MINUTES

Massachusetts Health Information Technology Council Meeting
September 15, 2009
4:00 – 6:00 pm

Matta Conference Room
One Ashburton Place
Boston, Massachusetts

MINUTES
MASSACHUSETTS HEALTH INFORMATION TECHNOLOGY COUNCIL

September 15, 2009

Attendees:

Council Members
JudyAnn Bigby, MD - *(Chair) Secretary of Health and Human Services*
(Leslie Kirwan - *Secretary of Administration and Finance)***
Represented by: Marcie Desmond
Tom Dehner - *Director of Medicaid*
Deborah Adair - *Director of Health Information Services / Privacy Officer Massachusetts General Hospital*
Karen Bell, MD - *Senior Vice President of HIT Service at Masspro*
David S. Szabo - *Partner with Edwards Angell Palmer & Dodge*
Lisa Fenichel, M.P.H. - *E-Health Consumer Advocate*
Meg Aranow - *VP & Chief Information Officer, Boston Medical Center*

Other
David Martin (EOHHS)
Kimberly Haddad (Committee on Health Care Financing - Senate)
Bert Ng (Committee on Health Care Financing - House)
Cathleen McElligott (DPH – Office of Rural Health)
Henry Och (Lowell Community Health Center)
Jessica Long (Conference of Boston Teaching Hospitals)
Foster Kerrison (J.F. Kerrison)
Karen Welsh (Student)

MTC Staff
Mitchell Adams
Rick Shoup
Glen Comiso
Bethany Gilboard
Judy Silvia
Barbara-Jo Thompson

Deloitte Staff
Doug Beaudoin
Lisa Sherwin
Randy Gordon, MD
Kevin Carr, MD
Kerry Moyer
Rachael Cassleman
Jyotin Gambhir
Hussein Jaffer
Esther Ndungu

The fourteenth meeting of the Massachusetts Health Information Technology Council was held on September 15, 2009, in the Matta Conference Room at One Ashburton Place in Boston, Massachusetts.

Secretary Bigby called the Meeting to order at 4:01 p.m.

AGENDA ITEMS

I. Approval of September 2nd Minutes will be deferred to Sept. 30

With no minutes to review, we moved to item two on the agenda

II. High Level Overview of Plan

Dr. Richard Shoup gave an update. We have been busy as we are applying for three grants at the same time as well as working on the statewide strategic plan. He shared with the Council the time line and due dates for the various grant applications. (Pasted below) He explained that we are on target as the preliminary application for the Regional Extension Center and the Letter of intent for the Health Information Exchange were both submitted on time.

Opportunity	**Key Date**
ARRA/HITECH Act Regional Extension Centers	
Preliminary Application due date	Complete
Preliminary approval	9/29/09
Full application due date	11/3/09
Selections announced	12/11/09
ARRA/HITECH Act Health Information Exchange	
Letter of intent (5 pages)	Complete
Application due date	10/16/09
Awards announced	12/15/09
Start date	1/15/09
Department of Labor/Workforce Development (Inter-agency project team)	
Application due date	10/5/09
Selection date	TBA

Secretary Bigby asked for the dollar amount associated with each of these applications. Dr Shoup responded that for the REC application we have identified roughly 2,000 providers. The rule of thumb is that the base funding, is about $5,000.00 per provider, so approximately $10 M.

Dr. Shoup then explained that the Workforce Development grant was an interagency approach but it will also be incorporated within the context of our Statewide HIT plan.

Ms Fenichel asked if the workforce grant was ARRA money. Rick explained that it was not. Those funds would be flowing through the U.S. Department of Labor.

For the HIE application it was explained that the process includes a state's self assessment of its current state of strategic and operational plans. The application requires that we focus on the following five domains:

- Governance
- Finance
- Technical infrastructure
- Business and technical operations
- Legal/Policy

The operational plan will include more detail than the strategic plan. That detail will include:
- Coordination with other ARRA programs and states (REC, Workforce Dev., etc.)
- Detailed cost estimates, financial controls, reporting, technical deployment, etc.

