

Meeting Minutes
Health Information Technology Council Meeting
December 7, 2015
3:30 – 5:00 P.M.

One Ashburton Place, 21st floor Conference Room
Boston, MA

HIT Council Members

Name	Organization	Attended
Alice Moore	<i>Undersecretary of Health and Human Services (Chair- Designee for Secretary Sudders)</i>	Y
Dan Tsai	<i>Assistant Secretary – Mass Health</i>	Y
Charlie Desourdy	<i>Acting Commonwealth Chief Information Officer</i>	Y
David Seltz	<i>Executive Director of Health Policy Commission</i>	Y
Aron Boros	<i>Executive Director of Massachusetts Center for Health Information and Analysis</i>	Y
Laurance Stuntz	<i>Director, Massachusetts eHealth Institute</i>	Y
Patricia Hopkins MD	<i>Rheumatology & Internal Medicine Doctor (Private Practice)</i>	Y
Meg Aranow	<i>Senior Research Director, The Advisory Board Company</i>	N
Deborah Adair	<i>Director of Health Information Services/Privacy Officer, Massachusetts General Hospital</i>	Y
John Halamka, MD	<i>Chief Information Officer, Beth Israel Deaconess Medical Center</i>	Y
Normand Deschene	<i>President and Chief Executive Officer , Lowell General Hospital</i>	Y
Jay Breines	<i>Executive Director, Holyoke Health Care Center</i>	N
Robert Driscoll	<i>Chief Operations Officer, Salter Healthcare</i>	N
Michael Lee, MD	<i>Director of Clinical Informatics, Atrius Health</i>	Y
Margie Sipe, RN	<i>Assistant Professor, MGHHP and Nursing Program Director at Brigham and Women's</i>	Y
Steven Fox	<i>Vice President, Network Management and Communications, Blue Cross Blue Shield MA</i>	Y
Larry Garber, MD	<i>Medical Director of Informatics, Reliant Medical Group</i>	Y
Karen Bell, MD	<i>Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED</i>	Y
Jessica Costantino	<i>Director of Advocacy, AARP Massachusetts</i>	N
Kristin Madison	<i>Professor of Law and Health Sciences, Northeastern School of Law, Bouve College of Health Sciences</i>	Y
Daniel Mumbauer	<i>President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA</i>	Y
TBD	<i>Secretary of Housing and Economic Development (or Designee)</i>	N

Guests

Name	Organization
Ed Barrett	Bay Cove Human Services
Brian Sandager	Circle Health
Lisa Fenichel	Consumer Advocate
David Bowditch	EOHHS
David Whitham	EOHHS
Gary Sing	EOHHS
Ipek Demirsoy	EOHHS
Jamal Diggs	EOHHS
Julie Creamer	EOHHS
Kathleen Snyder	EOHHS
Michael Chin	EOHHS
Nick Hieter	EOHHS
Ratna Dhavala	EOHHS
Stacy Piszcz	EOHHS
Iyah Romm	Health Policy Commission (HPC)
Jennifer Monahan	MAeHC
Jessica Hatch	MAeHC
Kelly Luchini	MAeHC
Mark Belanger	MAeHC
Micky Tripathi	MAeHC
David Bachand	NEQCA / Tufts Medical Center
Sarah Moore	Tufts Medical Center

Discussion Item 1: Welcome

The meeting was called to order by Alice Moore at 3:31 P.M.

Undersecretary Moore welcomed the Health Information Technology Council to the December meeting and noted that the agenda and slides were sent out in advance for review prior to the meeting.

Undersecretary Moore noted that the Council will be continuing our discussion about the Mass HIway and the way folks access the HIway for Direct messaging and beyond. She restated from the last meeting that we are actively engaged through Mass Health and Mass EOHHS IT in reviewing the Mass HIway strategic planning and that the Council provides a final report to the legislature on an annual basis. She stated that the strategic planning review of operations and consideration of the future of the HIway is a project that Secretary Sudders has asked those two entities within EOHHS to undertake and that it is within that framework that we started the discussion last month and why we also have several subgroups of this Council and the consent working subgroup looked specifically at consent.

Undersecretary Moore introduced David Whitham to give an update on Direct messaging.

Discussion Item 2: Direct Messaging

See slides 3-6 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Mr. Whitham provided a review of Direct messaging and the findings of the consent subgroup that had been put together earlier this year. He stated that direct messaging is defined by the Mass HIway as technical services that enables the private and secure transport of health information from one user or participant to another user or participant on the Mass HIway and that the HIway doesn't store any information that is transferred between those two users.

