**Meeting Minutes**

**Health Information Technology Council**

**August 1, 2022**

3:30 – 5 p.m.

**Due to COVID-19 precautions, meeting was held remotely   
in lieu of in-person meeting normally held at**

**One Ashburton Place  
Boston, MA 02108**

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| --- | --- | --- |
| Name | Organization | Attended |
| **Lauren Peters** | *Undersecretary of Health and Human Services (Designee for  Secretary Sudders)* | Y |
| **Deborah Adair** | *Executive Director, Enterprise Health Information Management/Privacy,  Partners Healthcare* | Y |
| **Keely Benson** | *Director, Massachusetts eHealth Institute* | Y |
| **John Addonizio** | *Chief Executive Officer, Addonizio & Company* |  |
| **Damon Cox** | *Assistant Secretary for Technology, Innovation, and Entrepreneurship (Designee for Secretary Mike Kennealy)* |  |
| **Frank Gervasio** | *Project Manager, Executive Office of Administration and Finance* |  |
| **Diane Gould** | *President and Chief Executive Officer, Advocates Inc.* | Y |
| **John Halamka, MD** | *President, Mayo Clinic Platform* |  |
| **Kelly Hall** | *Senior Director, Healthcare Transformation and Innovation, Massachusetts Health Policy Commission (HPC)* | Y |
| **Sean Kay** | *Global Accounts District Manager, EMC Corporation* |  |
| **Dicken S. C. Ko, MD** | *Chief Medical Officer/Vice President of Medical Affairs, St. Liz’s Medical Center, Steward Health Care* |  |
| **Michael Lee, MD** | *Medical Director, Boston Children’s Hospital* | Y |
| **Manuel Lopes** | *Chief Executive Officer, East Boston Neighborhood Health Center* |  |
| **Linda McGoldrick** | *President and CEO, Zillion* |  |
| **Michael Miltenberger** | *Vice President Healthcare Team, Advent International* | Y |
| **Naomi Prendergast** | *President and Chief Executive Officer, D’Youville Life and Wellness Community* |  |
| **Monica Sawhney** | *Chief of Staff, MassHealth* | Y |
| **Emma Schlitzer** | *Manager, External Affairs, CHIA* | Y |
| **Pramila Yadav, MD** | *Private Practice Obstetrics & Gynecology, Beth Israel Deaconess Medical Center* | Y |

**HIT Council Members**

## Discussion Item 1: Welcome

Undersecretary Lauren Peters called the meeting to order at 3:30 p.m. The Undersecretary welcomed the Health Information Technology Council to the August 1, 2022 meeting.

Undersecretary Peters announced that there was new news from Ben Linville-Engle. Ben announced that Keeley Benson is now the new Director of Massachusetts eHealth Institute (MeHI) and will be serving on the HITC council and that Liz Reardon has been promoted to the position of Project Director at MeHI.

Keely Benson added, “Thank you. I have worked at MeHI for ten plus years focused on the HIway and I am happy to support EOHHS and the HIway team.”

Undersecretary Peters added that “we look forward to having you in your new position, you are certainly not a new face.”

Undersecretary Peters: “Our first item on the agenda is the May meeting minutes, does anyone have any edits? “

No edits were made.

Undersecretary Peters called for a motion to approve the minutes of the May 2, 2022, HIT Council meeting.

Deborah Adair: “Motion to approve.”

Nancy Mizzoni: “Motion seconded.”

Undersecretary Peters: “All in favor?”

All “I’s “in favor.

Undersecretary Peters: “Opposed?”

No Opposition

Undersecretary Peters: “Motion approved; May 2,2022, Minutes approved.”

Undersecretary Peters: “First substantive item of the Attestation process”

## Discussion Item 2: Attestation Update

*See slides 5-9 of the presentation. The following are explanations from the presenter Julie Creamer, with additional comments, questions, and discussion among the Council Members.*

Julie Creamer gave an overview of the HIway Connection Requirement as outlined in MGL 118i and the breakdown of attestation statistic for 2021. She added that the team felt these were good numbers to end the year on. The impact of the expansion of attestation to include all DirectTrust HISPs increased attestation using this mode for this year. Julie announced that the Mass HIway will be closing out the attestation process this year as the timetable has been met by ACHs, CHCs, Medical and Ambulatory practices.