It was also explained that states must submit and receive approval of a Strategic Plan and an Operational Plan before funding will be allocated for the implementation of the HIE. An assessment of the Strategic and Operational Plans will be part of the application award process.

Dr. Shoup explained that the Commonwealth will be submitting a strategic plan first and we will not be negatively impacted by submitting an operational plan at a later date.

Ms Adair asked if there was more information on the Workforce Development Grant. *(It was explained that the workforce grant would be discussed later in the meeting).*

Next Lisa Sherwin of Deloitte Consultants gave an update.

III. Updates:

Ms. Sherwin began with the starting slide of the timeline showing what has been accomplished and what is left to do. Everyone is driving very hard to get to final presentations. We have met with the MA HIE's, and have updated our other meetings.

Meetings/Interviews Conducted:

- Brockton
- Newburyport
- North Adams
- Massachusetts Health Quality Partners (MHQP)
- Massachusetts Hospital Association (MHA)
- Massachusetts Medical Society (MMS)
- Department of Public Health (DPH)
- John Halamka, MD
- SAFEHealth/Fallon Clinic
- Micky Tripathi
- HIE/EHR Stakeholder Meeting
- NEHEN
- Partners
- Rich Platt and Ross Lazarus (ESP)

Scheduled Meetings:
- Security and Privacy interim deliverable review: HIT Council members and MeHI – week of September 14
- Employer Focus Group Meeting September 17
- Educational Institutions Focus Group Meeting September 22
- Security and Privacy Stakeholder Meeting September 24

Interim Recommendations and Next Steps
- Interim review of deliverables for the HITECH Impact Analysis, Public Health and Quality Reporting and Privacy and Security was completed at the last HIT Council Meeting
- This week we will review Interoperability, HIE/EHR updates and Workforce Development
- Next steps include:
  - Privacy/Security Stakeholder meeting September 24
  - Review of Public Health and Quality Reporting with key stakeholders
  - Final updates to Funding and Loan Processes
  - Updates to HIE and EHR governance, deployment and high level infrastructure
  - Workforce Development Focus Group meetings on September 17 and 22
  - Finalize HIE External Scan

Rachael Cassleman, from Deloitte Consultants, gave an update on the Workforce Development Grant.

IV. Workforce Development Grant

Workforce Development Research - Project Timeline

Purpose: Conduct primary research to inform the HITECH workforce development plan and provide potential options for program design and curricula.

1. Facilitate two focus groups to gather data on the HITECH workforce supply and demand
   - Group 1: Employers/Vendors - 9/17, Westborough, MA
   - Group 2: Massachusetts Higher Ed Institutions that provide HITECH degrees and certifications – 9/22, Lowell, MA
2. Develop high-level framework to accomplish workforce development plan
   - Sample Governance model, PMO structure, stakeholder engagement approach and tools

Applications must meet a number of specific requirements.

Target Recruiting Group
- Unemployed Workers
- Dislocated Workers
  - US Veterans
  - Auto Workers
- Incumbent Workers

We are focusing on the Health Information side. We need to learn what the workforce needs out there are and what does that mean from a competency perspective?

Learning Program Guidance

- Funding will be available **between $2-5 million** and focus on short-term and long-term wins
- Due by **October 5th, 2009**
- Integrate occupational skills with basic skills training
- Input from federally qualified health centers and healthcare employers
- Leverage smaller programs with previous successes to design components of the application
- Design career pathways for members of the program
- Obtain cost sharing support in addition to awarded grant funds

We have two focus groups scheduled. **Purpose:** Better understand the challenges in attracting, developing and retaining a workforce within the field of healthcare informatics. The output of the focus group will be to inform program design.

