice need only be provided once, even if the provider sees the patient multiple times. (OAR 333-025-0165 (4))

Provider's obligation to disclose an opt out to other providers: Direct care providers must, at the time they disclose biological specimen or clinical individually identifiable health information to an indirect provider, inform the indirect provider that the individual's biological specimen or clinical individually identifiable health information is subject to an opt out statement. (OAR 333-025-0165(9))

Provider receipt of an opt out statement or the patient changes their mind regarding opt out after the provider has disclosed information about the patient: If an opt out statement is received after completion of the first service delivery and within the first 14 days from the completion of the first service delivery, a health care provider is

encouraged, but is not required, to make a good faith effort to inform the indirect health care provider of the opt-out statement. (OAR 333-025-0165(9))

Provider requirements to notify indirect providers outside the state of Oregon: The law requires Oregon health care providers notify indirect providers who are the intended recipient of an individual's biological specimen or clinical individually identifiable health information of an opt out. The law does not create an exception for notification of indirect providers with business operations outside Oregon.

Providers notification of indirect providers of an opt out: Methods of informing indirect providers may include, but are not limited to, marking or noting the biological specimen container or clinical individually identifiable health information as subject to an opt out. (OAR 333-025-0165(9))

Enforcement: The genetic privacy statutes contain criminal as well as civil penalties. None of these penalties, however, appear to directly apply to the requirement to notify individuals of their right to opt out of disclosure of their clinical individually identifiable health information or biological specimen and notify indirect providers. (ORS 192.541, 192.543 and 192.545)

- e. **Minors** – Minors have a number of rights under Oregon statute. Some are defined by age, some are defined by age and condition and some are defined by virtue of the fact that the minor is emancipated. Following is a description of a minor's rights under all of these conditions in the state of Oregon. It should be noted that additional provisions regarding institutionalization (e.g., mental illness, juvenile crime, etc.) may allow the State and institutions greater access and ability to disclose protected minor health information (similar to laws governing the health information for institutionalized adults).

There is a conflict between Oregon law, HIPAA and ERISA. If the minor child seeks treatment in a situation where parental consent or knowledge is left up to the minor, if the minor seeks payment under the parent or guardian's health insurance policy, ERISA requires the policy holder be provided an explanation of benefits. This, in and of itself, often discloses the treatment provided the minor in a situation where the minor would have elected not to involve a parent or guardian or disclose any information about the treatment provided. At this point in time, there is no legal solution and it becomes a matter where the minor is required to pay for the services to avoid unwanted disclosure to a parent or guardian.

Right to treatment for venereal disease without parental consent: A minor who may have come into contact with any venereal disease may give the health care provider consent for diagnosis or treatment. If the disease or condition is one where Oregon law requires the diagnosis/treatment be reported to a public health agency, the information must still be reported.

The consent of a parent or legal guardian of the minor cannot be required to diagnosis and treatment from an Oregon health care provider. In this situation Oregon law clearly states that without parental or guardian consent, the parent or legal guardian is not be liable for payment of any such care rendered. This also means, though, that the parent or guardian does not have the right to

access diagnosis and treatment information without the authorization of the minor. (ORS 160.110)

Provision of birth control information and services: Any physician or nurse practitioner may provide birth control information and services to any person without regard to the age of the person. This means a minor has the right to consent to provision of birth control information and services. Generally if the patient (in this case, the minor) is “at the age of consent” for medical services, the minor in essence controls the information and access to the information. In other words, the minor would need to authorize the sharing of any birth control services information to parents or guardians, as an example. (ORS 190.640)

Right to medical or dental treatment without parental consent: A minor 15 years of age or older may consent to hospital care, medical or surgical diagnosis or treatment by a physician licensed by the Board of Medical Examiners for the State of Oregon, and dental or surgical diagnosis or treatment by a dentist licensed by the Oregon Board of Dentistry, without the consent of a parent or guardian. Also, a minor 15 years of age or older may consent to diagnosis and treatment by a nurse practitioner who is licensed by the Oregon State Board of Nursing without the consent of a parent or guardian of the minor. In this case, the parents or guardians may be informed or advised of treatment without minor consent (see following). (ORS 109.640)

Disclosure without minor’s consent: A hospital, physician, nurse practitioner or dentist may advise the parents or legal guardian of a minor of the care, diagnosis, treatment or need for treatment without the consent of the minor. Also, Oregon law specifically states that any hospital, physician, nurse practitioner or dentist who chooses to advise the parents or legal guardian without consent cannot be held liable. (ORS 109.650)

Right to diagnosis or treatment for mental health or chemical dependency without parental consent: A minor 14 years of age or older may obtain, without parental knowledge or consent, outpatient mental health or chemical dependency diagnosis or treatment by a licensed physician, psychologist, nurse practitioner, clinical social worker or a DHS approved community mental health and developmental disabilities program (see ORS 430.620).