(Slide 5) Direct Messaging: Summary of November HIT Council Meeting – Mr. Whitham noted that in November we made the recommendation that came out of our consent workgroup that these transactions, these Direct messages between two participants, should be covered by HIPAA. He asked that the Council be very focused here as what we are talking about with Direct secure messaging is essentially a very similar, but more secure method than traditional analog ways of communicating information between providers such as fax or mail. He noted that, because these transactions travel over the HIway, Section 118i requires an additional consent requirement beyond what HIPAA would normally apply. Mr. Whitham restated the consent workgroup finding that this is keeping our providers and participants on the HIway from actually utilizing direct messaging, and they are remaining on fax, email or phone. He noted that these transactions are secure transactions, that by utilizing HIPAA rules as the basis for Direct messaging, it would align with all other consent requirements that are currently in the market, and that a change in the consent policy would increase adoption of the HIway across Massachusetts. Mr. Whitham noted that all consent requirements that supersede HIPAA such as HIV results, substance abuse, behavioral health, etc., would still apply to the HIway Direct messaging, just as they do with any electronic or non-electronic messages or exchange.

(Slide 6) *Direct Messaging: Recommendations* – Mr. Whitham went over the three recommendations that came out from the consent workgroup. He noted that we agree with and are working on pulling together how we will educate patients and providers going forward in the future. He then stated that the primary recommendation that came out was the removal of consent for Direct messaging and that the consent workgroup suggested that the Mass HIway should not have a consent requirement that goes beyond what HIPAA currently requires. Mr. Whitham asked to open up the conversation to be sure the information was presented faithfully, to ask if there are any questions from the HIT Council as to moving forward, and to request a resolution to move forward.

- Comment (Deborah Adair): I just want to be clear that when we say “removed the consent requirement for Direct messaging” and again, from some of the concerns we had around the law, does that go hand-in-hand with changing the language in the regulation? That’s fine, and I agree with that recommendation, but again, the language says “opt-in for HIway” so I want to make sure I understand.
- Response (David Whitham): This particular recommendation is separate from the larger [topic of consent for storing patient data on the HIway], so it would be a clarification of the language so that it would have that update for Direct messaging on the HIway as being covered by HIPAA.
- Comment (Alice Moore): Are you asking – does it require a regulatory change?
- Response (Deborah Adair): Yes.
- Response (David Whitham): Right now at EOHHS we are looking through what our options are for that change, whether it be sub-regulatory or actual change to the language.
- Comment (Deborah Adair): Just to be clear, I did bring this back to our group, and we would be fine with it if there was a regulatory change.
- Comment (Alice Moore): So, that is supportive of a regulatory change which would remove the requirement for Direct secure messaging, period.
- Comment (Larry Garber): In the wording that says “follows HIPAA,” it should really say “HIPAA and other applicable state and federal consent requirements.”
- Comment (Deb Adair): Working with this over the last several years, the opt in was to use the HIway, not for the disclosure. The patient’s participation in the HIway was completely separate from the disclosure rules of HIPAA- that is how we interpreted it and practiced it.
- Comment (Karen Bell): I am not sure if this is absolutely relevant because I am not a lawyer by any stretch of the imagination, but if you go back to Chapter 224 it defines health information exchange as clearly being sharing information among multiple different partners. A Direct message is very clear in that it is a transmission from one provider to another provider - it doesn’t really fall into the rubric of health information exchange. I do not know if that is relevant in terms of requiring a regulation change or not, but the way the intent and the wording was of Chapter 224 is that the exchange functions as a way of providing information from many, to many, not a one to one such as mail, fax or Direct.
- Comment (David Whitham): That is among the items we are discussing. Some of the language is extremely vague and that is where we really need to go back into those items and get a very clear opinion on them.

- Comment (Mike Lee): I think that the regulations predated the technology and I think people always assumed there would be a body of data at the state- but now we are not using a repository and we are stuck with the language. The only thing I would ask is do you have a sense of what the timing is on when you might have an opinion, or what the path is moving forward? For many of us, and certainly for Meaningful Use which requires the sending of messages, if we can't use the Hlway, for those of us who have a lot of community referral partners who are not signing up for the Hlway, its actually creating a disadvantage for community health organizations that is different from those that the hospital face.
- Question (Daniel Tsai): When you say community providers are not signing up, do you think that is because of the current consent barriers to Direct messaging or other pieces related to that.
 - Response (Mike Lee): I think there are several- one, who is going to bother if there is not clear value there - so only the large organizations sign up initially, we were already exchanging information; I didn't need help to exchange with BI or Partners in many ways, but we did that because we said this will actually be a system we can all use, as opposed to just the large healthcare organizations. If I refer out to all of these people, and they cannot accept these transactions and I cannot send it to them because the patients haven't opted in, then they are signing up for something that takes real work and there is still no value. I think that is what is driving everyone nuts, and most of the EHR vendors still cannot consume these transactions so even when they sign up they are still stuck. It is not as easy as people think to move info back and forth; but it is secure!
- Comment (Larry Garber): We have it set up so if I put in an order for an outside referral, I get the option of who I am sending to, so when I hit a button it automatically generates a Direct message to be sent over the Hlway to the recipient. It very clearly says that you must obtain consent before hitting the send button and doctors have told me they do not hit that button because they just don't want to deal with the time it takes to print out the consent form and get that information entered before sending. I find it very frustrating – I am in a group practice, we do not have a neurosurgeons as an example, if I want to refer a patient to a UMass neurologist normally I would dictate a letter and send it to them so they know the patient is coming. I could make a phone to call, I could fax the information, we have a secure email directly with UMass so I could send an email securely to them, I could even make a point to point interface. But if I want to use the Hlway I must get a separate consent, and the neurosurgeon can't send that information back to me unless they also get a signature. I do not think that is in the best interest of the patient, it is inconvenient for the patient, it is inconvenient for the provider, it's an obstacle.
- Comment (Normand Deschene): The obstacle is compounded for many physicians in the state that are in small practices. For one or two practitioner offices, that's a pretty heavy lift and there is a lot of care provided in those settings.
- Comment (Mike Lee): Meaningful Use was an incentive program that is now in its penalty phase from the federal government. For those that are not familiar, 2015 is really the first penalty that will appear in 2017 for those providers and 2016 is a full reporting year. For transitions of care, patients moving from one clinical setting to another, if they have more than 100 transitions of care, more than 10% of those must be sent using a certified EHR Direct message. Because the number of visits is