Focus Group 1: Employers*
Date: September 17
Invitees: 33 employer organizations in MA including representatives from the following:

- Hospitals
- Implementation Organizations
- Technology Vendors
- Large Independent Practice Groups
- Associations
- Community Health Centers
- Integrated delivery networks

Objectives:

- To inform the talent gaps, both current and anticipated
- To identify competencies that are difficult to recruit
- To gain an understanding of current internal training efforts within the organizations

Focus Group 2: Education Institutions*
Date: September 22
Invitees: 15 education institutions / organizations in MA including representatives from the following:

- Universities
- State Colleges
- Community Colleges
- Unions
- Massachusetts Health Data Consortium
- Community based programs

Objectives:

- To inform the quality and rate of applications
- To gain an understanding of existing curricula and program capabilities
- To identify qualities of successful graduates

Council members asked questions including, "Does this list include IT, Technical Vocational schools and high schools?" Ms Adair added that HEMA has model curriculum.

Mr. Dehner brought up the topic of individuals with disabilities, and if any of the invitees focus on those individuals and if the council knows of others that are doing work in that area.

Ms Sherwin explained that there is not a particular area that focus on disabled workers. However, there is a group of nurses that cannot do hands on nursing, but they have the technical skills.

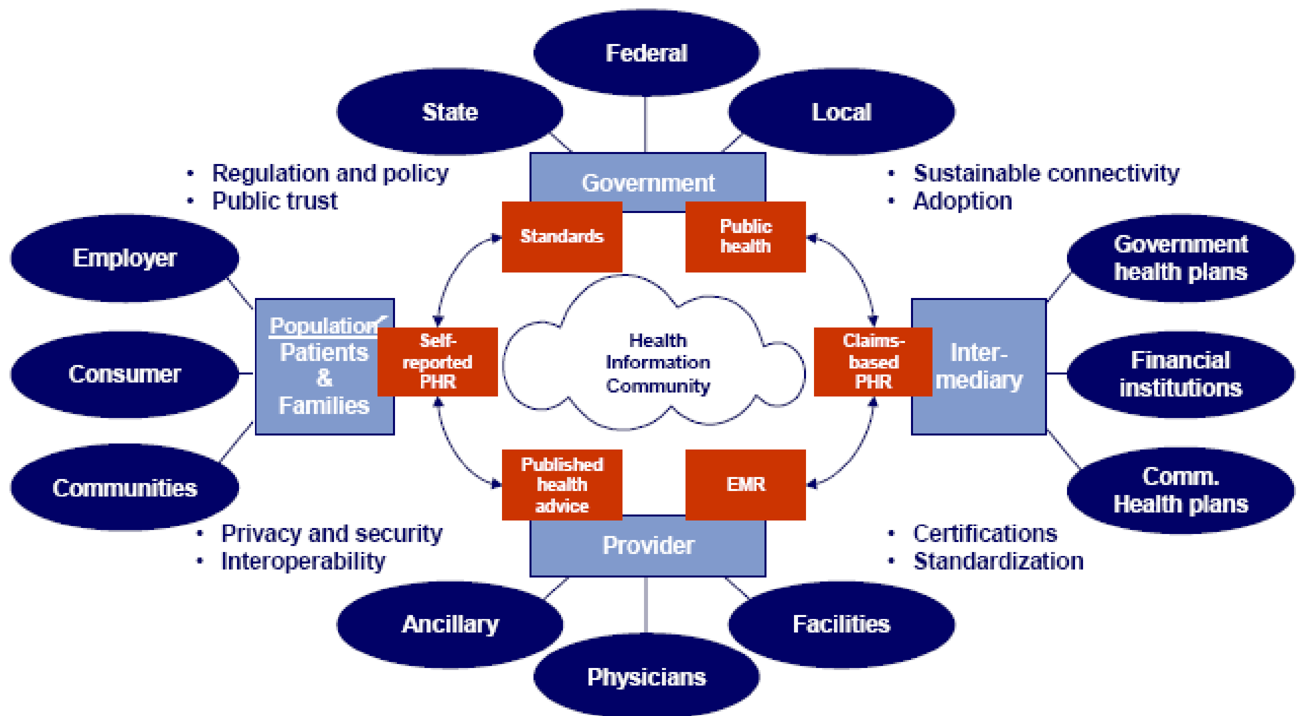
Secretary Bigby thanked Mr. Dehner for his input then added that the Commonwealth has just become a model employer for disabled workers, and breaking down barriers. We can get you information as this demographic has a high rate of unemployment.