Exception: The approved health care provider managing or providing treatment is required to involve the parents or guardians of the minor before the end of treatment unless the parents refuse or unless there are clear clinical indications where the provider determines parental involvement would be to the detriment of the minor (must be documented in the treatment record). This exception does not apply to:

- A minor who has been sexually abused by a parent or guardian; or

- An emancipated minor (see ORS 109.510 and 109.520 or 419B.550 to 419B.558). The minor is considered emancipated for mental health or chemical dependency treatment only if the minor has not lived with the parents or guardian and is self-sustaining for a period of 90 days prior to seeking treatment. (ORS 109.675)

Mental health or chemical dependency treatment disclosure without minor's consent: A physician, psychologist, nurse practitioner, licensed clinical social worker or community mental health and developmental disabilities program may advise the parent or parents or legal guardian of any minor regarding diagnosis or treatment when the disclosure is deemed by the provider to be clinically appropriate and the provider considers such disclosure to be in the best interests of the minor's treatment because the minor's condition has deteriorated or the risk of a suicide attempt requires inpatient treatment, or the minor's condition requires detoxification in a residential or acute care facility. If the parents or guardian are notified, the physician, psychologist, nurse practitioner, licensed clinical social worker or community mental health and developmental disabilities program is not be subject to any civil liability for advising the parent or legal guardian without the consent of the minor.

It should be noted that the general practice of mental health practitioners is a reluctance to notify parents or the guardian. There is a concern that such notification will not be in the best interest of the minor. (ORS 109.680)

Parent or guardian not liable for payment: If a minor is diagnosed or treated for mental health or chemical dependency without the consent of the minor's parent or legal guardian, the parents or legal guardian are not be liable for payment for treatment or diagnosis. If the minor elects to seek payment under the parents or guardian's health insurance policy, the policy holder (parent or guardian) will be notified by the health plan through an explanation of benefits. (ORS 109.690)

Emancipation: A minor is treated as an adult regarding health care and health care privacy rights if the minor is legally emancipated by the courts. That means that any provisions regarding specially protected health information (e.g., mental health, HIV/AIDS, etc.) apply regarding release and the requirement for authorization for release. (ORS 419B.552)

Majority of married persons: Even if a minor has not reached the age of majority, the minor is considered an adult if the minor is legally married. A minor can marry at the age of 17 with the consent of parents or legal guardian. (ORS 109.520)

D. Summary:

Oregon law provides certain additional privacy protections for what are generally

considered specially protected health information. Also, federal law aside from HIPAA provides additional protections for certain types of health conditions. Most federal and state laws that are more stringent than HIPAA were enacted prior to the advent of electronic health information exchanges. Congress is reluctant to preempt any state law and it is especially politically unpalatable to preempt more stringent privacy laws (provides greater protections to the patient). The same is true at the state level. The Oregon Legislative Assembly would be equally reluctant to tamper with additional privacy protections because of consumer and political backlash.

While it is worth reviewing Oregon law in an effort to make it more consistent and takes into account the different world presented by electronic health information exchange, it would be wise to conduct a thorough review, involve the appropriate advocates and the appropriate practitioners. As an example, behavioral health practitioners are especially protective of the health information of their patients, whether legally required or not.

It is important to remember that a number of the statutes on the books today that provide special protections are there for a reason. Mental illness and chemical dependency, as an example are conditions where individuals with mental illness or chemical dependency have been stigmatized by society and, to some extent, the health care system. There are a number of vocal advocates that will strongly oppose any changes if such changes do not continue to provide what would be considered adequate protections or appear to take privacy rights away. In the meantime, the healthcare industry takes specially sensitive health information very seriously and, even if not specifically protected by statute, may impose additional restrictions to access over and above legal requirements. Any changes would also require a cultural change in addition to a legal one.