

Technology Advisory Group Meeting

March 29, 2013 2-3:30p

Name	Organization
Atia Amin	Network Health
Claudia Boldman	Information Technology Division
Larry Garber	Reliant Medical Group
Bill Gillis	BIDMC
Adrian Gropper	HealthURL Consulting
John Halamka	BIDMC
Sean Kennedy	MeHI
Anurag Lal	EOHHS
Pamela May	Partners Healthcare
Matthew Moss	South Shore Hospital
Mark Taricco	UMass Memorial Medical Center
David Whitham	The Dimock Center
Keith Worthley	BIDMC
Eric Hilman	EOHHS
Support Staff	Massachusetts eHealth Collaborative
Micky Tripathi	Massachusetts eHealth Collaborative
Dave Delano	Massachusetts eHealth Collaborative
Mark Belanger	Massachusetts eHealth Collaborative
Carol Jeffery	Massachusetts eHealth Collaborative
Erich Schatzlein	Massachusetts eHealth Collaborative
John Virgona	Massachusetts eHealth Collaborative

Summary of Input and Feedback from the Provider Advisory Group

- General feedback
 - We should leverage messaging standards where they exist and are having successful uptake in the market – We should use RESTful with XML message constructs for new messages not previously standardized
- Feedback regarding Master Person Index (MPI) and Patient Matching
 - We should only allow EXACT MATCH returns from a patient search in the RLS. No partial lookups or ‘pick from a list’ responses allowed. We can use some ‘fuzzy logic’ lookup capabilities however such as soundex which produce reliable matches
 - We can return a variety of error messages such as ‘Message Failure’ or ‘No match found’ for example but we CANNOT disclose any status of a patient via these messages, such as ‘no patient records found at XYZ fertility clinic’
- Feedback regarding Record Locator Service

- Once a patient match is made the RLS will return a list and dates of recent encounters (10 most recent for example) so the requestor can choose to seek the patient information or not. This implies sending an Event Date Segment as a part of the HL7 ADT (PID) segment to populate the eMPI. If there is an encounter type (ED, PT, etc.) that would be ideal
- The RLS will only return matches for patients with a positive consent in the consent DB
- The HIE will not collect and aggregate CCDs from multiple EMR's and present to the requestor. The RLS will issue a message to the EMR to send a CCD to the requestor as a separate message (push transaction from the source EMR)
- An option to subscribe to a patient record in the RLS could facilitate push of any new updates to the subscribing provider
- A "CCD to be pushed at a future time message" could be sent to the EMR to tell it that a requester is waiting for a patient record and to please send it directly to them.
- Feedback regarding Consent
 - Since general consent is only needed for query (pull) transactions then the consent DB in the HIE will be used to validate consent at the time of an RLS query. EMR's should also only release CCDs to the HIE / requestors for consented patients
 - Patient opt-in should be simple – there may be a future opportunity to leverage patient portals for gathering/changing consent.

Review of Materials and Discussion

Project Updates

- Mass HIway Phase 2 Timeline Update (Slide 2)
 - Currently, we are waiting for final approval from CMS for phase 2 services. The expectation is to hear back within this month. Our understanding is that there are no reasons to not be approved.
 - Please see slide deck for full timeline updates
 - A member noted the national level Standards Committee is working on pull-based transactions but there have been no definitions. The HIway may lead the way on the standards definitions.
- HIway Implementation Grant Update (Slide 3)
 - HIway grant opportunities have been posted by MeHI. Potential HIway participant organizations may be able to obtain up to \$75K to use toward migrating existing services onto the HIway.
 - Three webinars were run by MeHI to give information on grant program. A total of 90 participants joined the webinars. The basic concept is to accelerate adoption of the HIway, and the goal of the grants is for organizations to take existing processes and move them onto the HIway. Ultimately, the HIway hopes to have successful use cases built by the grants, and use these success stories to market HIway use in the future.
 - \$2M overall funding, up to \$75 each proposal.

- There is a very quick timeline for application. The due date for grant submission is 4/16, by 8:00am
 - A member noted that the grant won't cover the overhead for what an organization wants to do, but is a catalyst for action. BIDPO has already been contacted to be a partner for a number of grant applications.

Discussion Items:

