

MINUTES

**Massachusetts Health Information Technology Council
Meeting
September 2, 2009
8:30 – 10:30 am**

**Matta Conference Room
One Ashburton Place
Boston, Massachusetts**

MINUTES

MASSACHUSETTS HEALTH INFORMATION TECHNOLOGY COUNCIL

September 2, 2009

Attendees:

Council Members	JudyAnn Bigby, MD - (<i>Chair</i>) <i>Secretary of Health and Human Services</i> Deborah Adair - <i>Director of Health Information Services / Privacy Officer at Massachusetts General Hospital</i> Karen Bell, MD - <i>Senior Vice President of HIT Service at Masspro</i> David S. Szabo - <i>Partner with Nutter, McClennen & Fish, LLP</i> Lisa Fenichel, M.P.H. - <i>E-Health Consumer Advocate</i> Meg Aranow - <i>VP & Chief Information Officer, Boston Medical Center</i>
Other	David Martin (EOHHS) John Samuelian (EOHHS) Jim Daniel (DPH) Kimberly Haddad (Committee on Health Care Financing - Senate) Bert Ng (Committee on Health Care Financing - House) Lorllyn Allan (Lahey Clinic) Adam Delmolino (Mass Hospital Association) Henry Och (Lowell Community Health Center) Jessica Long (Conference of Boston Teaching Hospitals) Karen Welsh (Student)
MTC Staff	Mitchell Adams Rick Shoup Glen Comiso Bethany Gilboard Judy Silvia Barbara-Jo Thompson
Deloitte Staff	Doug Beaudoin Michael Marino Lisa Sherwin Randy Gordon, MD Kevin Carr, MD Kerry Moyer Jyotin Gambhir Hussein Jaffer Esther Ndungu

The thirteenth meeting of the Massachusetts Health Information Technology Council was held on September 2, 2009, in the Matta Conference Room at One Ashburton Place in Boston, Massachusetts.

Secretary Bigby called the Meeting to order at 8:30 a.m.

AGENDA ITEMS

I. Review and Approve Minutes of August 19

After motions made and seconded, it was unanimously agreed to accept the draft minutes as the official minutes of the August 19th meeting.

On August 20th the Office of the National Coordinator(ONC) announced that they are accepting applications for HITECH funds. Dr. Richard Shoup gave an overview of the current status of these applications, deadlines, and key milestones.

II. Review and Discuss Regional Extension Center (REC) Preliminary Application (Due Sept 8 to ONC)

III. Review and Discuss Health Information Exchange Letter of Intent (HIE LOI) (Due Sept 11 to ONC)

Dr. Shoup gave an update on both the REC Extension Center and the Health Information Exchange Application process. (Presentation Incorporated as part of the minutes).

Dr Shoup started his presentation explaining that all along the plan was to apply for REC and HIE grants on behalf of the Commonwealth of Massachusetts. The first deadline is September 8th. On that day we will need to submit a preliminary application for the State-wide Regional Extension Center. MeHI will continue to work on the application past the 8th as there are a number of pieces of information required. The ONC plans to make a selection on December 11th. A second opportunity is for the Healthcare Information Exchange and a letter of intent is due to the ONC on September 11th. A third application is for workforce development. We are working with the Departments of Labor and Education as they are taking the lead on that application. Our focus is on HITECH workers, who will need to meet the needs of employers focused on health care technology implementation and development.

Secretary Bigby stated that there is a large role for community colleges in the area of EMRs.

Dr. Bell added that in the REC application workforce development was also mentioned.

Dr. Shoup added that in this preliminary application, we will need to provide numbers. We will also need to coordinate with other New England States. MeHI will apply for the funds; the work will be done by IOOs as required by Chapter 305..

There was a brief discussion regarding the Grants and the Application Process. It was discussed that consumer groups have questions, and they are critically important. MeHI acknowledges that the consumer MUST be involved and will be included in the full plan. On HIE, MeHI will contract for these services.