Mr. Szabo mentioned that Dr. Stan Hochberg, former Director of the Northeastern University Health Informatics program has worked on these issues.

Ms. Fenichel commented that Chapter 305 has requirements for Physicians to be competent. She didn't quite understand the goal of this workforce training. Dr. Shoup responded that this particular grant is not focused on physicians. Dr. Shoup responded that it is an attempt to get people on the ground qualified to do the work, this is in relation to extension centers and it could include other software vendors as well.

It was explained that within the next day or so invitations to participate in the workforce development focus group will be sent. At that, various council members mentioned people; groups and organizations that they felt should be added to the list of invitees. Once we have these focus groups, we will have a better idea of who else is also out there working in this space. Ms. Cassleman added that the focus group is a sampling. She also mentioned that some of these groups may be thinking about applying for a grant and there may be an opportunity to join forces.

Next, Ms. Sherwin spoke about Interoperability. This topic crosses all areas of the plan. MeHI will serve in a critical role of coordination to facilitate interoperability amongst the systems being constructed to serve multiple user constituencies including authorized providers and intermediaries, government agencies, patients and families.



MA HIE interoperability will be enabled through recognized standards categorized as follows:

- Standardized Architecture
- Interfaces
- Data Structures
- Functional Behavior
- Data Vocabularies

MeHI will need to develop a life cycle framework. The framework must be flexible and adaptable over time.

The proposed MA HIE Interoperability Guiding Principles were shared with the Council:

Adoptability
- The MA HIE conforms to the standards, policies and regulations put forth

Adaptability
- The MA HIE can be modified and expanded to integrate with newly introduced architecture components, additional services, interfaces and features that will cater to the needs of increased users, systems and networks

Reporting
- Provides the ability to collect, transmit and report required information in standards-based formats relying primarily on pull methods.

Maintainability
- MA HIE standards and requirements for participation are not onerous or overly complex, allowing greater participation by the MA community

Systems Integration
- Adapters and connection mechanisms are defined and developed for all MA HIE participants to use.

Extensibility

- Enables addition of new functionality or updates to existing functionality with minimal impact to existing functions

Patient-Centric

- Provide each individual in Massachusetts a record of their key health history and care information

Mr. Szabo, in reference to the principle of "Reporting", asked why the focus on 'pull'? If you need information pull, this is going to require a more robust security. Security requirements are different at the different levels. There is a guiding principle to develop something measureable, but can it adapt?

Ms. Aranow pointed out confusing terms in reference to reporting; maybe it could be a bit more direct. Ms Fenichel suggested a change in nomenclature in regards to 'allow patient access.'

Mr. Szabo added that there was a Google Health user who looked up his own information that caused an issue. We must be careful on what we promise and when we will get there. We need to make sure it is better and has information the consumer can understand.

Secretary Bigby added that we have mentioned in our council meetings that before you engage, it should be built on the user not the HIE's ability to pull additional data to have a more robust health record.

Dr. Bell reminded everyone that it is important to stay broad. As standards come down, make sure they are tested, they are piloted, and they are able to be adopted.

Next Steps

- Leverage the MeHI management/decision making structure and processes to review and endorse the interoperability plan
- Align and schedule the adoption of standards with the transaction roadmap and with the expected impacts and level of changes required for each stakeholder
- Evaluate the MITA framework in establishing a common reference architecture
- Coordinate implementation and enforcement of a common framework through the governance structure
- Coordinate the implementation of the common framework with the overall exchange deployment
- Implement the standards life-cycle management process

Dr. Kevin Carr from Deloitte Consultants gave the next update on EHR / HIE. He started by explaining that in each meeting he always likes to repeat the Secretary's direction to not only build on today but on tomorrow and 20 years from now.