- Goals for today's session:
 - Discuss Transactions for eMPI (electronic Master Person Index) & RLS (Record Locator Service)
 - Discuss Consent Flag Options re: eMPI & RLS
 - Patient Directed Messaging
 - Discussion of LAND device operational status
- Transactions Required for eMPI & RLS (slide 6)
 - Distill down discrete transactions needed for MPI (Master Person Index) and RLS (which includes consent). Refer to specifics of slide. The messages types indicated in the grid are not necessarily the standard.
 - Comment: There are implications on how we submit consent in the ADT (Admissions/Transfer/Discharge). If nothing but direct hits are returned, then ADTs can easily populate the MPI without consent. If divulging information in a list of possible patient matches, the risk of divulging too much information on nearly-matching patients becomes a real issue.
 - Comment: Agrees there is a huge danger of matching the incorrect patient where a person at the receiving end can make the wrong decision. As noted in other discussions, the State will only return a record locator response for a direct hit. There will be no fishing requests or returns of long lists of possible matches. It was noted that it might be possible to create some rules on possible matches based on transposition of certain fields but these have not yet been defined.
 - Question: Was the theory that a direct match would give an opportunity to exclude consent before populating the MPI?
 - In theory it is possible to return a list of locations based on a positive match even if the patient has not yet consented, but this theory will not be address during this call. The Legal Advisory Group should consider this issue.
 - Comment: If consent is stored in MPI and sent with the ADT message, then the RLS would only return exact match hits WITH consent.
 - Comment: As a query result, Careweb only shows those locations where a patient has specifically consented. In a similar example, another organization listed search results which included visits to a substance abuse facility and this sort of disclosure became a news story in the NY Times.

- Suggestion: Add intelligent response messages w/out disclosing patient identification or confidentiality.
- Comment: General consent for care (the method is up to organization, but can be included in NPP (Notice of Privacy Practices)). ADT goes to HIway and internal areas, populated in MPI, and consent flag says “YES.” Patient may have multiple registration records from multiple institutions, but has NOT consented for disclosure in some of those organizations. Query will show exact match patient, and only the places that consent IS present, doesn’t show where consent was not present.
- Question: Would a return message state “no record found” or would it say “ambiguous match” which would indicate that more information would be needed to identify and match a patient.
 - Is it possible to state “consent not received at OTHER facilities”
 - It might say “patient found” but no consented records.
- Sometimes providers know a patient record is there, but will get frustrated if it a message return states NO based on consent, without the indicator that consent is not present.
- Question: Feels this process is somewhat coercive, sending data to the HIE and affiliated locations as part of the registration process. If this process if followed, it may not be easy to disclose what the eMPI knows about the patient. If we don’t make provision (rules) from the start, like a covered entity would have, we will run into problems. This seems to be a separate and duplicate universe that the Blue Button technology already being developed. Why do we want to introduce a parallel universe to Blue Button Plus?
 - A member requested to have the Blue Button information distributed to this group for review. If Blue Button, or MITRE, has a process, this can be reviewed.
- Comment: HL7 does have a consent message defined
 - This may be for clinical consent, but could potentially be expanded and used for the HIE.
 - Comment: The HIway will use “restful” XML over rest seems easy.
- Comment: If we start creating databases that are inaccessible to the patient, the HIway should be careful. He suggests making sure the HIway acts as a covered entity.
- Question: Would the HIway allow patient directed access, and ability to manage consent directly through a portal?
 - Answer: That is being contemplated in the future model.
 - RLS would be accessible to patient through portal. Patient would also potentially have an audit list (disclosures, views).
 - Comment: This should not be a later development, but should be included up front as the database is created. We are setting a lower bar

than a covered entity if we don't provide the patient access within 30 days.

- A request to A. Gropper to provide a current edition of the RLS to D. Delano who will distribute this to this group.
- Comment: A member cautions that the HIE might not have an audit trail. It might not go through the HIE, but would be available from peer to peer to identify what was pulled from the EMPI for a patient record at a specific location. The patient would be in the best position to enforce who has access to their records. There would be a probabilistic pattern of access and the patient would be able to identify this access. He referred to Chapter 224 for guidance; every entity that is a data source is expected to provide the patient with information that was disclosed.
- Question: Are there standards for consolidated CDR?
 - Answer: Not at this time.
- Comment: RLS indicates patient location. EHR does P2P query with one of those organizations, and obtains CCDA from that site, without the HIway.
- Comment: Business of allowing parties to exchange information through a third entity is not a new concept for healthcare. Suggestion of using 'OAuth' as protocol for secure authorization.
- Comment: If a provider wants to know NEW information from the RLS from the last time they looked, there should be relevant dates or a notion of updates to CDA information. A provider doesn't want to pull down data already retrieved. A suggestion was made to include dates or notification options in the build for Phase 2.
 - Comment: Could there be automated trigger events to send a message?
 - Comment: Most recent dates of encounters with response from RLS. A push or trigger event that would fire a message to the RLS to make some type of indication.
 - Comment: The 7th field of MSH segment of the ADT has a date and time segment.
- Comment: The Push-Push transaction: RLS could initiate an asynchronous query to a distant EHR. A direct message queue for a future time.
- Comment: The Technology Advisory Group should discuss the Push/Pull transactions.
- Comment: Move towards a subscription and set up a queue for 'send me everything that's new on this patient'

MassHIway eMPI & Record Locator Service Transactions (Slide 7)

- Pictorial view of what the Advisory Group has been discussing
- Re-architect slide to show new transaction suggestions like the Push at a future time message
- Date/time segment information in the events segment of the HL7 ADT

Consent Flag Topics for Discussion (slide 8)