It was also noted that the funding we are seeing, is about twice what we thought it would be. Mitchell Adams added that there is no real reason we can expect more than a pro-rata share or 2% of total amount. Dr. Bell added that it was fair to estimate on a pro-capita basis for planning purposes. Dr. Shoup stated that for the REC, there are 3 cycles of funding. If you get in on one cycle you can not in another, you can not double dip. On the HIE side that is funding for planning and operation.

The State will work with stakeholders based on the requirements in chapter 305. This is an active conversation with the legal team. We must insure we work with the stakeholders in a manner that does not violate any state law. If you are the participant that is going to apply for funds, you can only act in an advisory role. We are talking about creating an ad hoc forum to permit input from the valuable resources without triggering any ethics violations. We need to strike a delicate balance..

Dr. Shoup went on to explain that we are looking for different venues to engage stakeholders but not precluded them for bidding on work. He also listed the stakeholders and spoke of the focus group meeting that was held on August 17th. (The presentation and minutes can be found on the website www.maehi.org and were included in the Council member's packet for this meeting).

The primary focus on 17th was EHR/HIE and those in the conversation were a broad group but other meetings will include even more of the stakeholders throughout the state.

In regards to the RFP Dr. Shoup explained that the plan is to release something so that organizations can respond to and then there will be a review period. Stakeholders will be welcome to comment on the RFP.

Dr. Bell asked about the time line for this and will it be concurrent? Answer: The draft RFPs will be due by mid October and MeHI will try to turn around as fast as we can. Then Council / MTC board will approve. Secretary Bigby expressed that we have a busy fall.

Next Lisa Sherwin of Deloitte introduced Kerry Moyer who has been added to the team as the Workforce Development Manager and then she gave an overview of all the work that has occurred since the last Council meeting, followed with an update on the funding and loan program. Highlights below:
[Summary of Massachusetts Hospitals](#)

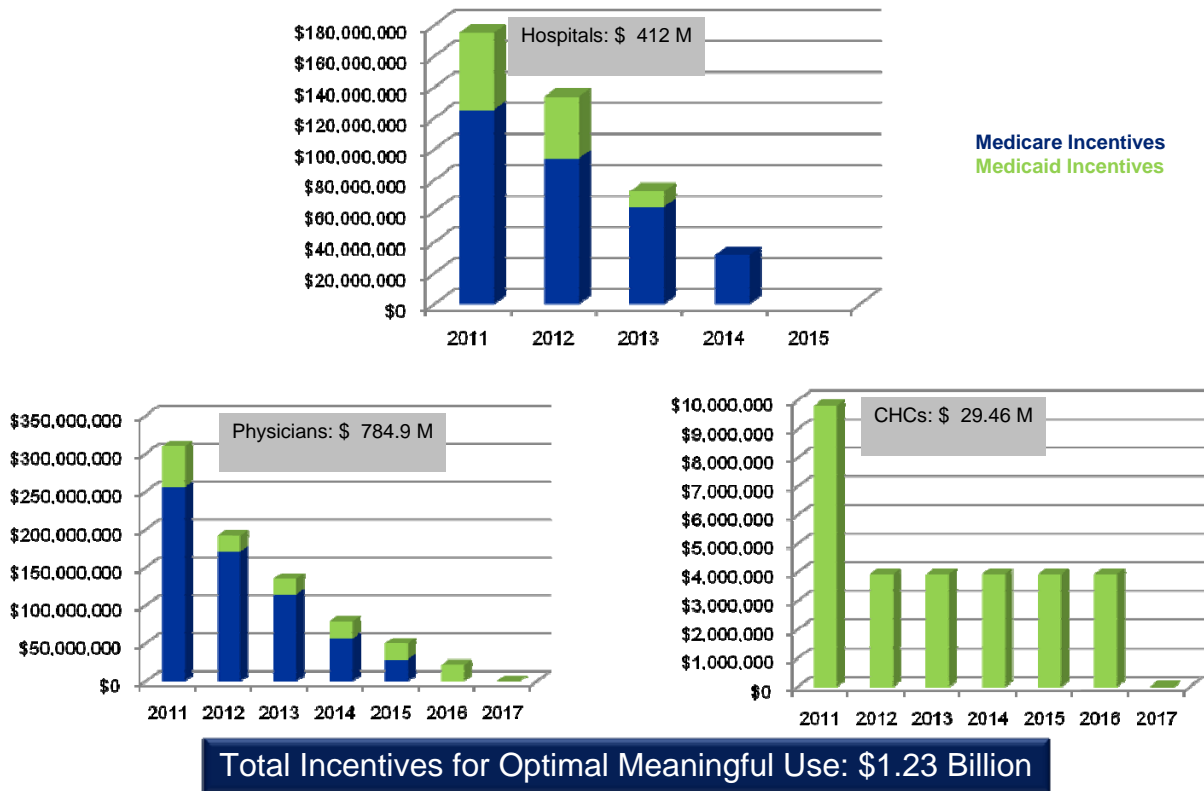
- ◆ \$438M in total costs to implement Meaningful Use by 2011
 - 72 hospitals were surveyed (100% response rate)
 - Approximately \$6M+ per hospital
- ◆ More than 50% of the \$438M is estimated for implementation and training support
- ◆ More than 7 out of 10 have MEDITECH
 - Only MEDITECH 5.6 and 6.0 are CCHIT Certified
- ◆ Total Costs were segmented by Target & Non-Target hospitals
 - 64 Target Hospitals \$298M – Average to \$4.65 M / hospital
 - 8 Non-Target Hospitals \$140M – Average to \$17.5 M / hospital
- ◆ Costs by Hospital Type for Target Hospitals: (\$298M)
 - Academic = 43% (\$128M)
 - Community = 33% (\$98M)
 - Disproportionate Share hospital(DSH) = 23% (\$69M)
 - Critical Access = <1% (<\$3M)
 - Public = 1% (\$4M)