Julie Creamer: “Over 550 organizations have completed attestations over the last 5 years. The process has been integrated into daily workflows and the teams does not expect a downturn in transaction volume. We will be monitoring MA HIway transaction rates and will report any significant drop. If the Mass HIway determines that an attestation process will be needed in the future, there will be a new form and a new process. But we feel we have gotten as much data as possible out of this process. Any questions?”

Deb Adair responded: “No questions, but much appreciation!”

Julie Creamer: “Yes, thank you”

Undersecretary Peters introduced the next section:

## Discussion Item 3: ADT/ENS Research Update

*See slides 10-18 of the presentation. The following are explanations from the presenter, Liz Reardon with additional comments, questions, and discussion among the Council Members.*

Liz Reardon presented an update on ADT and ENS Research

Liz: “The team has been looking into challenges related to the ENS notification systems that are impacting the quality and value of ADT alerts. ENS vendors have different approaches to sharing clinical information and it may be beneficial for them to share best practices. “We’re looking for Quality improvement, looking into reported challenges.”

Liz: “The CoP solution and the ENS framework went live at the same time, causing duplications and alert fatigue. The CoP solution sends all notifications without the ability to filter. Providers can opt out of the CoP solution, but most are not aware they can do so. Additionally, if they are a part of the EPIC system, Care Everywhere may also be sending duplicate notifications.”

“The CoP solution doesn’t require diagnosis codes. With Stakeholders key pain points are duplicate ADTs and missing diagnosis codes, as theses impact quality and value. ENS vendors have different approaches, and it may be a benefit to talk about best practices.

We have found that only one of the two Certified ENS vendors includes diagnosis code because it is not required. One of the certified vendors does not pass on diagnosis code if Social Security number or zip code is missing. Because Diagnosis code is not a requirement. This results in a lack of clinical data. Diagnosis codes related to substance abuse and mental health 42 CFR codes are often filtered out so there are multiple factors for missing diagnosis codes. There are also technical workflow issues and not enough meta data. Direct Trust is working on Data Standards but not all EHR vendors have a sense of urgency about implementing these standards.”

Kevin Mullen” “Liz can we pause, and could you highlight areas the team is looking to address?”

Liz: “Thank you Kevin, the team is looking to get additional info on “fill rates” from vendors- info on what data points are missing from the hospitals, it’s the main thing we can address for diagnosis codes. So, we can see and help with filling in. Additionally, there are other areas where the team can work with providers to prevent duplication of data. For example, the team can educate providers that the CoP solution can be “turned off” if they are a participant of the ENS framework.”

Dr. Mike Lee: “So there are purely technical issues for some parts, like social security numbers or zip codes. Zip codes are used for identifying patients and Social Security numbers; especially for children are often not available. We really need to pressure vendors into change; we have been trying to discourage social security number use, and who in the office will do something with this? Identified care team messages need to appear for different cases. EPIC sends only to provider, ENS goes to care team, so sometimes redundancy is good!

Debbie Adair: “I want to be sure of why there is no Diagnosis code? Is it because of lack of ID?”

Liz: “They need an extra level of confidence, so they use SS or zip codes

Debbie Adair: “So either one?”

Liz Reardon: “Yes”

Undersecretary Peters: “Is it primarily Behavioral Health or all?”

Liz Reardon: “All Diagnoses’ for one vendor”

Undersecretary Peters: “Hmm, that’s a problem.”

Liz Reardon: “Yes, I agree.”

Keely Benson: “I know you can try to make changes through the recertification process, recertification for ENS vendors is January 2023.”

Undersecretary Peters: “Thanks Keely, you took the words right out of my mouth. What are modifications and adjustments we need to make here? Let’s hear from you regarding the recent standards, for the beginning of the next calendar year.”

Debbie Adair: “Yes, we will think about it.”