so much higher in a full calendar year the number of providers that will exceed that 100 threshold will increase dramatically. That really puts these small practices and ambulatory providers in the penalty phase in 2018 even though we are the most advanced in the world in terms of using electronic patient records, and one of the most advanced states in the country, it's just sad to see us in this position. That's why I am asking about timing – it's critical for some of us.

- Comment (John Halamka): Rightly or wrongly, the way Beth Israel Deaconess interpreted all of the historical regulation and sub regulatory guidance, was that as Karen said, Direct messaging was simply a secure fax. It did not require any new process, or procedure nor any consent different than what we had internally because we already had consent procedures in place, medical record releases etc. So we just followed whatever we had in place for the old way of sending information from place to place. When we talk about full blown HIE, many to many, and the state stores some data – that's a different problem. BID totally supports what we've said here. I will defer to the Partners legal counsel, but even sub-regulatory guidance to say - what we meant in this regulation was to cover HIE as written with 'many to many,' not Direct messaging - so don't worry you will not be in violation- you used secure mechanisms instead of faxing with your existing consent processes.
- Comment (Deborah Adair): I know that we've just agreed about that point and we've talked about that with our legal counsel as well, but just as a note when we started collecting consent for the long term. The consent they sign for the Hlway is the full blown phase 2 services because we don't want to go back.
- Comment (John Halamka): Yes, we did the exact same thing.
- Question (Patricia Hopkins): Is it the consent a documented piece within their medical record or is it really a separate silo of information?
 - Response (Deborah Adair): It is part of their administrative forms, it goes with all of the other admission paperwork, like their Notice of Privacy Practices. We also track it in the system using a check box so that providers can see whether it's been signed.
- Comment (David Whitham): I do want to address Mike's question and I will not be able to address it very well, but as to the time table, this is at the highest level of consideration and review right now. But I can assure you we are working on this very consistently and very diligently.
- Comment (Alice Moore): I think I am hearing consensus with respect to moving ahead with implementation of removing consent for Direct messaging. If that is the case I think it would be helpful to have a resolution of this group and then a vote on that resolution to support that.

A motion was made to move forward with the recommendation for removal of consent for Direct messaging by Normand Deschene. The motion was and seconded. All were in favor with one abstention.

- Comment (Deborah Adair): I still have just one last clarification question.
 - Response (Alice Moore): We are in the middle of a vote, do you want to restart it?
 - Response (Deborah Adair): I am sorry, I didn't understand and I did not vote, it's the same if the regulatory comment was part of that resolution?
- (Alice Moore): Yes, so let me read it back to you. The resolution currently reads:

The HIT Council voted to support the removal of consent for Direct messaging, and consideration of regulatory or legal changes that may be necessary thereto.

A vote on the resolution was restarted – all were in favor.

Discussion Item 3: Phase 2 HIway Services

See slides 7-13 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Ipek Demirsoy, Director of Payment and Care Delivery Innovation at MassHealth, provided an update on the Phase 2 initiatives

Ms. Demirsoy introduced the discussion of phase 2 Mass HIway services where, separate from the Phase 1 services, phase 2 services involve actual storing of patient demographic information. She noted that the phase 1 and phase 2 discussions are separate, that we are clearly in the early phases of discussions around phase 2 consent, and that the HIT Council will always review any steps that might be taken.