All the states are working vigorously on their projects. Deloitte has been scanning other state HIE's to determine best practices and identify any models that could be applicable to Massachusetts. His team has sent draft outlines to each state HIE representative asking them to validate their structure as we wish to add this information to the end of the plan.

Dr. Carr went through a couple of the state HIE Scans and started with Michigan. It is community based. They have $10M in funds, and are high level, similar to Massachusetts, and all linking into one statewide exchange.

Rhode Island was presented next. They have a unique factor, as they have selected a single outpatient EHR and link it to a single HIE. Another unique factor, the HIE organization is also a quality improvement organization.

A state that is just getting started is Wisconsin. Currently Deloitte has folks out there to help them walk through the process. An interesting thing to hear regarding Wisconsin, is a lot of their providers have an electronic health record, with a high adoption rate, potentially you may see them moving quickly.

Secretary Bigby clarified that 60% of Wisconsin uses Electronic health records? To which Ms. Fenichel responded with a question regarding their capability to interconnect. Dr. Carr stated that he is not aware if they can interconnect, but he does know they will have to upgrade.

New York was highlighted next. The HIT Coordinator that sits in the department of health helps state agencies insure that they are moving along the right path. NY eHealth Collaborative brings public and private together. If you ever Google you will find a lot of their programs come from the Heal New York funding program.

The Secretary asked if they have any other funding. Dr. Carr explained that it is mostly state funding.

Other questions asked included: Did you ask if there is a stream of funding for state proportionately? What is the relationship between Heal NY funding? What does it mean in response, to public / private funding?

It was then suggested that it might be a good idea to dig below the surface.

Dr. Carr explained that after doing the state scans, the first theme that emerged was that times are changing. For example, NY changed from 19 REC to 3. Secretary Bigby added that NY had 19 because they had different projects going on.

HIE Scans

- States are using a combination of approaches to developing Public Private Partnership models
    - Some are designating a not-for-profit entity to receive funding
    - Some are using state agencies
- Many states are appointing HIT Councils with appointment by the Governor (or other state legislators) to oversee the HIE and REC
- HIT Councils include representation from state government as well as multiple stakeholders

- Many are in planning stages and are still working through their sustainable funding model. They are using Federal funding to get them to operational status.
- Number of regional exchanges varies, from 1 state level HIE in Wisconsin, to 19 in New York.

HIE Findings of Interest

Vermont

- Developed shared lab interface engine to reduce cost of deploying EHRs to small office providers
- Implemented a tax on inpatient hospital payments to fund the HIE and centralized lab interface engine (along with governance)

Rhode Island

- Implementing a single vendor EHR across all outpatient clinics

New York

- New York eHealth Collaborative provides governance, project management, and design support; has ability to subcontract with other entities
- Funded numerous pilots, but now strongly considering movement to three regions linking into the SHINY (State Health Information New York)

Connecticut

- Developed a common patient consent form to be applied across all organizations participating in the HIE
- Department of Public Health will lead the HIE; Public/ Private Partnership will serve as the REC

Washington, DC

- DC Patient Hub will provide Medicaid data to providers through a patient portal

Delaware

- Developed a shared lab interface engine that also builds historical data available to providers in the HIE

Not a standard approach for HIEs.

Next was a discussion around governance, and what can we utilize, what is helpful, what can we do? Similar conversations are going on, if the box is too small, stakeholders are not willing to participate. We have to have the right involvement from stakeholders. There is not another state that is as advanced as MA in HIE.

Mr. Dehner pointed out that all states experience challenges with Medicaid funds, but asked which state portrays their effort in Federal Medicaid. Kevin responded that Connecticut was an example.

A general conversation took place about governance, security, privacy and consent.
Mr. Adams acknowledged that the governance issue is one of the most important issues we are addressing right now; it is at the core of the whole matter.