Undersecretary Peters: “We can circle back prior to the next council meeting.”

Debbie Adair: “Great thanks.”

Undersecretary Peters: “Go on Liz- “

Liz Reardon: “ADTs for psych are not being sent despite the requirement- lack of an EHR or a requirement to include consent may be away that is used to get around the requirement. Legal feasibility or cultural concerns may also be a challenge to using consents. Also, there are no financial incentives for psychiatric hospitals and only 20% have EHRs

Kelly Hall: “I’ve never seen the statistic indicating 20% adoption of EHRs by psychiatric hospitals. is there any activity to increase this number at the Federal level?”

Liz Reardon: “I don’t have treatment info but, I will look into it.”

Kevin Mullen: “I’m not aware of any Federal level program to incentivize EHR adoption. Limited integration with ENS vendors makes it difficult to quantify the depth of the gap, I’m interested in understanding without Federal or State incentives how we can close this gap.”

Undersecretary Peters: “We will tee up thoughts. I’m interested in hearing from stakeholders and to encourage participation.”

Kelly Hall: “Thanks Kevin and Lauren.”

Dr. Mike Lee: “Payors know status, appointments, admission, and boarding. Payors get inbound notifications; can we get info from payors and have vendors distribute this? They get it within 24 hours.”

Debbie Adair: “One reason I think it’s worthwhile to re-educate providers on this is not everyone realizes that they can share. There have been changes and we can Some organizations are still afraid.”

Undersecretary Peters: “Which authority would be most effective to convey that information?”

Debbie Adair: “Start at hospital leadership.”

Undersecretary Peters: “But from the State? Is it the state you’d want it to come from? Just to clarify.”

Debbie Adair: “Yes, absolutely the state and you know, refresh or highlight that regulations allow and require this.”

Undersecretary Peters: “Thoughts? Not to put you on the spot but, thoughts on operational lift at a time of constraint.”

Debbie Adair: “In terms of psych hospitals, strain on budget is probably a big thing. I don’t know how many hospitals but that plays into it.I don’t know how many hospitals or sizes but, that plays into it. I wonder where they are with respect to becoming electronic. Are there any alternatives? Those are actual hospitals the less than 20 percent? In Massachusetts?

Julie Creamer: “Nationwide, this information is a few years old, but most people didn’t think this had changed significantly”

Undersecretary Peters: “Think of State levers in moving forward in Health Care exchange.”

Kevin Mullen: “I’ll speak to this, we wanted to flag this as an area we wanted to hear feedback on. We’d like to start with low hanging fruit but, we’d like a sense of other problems.”

Debbie Adair: “I would like to know numbers of our own state.”

Undersecretary Peters: “There are not too many freestanding psychiatric hospitals so that should be a “knowable” number. Liz is there anything else on the slide?”

Liz Reardon: “Nope.”

Undersecretary Peters: “Room for improvement in another area?”

Liz Reardon: “To limit that potential for duplication”

Kevin Mullen: “Thanks Liz.”

**Discussion Item 4: Program Updates - *BH Treatment and Referral Platform***

*See slides 19-22 of the presentation. The following are explanations from the presenter Kevin Mullen, and comments, questions, and discussion among the Council Members that supplement the content on the slides.*

Kevin Mullen: “Happy to report that the RFR has been released, currently this process is a manual and paper-based process. This will change to an electronic medium and to a standardized set of data with a dashboard for real time and a transparent view of where patients are waiting. We want to leverage existing vendors for future integration with bed finding and utilization across the state.

Kevin Mullen added: “Proposals have closed, we’re working on the formal evaluation process with the evaluation committee. Technical responses and cost responses are anticipated for later this month.

Diane Gould: “This looks promising. Anticipating a shift in the road map and hospital teams doing evaluations on their own. Is this initiative for referrals and inpatient stays only and transfers for inpatients?”

Kevin Mullen: “Great question. In the initial phase there is no significant change to workflows. It’s more about automating existing processes and workflows. Evaluation teams are not changing, just being given automation tools and supporting downstream efforts.”