Secretary Bigby asked if the desire is that the hospitals get to 6.0 if they are at 5.6. Ms. Sherwin said it isn't clear what hospitals intend to do. Ms. Fenichel asked if the two versions were interoperable, unfortunately the answer is they are not. Another question was asked regarding who the public hospitals are in the group. Ms. Gilboard indicated for purposes of the study the two state hospitals were considered public. It was just a grouping mechanism.

Using Data compiled from a BCG Study and the Mass League, Ms. Sherwin explained that to reach meaningful use it is estimated the total cost for Health IT is at \$628.7M.

- \$438M for Hospitals
- \$250.7M for Physicians
- \$30M for Community Health Centers
- \$50M for HIEs

Optimal Total Provider Adoption Value



Mr. Szabo stated that it was his understanding that there is no difference if you hit 2011 / 2012 and then asked if that was correct. Dr. Shoup responded that there is less and less money available if you slide into 2013.

Ms Sherwin then shared that acceleration is key.

Scenario 1: If 25% of Massachusetts hospitals achieved Meaningful Use each year over 4 years:

- 2011: 25% meaningful use achievement
- 2012: 25% meaningful use achievement
- 2013: 25% meaningful use achievement
- 2014: 25% meaningful use achievement ◊ 16 hospitals lose estimated 40% of incentives

A rate of 25% achievement per year results in an Opportunity Lost of approximately 40% for year 2014, or \$43 M. (Based on average incentive per hospital estimate of \$6.65M)

Scenario 2: If 20% of Massachusetts hospitals achieved Meaningful Use each year over 5 years:

- 2011: 20% meaningful use achievement
- 2012: 20% meaningful use achievement
- 2013: 20% meaningful use achievement
- 2014: 20% meaningful use achievement ◊ 12 hospitals lose estimated 40% of incentives

- 2015: 20% meaningful use achievement ◇ 12 hospitals lose estimated 70% of incentives

A rate of 20% achievement per year results in an Opportunity Lost of approximately 40% (\$32M) in 2014, and 70% (\$56M) in 2015 for a total of \$88M (Based on average incentive per hospital of \$6.65M)

Ms Aranow asked is the 25% is referring to hospitals, or patients? Rick Shoup explained that this is calculated based on discharge.