Ms. Adair noted that RI has a law around privacy and consent. Have we seen that law? Rhode Island is advanced in dealing with issues of privacy and security - passing one of the first HIE laws in the nation to assure strong consumer protections, going well beyond HIPAA

Ms. Fenichel asked about the Veteran's Administration (VA). Dr. Carr stated that the VA uses Health Connect.

Secretary Bigby mentioned a letter that she had received from Pat Kelleher requesting to include home care as part of the plan. We don't have anyone other than providers listed. What is mentioned is what the feds are paying for; however, in fact, that is not the whole health care system. If we are going to promote integration we should include the full continuum of care. You have "x" amount of dollars, how do you prioritize what the infrastructure will support?

Secretary Bigby remarked that in truth the most cost savings will come from a small percentage of the population that consumes the most health care costs, such as readmissions to hospitals from nursing homes or home health care. Better integration of these small populations can result in cost savings and better coordination of care throughout the health care system.

Dr. Bell stated that if we are developing a strategic plan, we are going to prioritize. We will start with primary care; we will have to bring in the others, home monitoring devices, etc. We will need to determine what we are doing year to year. What do we bring in and when.

Dr. Carr then presented the issue of consent management. It is a discussion that we are having next week with the privacy and security stakeholders. One of the Council members mentioned Chapter 305 and the specific requirements around Opt in.

Dr. Carr presented a framework that will be discussed regarding Consent Management.

- Establish a mechanism to allow patients to opt-in to the health information network and opt-out at any time
- Give patients the option of allowing only designated health care providers to disseminate their individually identifiable information
- Keep sensitive patient information confidential by exclusively utilizing electronic health records products that are certified by the Certification Commission for Healthcare Information Technology
- Inform individuals of what information about them is available, who may access their information, and the purposes for which their information may be accessed.

<u>Common Themes in Discussions about Consent Management</u>

- MeHI should lead the effort to develop a common consent approach across the Commonwealth
- Patient consent should be acknowledged in the same way across organizations participating in the Health Information Exchange
- Current consent standards can limit our ability to recognize multiple levels of patient consents (e.g. Admission Discharge Transfer (ADT) message from a practice management system vs. standard consent document from an EHR)

- The consent management approach must be ‘comprehensive’ and ‘comprehendible’
- Patients and providers must understand how the information is shared
- If the Commonwealth pursues an ‘opt in’ model, then there must be a universal way to link the patient’s data with acknowledgement of his/ her consent (i.e. enterprise Master Patient Index (eMPI) likely required to manage consent across a statewide HIE)

Dr. Carr mentioned that there will be an upcoming stakeholder meeting on Security and Privacy.
- Upcoming Security and Privacy Stakeholder Meeting will review current Consent Management recommendations to gain additional input
- Topics of discussion:
  - Consent approaches currently utilized in the Commonwealth
  - Ability to create an enterprise master patient index (eMPI) to ensure patient consent is applied uniformly across participating organizations

Mr. Szabo commented that there must be a protocol for Identity theft. There needs to be a way to monitor who is in there, who is getting access to data? Is it common place to have a state-wide identifier?

Ms. Adair commented this reminds me of how we deal with privacy issues at Partners. Where ever the patient enters, it is fed up to all the other hospitals that it has been acknowledged. The concept of a Master patient Index (MPI) There is a very small number of people who have access to it.

<u>EHR / HIE Next Steps</u>
- Repeat request for states to complete the HIE scan (for those who have not returned their response)
- Define patient consent recommendations that will heavily frame the future technical architecture approach
- Develop final EHR/ HIE recommendations
  - PowerPoint deck
  - Word document

Ms. Aranow asked about the issue of data duplication? No matter how good of a job we do, I am concerned, about duplication. How are other states addressing this?

Dr. Shoup discussed the Workforce Development Grant. EOHHS is taking the lead and will submit the grant on behalf of the Commonwealth. MeHI is interviewing consultants to help EOHHS with the grant application process.

Meeting adjourned at 6:00 pm.