Undersecretary Peters: “No, not just inpatient psych, admission to facilities and to community program providers. Facilitate out of the emergency department and into patient psych facilities or community programs. This is an agnostic process- it works provider to provider and with patient’s insurers to be more helpful and give clarity on community crisis beds and automation of existing processes is great. Is there anything about standardizing diagnosis info?”

Kevin Mullen: “Yes, current EPI data sets are standardized. When inpatient facilities move info this might benefit from standardization.

Keeley Benson: “How many proposals? Can you share?

Kevin Mullen: “I’m not sure, I defer to Lauren”

Undersecretary Peters: “No, the key is there were responses.”

Debbie Adair: “Can you go back to the slide regarding leveraging existing networks and exchanges; you wouldn’t have to change existing ENS contracts or for different use of data sharing.”

Kevin Mullen: “Clarity? Does the state have an update to the contract? “

Debbie Adair: “Do providers have to sign something, like a few years ago?”

Kevin Mullen: “ACHs had to contract. This won’t need any revisions to that. We wanted vendors to come aboard with existing integrations, otherwise it’s not cost effective, they may need to update contracts or create new order sets for new use cases.”

Debbie Adair: “For a new use case, right?”

Kevin Mullen: “We don’t expect this to overreach contracts with existing vendors or existing contracts. The universe of participants is very sizeable 100’s. Bidders should tell who is connected and the lift required to see who can provide best value to the state.”

Debbie Adair: “That’s helpful, thank you.”

Undersecretary Peters: “Debbie, what is your specific concern about this?”

Debbie Adair: “No, just concerned about changes to existing contracts.”

Kevin Mullen: “That’s a good concern.”

Debbie Adair: “Thank you. “

Kevin Mullen: “Other questions?”

Debbie Adair: “No, good progress though. “

Kevin Mullen: “Thank you”

**Discussion Item 5: Clinical Gateway API Development- Update**

*See slides 23-30 of the presentation. The following are explanations from the presenters: Julie Creamer and Liz Reardon, and comments, questions, and discussion among the Council Members that supplement the content on the slides.*

*Julie Creamer began with background of the development*

Liz Reardon recapped key objectives: “The team thought it was important to explore different ways to connect – get rid of LAN devices. Key project updates, the biggest program was OAU, we have also been working to reach out and identify key tasks. There has been a lot going on in different areas a lot of teams at work- and Ratna jump in here if you would like- we will publish a guide by the end of the year. Any questions or clarification needed?””

Liz Reardon: “We’ve had many conversations with large hospitals. First it will be an app orchard, the preferred approach is Orchard, because of its simple adoption.”

Kevin Mullen: “Thanks Liz I’m curious if there was anyone with experience or if you heard interest in moving toward FHIR in terms of a two-to-three-year timeline, for any groups?

Dr. Mike Lee: “If it’s important we can look at it I suppose”

Debbie Adair: “What specifically?”

Kevin Mullen: “The use of FHIR for public health reporting.”

Debbie Adair: “We’re moving that way but I don’t know the timeline.”

Kevin Mullen: “One of our next steps is to talk with providers stakeholders and the Department of Public Health- to see how they are trying to align systems such as CDC modernization. There is more to come on that.”

Dr. Mike Lee: “I do think this is a rocky trip, talks about this so, we need to get going.”

Ben Linville-Engler: “We can also follow up on this, we work with MITRE they might be able to give us info across Mass.”

Kevin Mullen: “We will continue to explore, any other questions or comments?”

Debbie Adair: “It’s great thanks!”

Kevin Mullen: “Thanks Liz and Julie.”

## Conclusion: Undersecretary Lauren Peters

Undersecretary Peters: “Thanks team, that’s the end of the agenda – if there aren’t any questions I’ll move to adjourn. The next meeting will be November 7, 2022. It is hard to believe we are there. I hope to have updates on lots of work being done and provide updates on the BH referral work and treatment platform. If there are no other comments or questions I move to adjourn. Thanks all- “

Undersecretary Peters adjourned the HIT Council Meeting at 4:57 p.m.