There would be no decrease in federal incentive dollars for physicians who adopt meaningful use in 2011 or 2012. However, adoption after 2012 results in significant opportunity loss, for example:

Scenario 1: Each Medicare physician who delays adoption to 2013 will receive \$5,000 less in incentives

- If 25% of physicians (approximately 3,500) delay to 2013, total loss in incentives is \$17.5M

Scenario 2: Each Medicare physician who delays adoption to 2014 will receive \$20,000 less in incentives

- If 25% of physicians (approximately 3,500) delay to 2014, total loss in incentives is \$70M

If 50% of MA physicians adopt in 2011 or 2012, but 25% adopt in 2013 and the remaining 25% adopt in 2014, the total Opportunity Lost for the Commonwealth of Massachusetts in federal incentive funds is approximately \$90M

Regional HIT Extension Centers

- Summary of Funding – Total \$598 Million
- Average Award is estimated to be \$8.5 Million
- Awards are anticipated to range from \$1 Million to \$30 Million
- There will be approximately 70 awards
- Award length = 4 year project – two separate two-year budgets.
- Estimated start date is January 15, 2010

Award of 4 year cooperative agreements. Initial preliminary application due on September 8th

FUNDING =

FY2010 = 90/10

FY2011 = 90/10

FY2012 = 10/90

FY2013 = 10/90

It is anticipated that the first cycle of awards will result in four-year cooperative agreements with at least one successful applicant furnishing services within each of the ten HHS/CMS Regions

Secretary Bigby stated that there is a requirement in Chapter 305, that all doctors and hospitals must reach EHR and CPOE. To which Ms. Fenichel responded these are additional accelerator incentives.

Someone also added that it is a consideration for licensure. And Mr. Adams stated that we must integrate the requirements of Chapter 305 into the plan.

Mr. Szabo mentioned that if the discussion is about EHR implementation, he recalled breaking out how much was for hardware, software, etc. How much are we short? Ms. Sherwin stated, as we go through the process we don't have that information on a slide, but we just got information that we are planning to integrate into the plan.

The REC the funding is about \$5000 per provider. *(More analysis is being done to determine how much actual funding may be needed in a grant or loan fund in addition to the REC funding.)*

Next Dr. Randy Gordon gave a brief presentation about Quality and Public Health Reporting. This is information he had hoped to share at the last council meeting, but we had run out of time.

Dr. Gordon first explained that the definition of meaningful use is about quality of care. HIE will enhance the quality scores for providers. Keep in mind that it is possible to achieve meaningful use without raising quality of care. It will be enhanced if you have an HIE but you don't need it to reach meaningful use, and HIE doesn't need to be in place to reach meaningful use.

Secretary Bigby asked, so what you are saying they could report with out having HIE. They can use old paper and pencils. Answer – That is correct.

Dr. Gordon continued, there are two current reporting requirements.

Physician Quality Reporting Initiative (CMS)

- Established by 2006 Tax Relief and Health Care Act
- 2.0% incentive payment on total allowed charges for Physician Fee Schedule for eligible professionals who meet criteria for satisfactory submission of quality measures data
- 153 quality measures in 7 measures groups
- Reported via codes on billing sheets submitted to Medicare for reimbursement (pseudo-electronic reporting)
- Limited participation due to large initial investment required

NCQA Healthcare Effectiveness Data and Information Set (HEDIS) Measures

- 71 measures across 8 domains of care
- Abstracted by Health Plans from claims data and reported to NCQA for certification

Dr. Gordon continued, in hospitals there are a bunch of applications that would have to be sorted by hand to find the data points for reporting. Getting the data from the records is tedious... and takes a lot of resources... Even though the core measures have been out there for a decade; we haven't worked out yet how to get automatic data abstraction. There is an opportunity for HIE to give a more accurate view.

Mr. Szabo asked, if I could snap my fingers and everyone in the state had a CCHIT certified system, we still would not have the quality? Answer - that is true, they are working on it – but they aren't there.