(Slide 8) *Phase 2 Services: Definitions* – Ms. Demirsoy started by defining phase 2 services as the relationship listing service (RLS), the medical record request service (MRR), and the newly contemplated event notification service (ENS). She noted that there is clear need among providers in the state for the ENS and that it is a service the HIway could take on, and that we are just in the conceptual phase right now for including this service in Phase 2. Ms. Demirsoy noted that the RLS is populated by participants that transmit patient demographic information and that, in that sense, this is very different from Phase 1. She explained that RLS allows other participants with an existing relationship to access this information, or to request those records from the other participant organization through a query and retrieve type of capability. Ms. Demirsoy also explained that the event notification, though still in early conceptual phase, is really related to transitions of care, admissions, discharges, transfers, scheduling and fulfilled appointments.

(Slide 9) *Phase 2 Services: Summary of November Hit Council meeting* – Ms. Demirsoy provided a quick summary of the last meeting since we ran out of time last meeting and did not get the opportunity for a robust discussion. She noted that the November meeting was the first time we introduced the topic to the Council and that we want to emphasize that no decisions have been made. She mentioned that, because this is Phase 2, and because it requires retention of patient demographic information, ENS will trigger different consent considerations [than phase 1 Direct Messaging]. Ms. Demirsoy stated that MassHealth had a small discussion around whether to even contemplate the potential storage of clinical data for ENS and that this group [the HIT Council] was very clear that clinical information should not be on the table. Ms. Demirsoy explained that the potential consideration is to have an ADT type registry which would store patient demographics and limited event information such as discharge date and time etc., but under no circumstances consider actual storage of clinical information. She noted that, as a Business Associate of all participants, HIPAA does allow the HIway to collect and store patient account information but that there is an opt-in consent requirement from Chapter 118i. She explained that what we are hearing from some participants in the marketplace is that this has been difficult to implement

and this is why we are having this discussion about whether we should contemplate potentially changing phase 2 consent. Ms. Demirsoy reminded the Council of the three models that were discussed last time: opt-in, federated opt-out where providers keep the function for managing the consent, and a centralized model where the state manages the consent preference for patients.

(Slide 10) *Phase 2 Services Discussion* – Ms. Demirsoy posed discussion questions on three topics: Impact of consent model on patient privacy, on scale, and on operationalization. She asked that the Council review some data (next 3 slides) and then open up the discussion.

(Slide 11) *Provider Organization Participation* – Ms. Demirsoy presented the graph showing the participation across different provider types over the HIway. She noted that we have larger hospitals, smaller hospitals, health centers as well as small ambulatory practices, that the shading shows whether they are actively using, connected, signed on or not participating, and that active use includes all use cases: it can be just public health reporting as well as provider to provider types of transactions. She pointed out that the use of the HIway is more prevalent around larger organizations than smaller and that smaller providers could be using a Health Information Services Provider (HISP) to connect.

(Slide 12) *Current Transactions over the HIway*- Ms. Demirsoy presented the active use graph noting the up ramp on public health reporting which accounts for a majority of transactions, versus some of the provider to provider transactions which remain small, only 5%, and that have been flat if you look across the year. She pointed out that one of the very clear impediments we are hearing is that, in the context of ACO, we are really trying to think about provider to provider interactions, and getting that number from 5% to a much higher number over time is needed for many organizations to succeed. Ms. Demirsoy asked that part of the discussion be on determining a reasonable adoption curve going forward on the current set of consent requirements versus potential changes.

(Slide 13) *HIway RLS: Unique Patients*- Ms. Demirsoy presented the graph on unique patients in the RLS from the four pilot sites that started in January of 2014, pointing out that this is relevant because these are some of the most advanced organizations in the state that wanted to take on RLS and are currently operating under an opt-in consent requirement. She noted that we currently we have 32,000 unique patients that have been added to the RLS, which is less than 1% of the state's population, that only one site is actively populating the RLS with patient information, and that all of them said they needed at least a year to refine processes. Ms. Demirsoy pointed out that even the most advanced organizations are struggling, so adoption is not as fast as we would expect.

Ms. Demirsoy then went back to the discussion slide and opened discussion.

- Question (Patricia Hopkins): Can you just walk us through the process for populating the RLS? Is it a separate logon, or is it seamless within their patient demographic system so that it will populate?
 - Response (Ipek Demirsoy): I would actually look to Dave and some of my more technical colleagues for this, I am not exactly familiar.
 - Response (David Whitham): Through the collection of ADT's.
 - Response (John Halamka): If I can describe an example. At BID we have a scheduling and registration system. As a patient schedules or registers we send a copy of that transaction to