- Any issues with consent flag being created/stored in EHR, and being sent in HL7 ADT? Any other implications on the EHR side?
- If there is a local HIE in your community and there is an existing consent model, it could conflict with the Hlway process.
 - Comment: This discussion covers consent in a very generic way. Different consent levels are being discussed in Legal and Policy group. Can we refer to this as HIE participation consent flag? Yes.
 - Comment: There may be a need to refer to this as the Hlway participation consent and not to specific types of clinical consent. It may not be able to separate these types of consent, but could be viewed as nested consent; first consent level at the HIE, then consent into the clinical information (and specifics about clinical release of information such as HIV or genetic testing, etc).
 - Comment: This should be covered in the Legal/Policy Advisory Group. Statutorily protected data has even more narrow definitions so cautions against consent generalities. The Legal/Policy Advisory Group will need to address the specifics.
 - Comment: One type of consent can't discuss one without the other. If there is HIV information, there must be an ability to filter, or a separate consent is needed for every release of information.
 - Comment: If there is NO consent to the HIE exchange, then nothing matters. If there is consent (Yes), then we need to get to the clinical consent.
 - Comment: This implies it can be segregated. If you can't segregate, they must be addressed at the same time.
 - Comment: Having a centralized consent management system would be hugely beneficial.
 - Comment: If we leave the issue of disclosure to the data holders, we may get into a situation of needing to allow role based access. If we only have a single, general, consent flag, we lose the ability to have role based constraints.
 - Comment: If this process doesn't make this easy for patients to participate, they won't. The same holds for organizations and their requirements to capture consent. The option to "opt in" with the ability to exclude specific places is easier than consenting at each location. In other words, blanket, or global, consent: "everywhere I go is fine, except here." If we could allow this on top of what is being proposed now. In the ER example, this would be extremely helpful to have the global "opt-in".
 - Proposal: Another transaction type to include a global consent option. The update would need to out to the EMR side which would update the consent preferences at the EHR side.
 - Comment: No EHR would be able to receive or do anything with that message.

Patient Directed Messaging (Slide 9-10)

- The group briefly reviewed the slides and information.

LAND Question: Is anybody successfully using the LAND device?

- Comment: They do have LAND functioning, but it is not being used in production. Biggest concern is timeline going for Stage 2 MU in the future, and want to make sure the HIway and LAND device will be certified for MU
 - Software is currently certified for Stage 1, but Stage 2 is not out yet.
 - There will almost certainly be something certified. Orion will certainly seek certification.
 - Question: Does the HIway itself need to get certified on its own?
 - That would be a big help, and the timing may be important.
- EOHHS is ironing out issues with Orion on the LAND device. A new update should be out in the next couple weeks. Thousands of test transactions have been giving necessary data to update the device software. There have been “teething pains” in the testing, but updates for production will be coming soon.
- Question: When are the webmail accounts coming out?
 - Answer: Web accounts are available. Dr. Greg Harris has already been configured. Contact MeHI for address.

Next steps

- Bring for discussion and comment the EOHHS ADT content requirements for the eMPI and RLS services to the next Tech WG Mtg.
- Key points and recommendations synthesized and provided back to Advisory Group for final comments
- Presentation materials and notes to be posted to EOHHS website
- Next HIT Council – April 8, 2013, One Ashburton Place, 21st Floor
- HIT Council meeting schedule, presentations, and minutes may be found at <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/masshiway/hit-council-meetings.html>

Post Meeting e-mail discussion with clarifying points:

I believe we agreed that the HIE level consent was to be kept at the HIE for each organization that sends an ADT message – presuming the patient has indicated one. This way the RLS would only return records for those EMR’s with a positive consent status. Negative or Null consent flags at the RLS will not return hits. We discussed that eventually these statuses may be updated by the patient via a patient portal – with a universal opt-in with exceptions option.

Lastly, we agreed that the EMR would need to keep a local consent flag as well (whether updated by the HIE/RLS as a ‘new’ transaction type or kept locally by the staff) for the purposes of not releasing clinical content inadvertently via direct requests from other EMR’s or as the result of the RLS issuing a request to send records from that EMR. There is a (remote) possibility that the RLS and the local EMR could be out-of-sync in regards to patient consent preferences so the local EMR should always verify a positive consent flag before sending CCD’s via the HIway. Note that the consent flag is required for query (pull) transactions only. If a user pushes a CCD via the HIway there is the presumption of TPO as in the phase I

Hiway model and no HIE consent is required. This is no different than sending a fax today for TPO purposes.

Just one clarification. Where you say:

- Proposal: Another transaction type to include a global consent option. The update would need to out to the EMR side which would update the consent preferences at the EHR side.
- Comment: No EHR would be able to receive or do anything with that message.

The rest of the comment was that you don't necessarily need to store global consent in every EHR that registers the patient. Indeed, it would be helpful so that they know not to ask for individual consent at each organization, but not required. What is most important is the way the RLS would handle a global consent that is stored centrally. It would look to that consent first, and if present, look for any organizations that are excluded by the patient. The need for exclusion has one more implication in that a consent statement received from an organization would have 3 possible states: Yes (consent received), No (consent refused, i.e. this organization is an exclusion), or Null (neither consented nor refused).