Mr. Beaudoin responded that it takes work on the side of the physician or hospital when they build their system. Ms Sherwin added that there is an opportunity for states to put pressure on CCHIT to move in that direction.

Secretary Bigby stated that something needs to be done to get uniform standards for reporting to get the right information... we must improve patient care.

Dr. Gordon responded that the core measures haven't changed– every time new measures are added, there is not a standard. Then he continued describing the current state of Public Health Reporting

We worked with Jim Daniel and the DPH to get the best information. It is a work in progress, but we have made advances. There is a huge reporting data, ESP is funded by CDC and filters medical record for reporting measures to report to CDC. Illustrations were shown to the Council. Not the best system, it uses EHR and HIE but only to transfer data, it does not use the technology available.

The state has made good strides in Quality and PH reporting pilots. A good example is the Massachusetts Health Quality Partnership (MHQP). They have figured out a physician's quality by site.

Public Health standards are at the state level. On the National level it is lacking so this is where the state needs to be actively involved. One example is the HL7 gateway

Community Health centers will receive funding. They have a lot to do to insure that funding get to the right cause.

Some Public Health considerations

- Most meaningful use criteria and measurements do not require HIE for compliance but may be enhanced by HIE.
- The Commonwealth has made significant progress on meeting the Meaningful Use criteria for 2011 related to immunization reporting for outpatient providers and lab results for inpatient providers.

- Quality measurement and reporting is driven and standardized at the national level. Statewide HIE should support the existing processes for quality reporting and not put additional requirements on providers.
- Quality related HIE reporting should utilize “pulling data” rather than “pushing data” to an additional data repository, thus reducing infrastructure support requirements and mitigating privacy and piracy risk.
- Initiatives that have developed standards, such as MHQP’s physician database, should be leveraged across the Commonwealth to accelerate quality analysis and reporting.
- Physician quality data reporting is currently done mainly utilizing claims data by health plans and through CMS for the Physician Quality Reporting Initiative. A Person Controlled Health Record made possible by the State HIE could facilitate the addition of patient satisfaction and other data elements to enhance ambulatory quality reporting.
- Electronic Public health data reporting is developing at the state level. National standardization and direction is lacking.
- HIE has the potential for significantly increasing the completeness and accuracy of public health reporting.
- Current pilots for communicable disease reporting (ESP), disease registry completion (Immunization Registry) and biosurveillance (AEGIS) should be refined where appropriate accelerated and leveraged to a statewide level.
- Provide additional resources should be provided to DPH to provide the capabilities to receive public health data through the Statewide HIE and to develop an HL7 Gateway.
- Assign a Public Health HIE Task Force to determine which public health data elements should be standardized at state level and which should wait for national standardization.
- Determine whether a public health algorithm for identifying reportable conditions should sit on the provider side of the HIE (the current ESP model) or in the HIE structure to push data to DPH and other organizations requiring public health information.
- Utilize an HL7 Gateway to collect information from Community Health Centers and recipients of Public Health program dollars to reduce their duplication of reporting data.

Jyotin Gambhir was introduced and presented on the work stream for Privacy and Security.

Guiding Principle for MA HIE.

Information Security

- Confidentiality, Integrity, and non-repudiation provide the basis of a good secure HIE framework for the commonwealth of MA.

Access

- Secure access to the EHR/PHR is a core component of the framework. As the state develops a patient centric HIE, this becomes a key component of the architecture and framework.

Scalability

- The architecture and the framework for Mass HIE should be scalable and extensible in order to accommodate changes in technology, process, and ownership.

Compliance and Regulation

- Commonwealth of MA Health Information Exchange provides a security and privacy framework that is compliant with the existing regulations for both the state and federal government.

Auditing & Logging

- As auditing and logging are key components of any secure exchange, this architecture will be built with the capability meet and exceed requirements.