- the state and that includes the consent flag that we are gathering from the patient portal where patients can turn on and off their consent preference. It is all automated.
- Response (David Whitham): It is an automated process that comes through the registration system so you only need a single contact with the health information exchange to be able to submit that information.
 - Question (Patricia Hunt): If I were seeing a patient in the community would I be able to look in the RLS?
 - Response (David Whitham): Yes, provided you are at another pilot site. And I'll ask Dave Bowditch to talk about this, but we actually have controls around who can see the information.
 - Response (David Bowditch): There is a two-step process for joining the RLS. The first, which is what the pilots have done, is to sign up and start to transmit records to the RLS database, so we start to collect that information. That information is coming from ADT messages from their systems. The second step is when an organization decides that there is a critical mass of data and they are interested in using, they can sign up to get credentials to either look at a portal, or to consume using a web service back into their own EHR to look at the data and use it to determine if there are other holders of records for their patients that have also provided consent. At this point none of the pilots have reached that stage yet. As you see on the graph we are just starting to collect the data. Once we get to the point where we have a number of organizations putting a bulk of their relationships into that database then we assume we will issue credentials and more people will start using.
 - Question (Patricia Hopkins): So these are admissions into hospital triggered events?
 - Response (David Bowditch): It is admissions, discharges and transfers.
 - Response (Patricia Hopkins): So it has nothing to do with community providers or outpatient? It is all based on inpatient data gathering?
 - Response (John Halamka): Our outpatient sites are registering as well.
 - Response (Mike Lee): They are not doing the event notification yet, I do not think that service is there.
 - Response (David Bowditch): If you've had an admission, discharge or transfer, then you have a relationship with patient and therefore you hold a record for them, so if the patient consents you are making the information that you have a record on them available to other people who hold their record.
 - Response (David Whitham): We actually have some significant slides on this from a previous meeting that we can send out.
 - Question (Mike Lee): I have two questions, one was around the Event Notification Service. It is not clear to me why that needs to be a repository at the state level. It seems to me that ENS should be phase 1 function because it is just sending a transaction from point A to point B. So if John's hospital admits my patient, and the patient identifies me, just as they would for a Direct message, that they want information sent to Dr. Lee at Atrius health, why wouldn't he just send that event notification like he does now? Why does the state have to store that and then create this issue of needing a Phase 2 service? It seems to me that this would be the simplest thing, to send as a straightforward

secure message, because many institutions do that now anyways. Making that a Phase 2 service makes us move backwards, not forward.

- Response (David Whitham): The way that I envision this is that it is as a subscription service. What you are describing is a point-to-point service that would need to be setup multiple times. Dr. Halamka may want to offer his information to a subscription service, so regardless of who you are in the state, provided you have the authenticated relationship with the RLS and to the patient, you can access that information. So if someone comes in from the Berkshires into Beth Israel, that relationship would not be preset as his is with you right now. So it would be more of a subscription service rather than a Phase one, a point-to-point service.
- Comment (John Halamka): Today if someone is in the ER we send you a message saying ‘hey they are in ER’ because that relationship is binary between you and me. But imagine if a patient has three specialists, a care team, a family member- you can imagine a constellation or team around them. But the orthopedist doesn’t really want to know, they saw the patient 10 years ago, but the cardiologist wants to know, the PCP wants to know and the care manager wants to know, so with an RLS ENS, as many people as want to can subscribe to such notifications.
- Question (Patricia Hopkins): So my mother was at BID Milton and none of this went on, then she went to South Shore and none of the information was there.
 - Response (John Halamka): None of those are part of the pilot.
- Comment (Patricia Hopkins): So these are narrow silos because I just walked through 4 hospitals and 3 days and none of the information was there.
 - Response (John Halamka): Right, the intent is that every acute care hospital and those giving outpatient care would participate and achieve a critical mass. I think that is why we are having a discussion today on consent, scale and the RLS. Today if the three of us, BID, Atrius and Mass General did it ,that’s great if you go from BID, to Atrius to Mass General, but nothing for Plymouth, South Shore and others yet.
- Comment (Karen Bell): I would like to just take us back and thank you for getting us into the depths of this discussion. We have been skirting this concept of ADTs for months now. We know that there are many other HIEs that find this valuable and make a strong business case for them. Also, I do not think you can really separate these things out. They all come together. The real key element here is defining the value of what ADTs and notifications will bring to us. Certainly for the ACOs, certainly for the patients, there are many other stakeholders that would find value. Once we are clear about that, and we all agree there is value, we need to look at how to articulate that value and then we can go back and really look at which models are going to work best in this state. There are other states where every single patient that’s admitted to a hospital or ER has to designate to whom their ADT information should be sent. There are many different ways that this can happen, but the reality of it is that this is happening in a lot of states and most states are finding that it is a very strong business model for their HIE and it brings providers to the HIE because in order to get that information which is critical to patient care you have to join the HIE. In addition to having easier access for Direct secure messaging, having access to this is a strong driver of HIE adoption.

- Response (Daniel Tsai): I'll speak from the standpoint of MassHealth as a payer participating on the HIT Council. As many of you know we are actively, in a very public process, designing and preparing for the role out of ACO models across as much of our business as possible as a population health construct. One of the things that has been very clear in our stakeholder design meetings, and in our individual meetings with providers, the question that is coming up time and time again is - how are you going to help us as providers with the infrastructure and capabilities to do that? And that results in a direct statement of cost. We are going to be shortly announcing some infrastructure and capacity building grants that we offer each year. One of the domains for that, one of the rewards for that, is to build some of these connections where we are spending state money doing that because there is not that scale of capability. Or when we tell our providers to take population accountability they are saying they cannot communicate – how are you going to help us. I think at least in our stakeholder discussions, from a MassHealth standpoint, I hear that need particularly acutely for smaller providers and I think the data charts indicate that. Both Community Health Centers that are thinking about population health management, and some Community Hospitals we talk to, and others, are saying that it is a little more difficult for us to have the resources to do a good job, and where John and others have figured it out already. So are you as the state going to help us in some way either by providing it through something like the HIway at scale, or funding us to build that? Those are the two choices we need to make. And for us as a payer, the direction that the HIway takes, whether it will become a scalable public utility? That is one direction we can go in. If it's clear that we are not going to be able to get more than 2% of the patient population, we can't credibly say for our provider population that's a workable option -we need to think about some alternatives.
- Comment (Larry Garber): To help make the decision, I think what Karen is saying is identifying the value. Reliant Medical Group is a multispecialty ambulatory group practice and we have Directly connected with St. Vincent Hospital and Milford Regional Medical Center. Today we subscribe to their ADTs which is equivalent to what RLS and event notifications would do. We do an end run around the state so that we do not have to deal with Chapter 118i. They send us ADTs [not via Mass HIway] regulated by HIPAA and whatever state and federal regulations they are required to follow. What is most important is not just that the patient is in the Emergency Room, but what we do is within 90 seconds of registering in the emergency room we are sending back a summary document on the patient. So in the Emergency Department, before the attending actually even sees the patient, for all of our patients from Milford and St. Vincent, they get the med list, allergy list, problem list, recent tests, immunizations etc. It's all there so that they can give better care to my patients and that is the beauty and power of the event notification service and what we can do because of that. I really think we need to think of these ADTs as a release of information, and I think we have to think of it as clinical information which in most cases is appropriate without requiring specific consents. But there are certain organizations, such as AdCare Hospital, a substance abuse hospital in central Mass, that have to get a specific separate consent when they send an ADT. But I

think when someone releases a Reliant Medical Group ADT it is covered by HIPAA and shouldn't need a specific consent and I shouldn't have to do it around the HIway in order to get the clinical documentation.

- Question (Patricia Hopkins): So, why even build this if we can already do an ADT then?
 - Response (Larry Garber): The beauty of the Record Locator Service is that right now I am playing the Record Locator Service in my region, I know who the primary care is, I know which ER they went to, I know the care manager and I am doing that, but we shouldn't each have to building these one off separate record locators. It could be a valuable statewide utility and I think Chapter 118i is an unnecessary obstacle to that.
- Comment (Mike Lee): For community based providers we cannot even begin to have this type of capability. We need someone like the Commonwealth to be at the table, otherwise we are never going to be integrated into the healthcare community quite frankly.
- Question (Patricia Hopkins): So going back to what you were saying about as a payer, what tools are you going to give physicians in the community? And people say 'do population management' -that's a very broad statement. Most every practice I've gone to, and I've interviewed all of the practices in the South Shore, they don't even know how to get in touch with their patients, they have no expanded connection, certainly not on a continuum, but not in a way that they can securely connect with their patients for identification notification, public health issues, strategic changes in monitoring their healthcare, that is an enormous tasks for a number of groups, I do not know what the number is, but we all take care of MassHealth patients.
 - Response (Daniel Tsai): The question of what is population management is much broader discussion. One of the goals we have is being able to break down some of the silos we have with care delivery between providers that are not formally part of the same organization but caring for the same members. In particular for the MassHealth population, we have a significant need, more so than the commercial Medicare population, for a bridge between community based providers. Places like behavioral health and long term care services, all of whom are touching our members in different ways, have very little interaction with each other. We are trying to get to them so that there is at least a discussion of how we think of care management, who is the care coordinator and how does that span across different settings of care. That is a great discussion to have, but right now we cannot even talk to one another. A community Health Center will say to us, we have good relationships with hospitals around us, but when our patient shows up at the ED, we do not find out about it sometimes until two days later. That is not conducive and not a great way to have the alerts setup. So those are the things we are getting to. If the HIway was getting to a point of enough scale and it had something like this ADT functionality, we can start to put the expectation on providers around the integration of care across different types of providers and there is a real credible way to do it.
- Comment (Mike Lee): I think that is why I am concerned about having an event notification service (ENS) as a Phase 2 service. Even if we have sub regulatory guidance or a regulatory change that gives