Sustainability

- Certification process is necessary to evaluate the health providers and payers willing to be part of state HIE network

Business Continuity

- Ability to develop processes that ensure uninterrupted flow of sensitive data as well as quick recovery in the event of a disruption is cornerstones of the health information exchange

Model today is too physician centric, it needs to move towards more patient centric.

Must be certified with a minimum in security – whether developed by HIE or CCHIT standards, or consider a certification body that exists.

Mr. Szabo stated that this is an extremely tall order. These regulations are hard to implement, basically the decisions we make today have an impact on the architecture

Mr. Gambhir continued, the third aspect is consent. It is a huge piece, it is complicated to implement. We will be walking very close with stakeholders on this issue. Patient education is extremely important here.

Based on the interviews/discussions/ focus groups we understand that the security and privacy framework needs to address the following issues:

- **Secure HIE Framework** – Understand the aspects of security that need to be deployed from a process and technology perspective for a Secure HIE deployment. A PHR (Patient Health Record) model focused on the patient as the

- center of this information. The recommendations are categorized into the various layers defined in the secure HIE framework
- **Certification of the individual HIE or participating organizations** – Developing a model to certify HIE's that would like to be part of the State HIE infrastructure. This would be the HITRUST form of certification with controls/remediation etc.
 - **Consent Management Model** – A clear process on informing the patient and giving them a choice to opt-in or opt-out of the HIE process. Developing records with signed scanned copies and updating these on a defined timeline

The Consent Model needs input from the Council. Needs agreed by the patient and needs to be understood by the physician. It is a costly and budget intensive process.

Summary

- Compliance with regulation and legislative requirements (e.g. HIPAA, PCI DSS, etc.)
- Demonstrating adoption of common practices (e.g. ISO, NIST, HITSP, etc.)
- Tackling a variety of internal practices (e.g. policies, procedures, standards, etc.)
- Interacting with internal compliance and assurance functions
- Statewide HIE is built of a standards based common secure framework. In building this framework we researched and applied security standards from NIST SP800, ISO/IEC 2700/12, MITA , HITSP/ TN900,
- The Secure HIE Framework will address security at each layer i.e. Presentation, Data, Infrastructure, etc
- Certification process will help the state to manage and develop governance around the statewide HIE. Additionally it will provide the capability to update infrastructure with changes to the certification process as new regulations are passed within the state
- Privacy will address the key aspect of consent from a patients perspective. It will help the state protect the patients rights to own there health records.
- This model is sustainable as the state moves from a physician centric to a patient centric HIE.

Mr. Szabo weighed in on the possibility that other states, or industry has consent management processes in place. Privacy is the most important requirement. We need to define an approach.

Ms Sherwin stated that there are other states that are dealing with how do we manage consent. There is an opportunity for a consent model.

Mr. Szabo posed some questions. What are the consequences of an opt out or failure to opt in? What is the business process permissible? What are the implications of quality reporting?

Secretary Bigby stated that there are levels of consent. One – patient agrees to share information with another physician, insurance, etc. It must be clear for the individual

what they are consenting. When a patient signs HIPAA, they don't know where that data is going. Difficult for individuals who care for children in state custody, in regards to sharing information.

Dr. Bell asked if there anything that would be modified or added for a consumer to have access to their own information.

Secretary asked where on this scheme an individual would have access to their own information.

Dr. Carr stated that MeHI is developing frameworks, and is discussing how to share that framework without precluding someone for responding to RFP.

Dr. Carr closed by stating that the state needs to take a leadership role in privacy and security laws and regulations.

IV. Other

Secretary Bigby pointed out that there is an updated schedule of the meetings through the end of the year in today's packet. We have added a half hour to each meeting through November. Secretary asked if anyone had anything to add.

Mitchell Adams commented that members of the council have become a part of a team as we proceed with all this work.

Dr. Bell mentioned that there was a conversation with all the New England state representatives in regards to a REC, that MeHI plans to draft a letter to all of the New England States regarding opportunities to explore areas of collaboration..

Karen we would like Secretary to review. There are two states (Maine and NH) not participating in the first round of funding.

Meeting adjourned at 10:30