us the removal of opt in consent for sending Direct secure messaging, I think about the work process for getting active consent across the commonwealth. We have one hundred thousand plus of them now, I am not sure technically why the state has not been able to collect all of those ADTs, but a lot of work has been done with Atrius and the state to get those ADTs correctly. But still that's only 15% of our population for a year's worth of work so trying to figure how to get beyond that to make something scalable in the near future is a challenge. I wonder if there is a way to do ENS as point to point for at least primary care providers who are the ones who are most invested in population healthcare. Then we can build an event notification service as we build Phase 2 consent and the value that way so you can see more of that entire value. Otherwise we are all left with these point to point things that only the larger organizations can do and it leaves out the entire community of healthcare. I just don't think we are going to be able to do that rapidly without moving the ENS service at least for point to point messages. So if a patient identifies a PCP, at a major event (ER or hospital admission), and we send that event notification message across the HIway securely, I do not think that requires an additional consent as long as we have that sub regulatory work. It would be added value for people trying to do population-based contracting. I think waiting for that in Phase 2 is a problem because I just don't think that is scalable in the next 12 months. If we really want to get this consent model going for larger scales, you are still out two or three years to get to scale and then you have to figure out what to build.

- Comment (Normand Deschene): I agree and I think that by adding scale it creates more value and hopefully to reach the tipping point where we will be able to acknowledge the value, but I think as it currently stands the current opt-in model is a major impediment to involvement.
- Comment (Larry Garber): I just wanted to say that even if we agree, and the state agrees that we can do more of an opt-out model, that doesn't mean that particular organizations could, since they are the ones sending the ADTs and holding information they could choose to be more conservative than that.
- Comment (Ipek Demirsoy): I guess I'll pose a question- I think ADT is, again, step one, but in Phase 2 services there can be a lot of other value added functionality that can be performed over the HIway. I think it is a brilliant idea to think about these ADTs and explore whether that can be done under Phase 1, but if we do want to eventually have the HIway support other types of value add services that might be under Phase 2, which does require information being stored. Can we have a bit of a discussion around what that means, getting to scale with the current consent model? We can potentially get away with this for ADTs, but again if you think five years out, ten years out, how do we really see the value-add services of the consent model? I think it is worth having a discussion around that.
- Question (Patricia Hopkins): Well one thing to look at is why these are flat in this chart, why is the use staying flat here and the public health so high, because that's the value. No doctor has a second left in the day to add another login. We need to develop seamless flow of information between the varied systems so that if a system comes onboard it comes on all at once. The breakdown, and I am living it right now with elderly parents and in-laws every single day, is that the system is completely unconnected because the needs get shifted around, and nobody is connected with the other person; we are still using the phone or we're texting. You are going to have this scale up, like Aaron

said, the minute you begin to have it so that it is not a burden on the provider. I am talking as a provider on the ground. We see over 200 people a week. Getting back to identifying a primary care provider, many say they do not need one and therefore they do not identify one, like the PPO model.

- Response (Daniel Tsai): What you just mentioned is a complaint I have heard from a whole bunch of different providers around this topic, and it usually comes back to – if it’s at the individual clinician level it comes back to the opt-out, it is the provider organization where there is an operational component. That does take a lot of time to do that for every single individual and for a provider to track that and manage that for five different specialists at different organizations gets quite complex. That is a very consistent reason; that it is a lot of work and there are a lot of members on it, but not actively using it. It is a lot of effort to put in, and not get much out of it.
- Comment (David Whitham): My hypothesis to as to this graph, is that the public health reporting is a mandate.
 - o Response (Patricia Hopkins): Right, exactly you’ve got to do it to stay in practice and if you don’t have to you take it off your plate.
 - o Response (David Whitham): This is also excluded from the current consent; sorry, it is excluded from 118i.
- Question (Steven Fox): When you said to think beyond ADTs, what are some things you think about? When you are planning or thinking about this 5-10 years out, what are the things that would be on that list of future value added services?
 - o Response (Ipek Demirsoy): I think if there is a way to link some of the RLS data, ED data, things like the prescription monitoring service, opioid program, community established better linkages, a better linkage between the more physical health providers and for example ASAPs, and elder services information system is very robust, but the system is not well connected. Those are just examples.
 - o Response (David Whitham): I’ll actually bring it more current, we are having discussions with the MA Hospital Association around their EDIE, Emergency Department Information Exchange, project and seeing where that synchronizes with the HIway and what I would say is a potential opportunity would be that vendor could exist as a node on the HIway. What we would want to do is provide the infrastructure and allow that vendor to participate in the HIway and participate in the Commonwealth. Not only do we have potential services that MassHealth and the state may develop, but we also have vendors that may be willing to, or want to participate in the HIway.
- Comment (John Halamka): If we look at that graph, as you might guess it is multi factorial and complex; influenced by a number complex issues. If, for example, I say to Patricia ‘you will not get paid until you send a summary to the next provider of care’; it could be at the PCP, or it could be a care manager. Ah, well suddenly the graph could take a big curve upwards. Or if we said your workflow in your EHR was such that it is ‘auto-magic,’ you registered the patient, it recognized who the patient’s PCP was and then automatically finds the address of the PCP and just as soon as you signed the note it went out; then the curve would go up. So, I think our answer here is that there are a lot of things that can be done to increase adoption, mostly

around workflow and value proposition. Our challenge is that EHRs today are mostly not designed to fully integrate workflow, as has been said, so that every time I see a patient the data about that patient is just shown to me. Hence we are dealing with a lot of workarounds, secondary logins, and portals, and physicians must be educated to do things at different times. A lot of that is BID data because we mandated, as part of our ACO, that each organization must send us 150 data elements at every transition of care; if you don't send it to us, we don't contract. Then we work with each of those practices and vendors to make it 'auto-magical.' This policy discussion we are having today is certainly a very important one.

- Comment (Larry Garber): I think we are getting into the notion of this RLS being more than a one way pipe; actually sending information back out, querying where relationships are and actually sending events through a similar process. I think it is important that we do clarify what we mean. I'd like to see opt-out, as opposed to not allowing opt out at all. I think it is important for us to enable opt-out. There is probably 5% of the population that really does want, and should have the right to control their information. I would love to see a granular opt-out to the point that they could opt out for particular types of organizations, for example staff wanting to opt out at their place of work. I think we have the technology needed to support that. I also think it must be easy for patients to opt-out; I do not think having a centralized state call center to opt-out is the only mechanism. I think we should do that at each provider office where we help facilitate the opt out information, even in person. We need to make a concerted effort, especially if we are switching, to explain this is how information moves, here is the benefit, but also here is how to opt out.
- Comment (Mike Lee): Around the education piece, I do not mean to be flip about this, but at Mass General when those patients sign the consent forms, how much of that do they really understand? Do they know what they are signing up for? As we think about Phase 2 we are actually asking someone to consent to something that may or may not happen in the future. I look at Dr. Halamka and Dr. Garber, not to dismiss anyone else, but these are two of the most intelligent physicians who understand this stuff more than anybody and it is really hard to get a solid explanation of exactly what is going to happen, and what should happen. How are we going to deliver this fairly to the public and actually get consent in a meaningful way which seems near impossible due to the complexity of the work. Some will sign it, and others will not understand it. One of the tricks with opt out, which Larry just recommended, is that if they turn it on and then tell people they can opt out, there is a period of time where people are all in and patients have to race before they are seen to opt out before they get caught in.
- Comment (Alice Moore): I just want to clarify that all of the legal provisions that apply federally and statewide will still apply unless there are some legislative changes.
 - Response (Mike Lee): Totally understand that, I am talking here about the mechanism.
- Comment (Daniel Tsai): John, I think you made a great point about the range of different policy levers beyond just consent. I would say that for at least a good portion of MassHealth providers, what I hear is - let's say if we said you cannot get paid unless you figure out the consent thing, a bunch of them will just turn around and say- well no, we do not have the capacity to be able to do that- so we are left with how to facilitate that. The question for the group is, that unless

there is some sort of change in the consent approach, all the right patient protections, legal, statutory all of that stuff, that the most realistic version of where the HIway will get to is maybe a slight trend up. So it becomes basically a fork in the road that either we decide to do something about the consent piece, with all of the patient education and resources needed with a feasible option and scalable plan, that's where we can figure out all of that statutory and legal stuff. If we do not go down that path this is the most likely view, it is almost like we should make sure we are doing things that are operationally related to public health reporting. We are spending a lot of time thinking about these things and would rather spend time on other things if it is not going to be a viable option. That's at least my impression. I've heard very strongly from MassHealth providers and I would be curious to hear from the rest of the council that folks share that this is not the answer on 'do you want to change it or not' its whether folks agree that this is a fork in the road and it's time to make a decision on it.

- Comment (Deborah Adair): Since the last meeting I did bring this back to our operating committee at Partners and we did talk about it and just to say a couple of things – we could support the opt out- given the regulatory considerations, the educational piece that we talked about here and then the one other thing we have concerns about and we put into place a lot of technical and operational work into -is the sensitive information, the substance abuse and HIV. As I'm sitting in meetings and presentations, it seems as though there are a number of different practices or interpretations of how that is being done. So whether the management of an opt-out is managed at the state level, or site level or a combination, I think it's really important to be succinct on how we apply these processes. Right now we are not sending any CCDs for those patients, which is not fair and defeats some of the purpose of why we are doing this exchange. We want to share that information, but consent is still a huge piece; I would like to see that worked on as well.
- Comment (Aaron Boros): I just wanted to say that I totally agree with the fork in the road especially based on the conversations I have had with staff, providers, insurers, and in looking at some of the HPC information on other states. You can make it work- Rhode Island has a different consent model- but I think where we are today we need to expand the opt-out model to remove those curves. I would go slightly further to say that there's something else that the most successful HIEs have, and I think we'd be well to look at this in other states, is the governance model. Today, as I understand it, this is run out of the Executive Office of Health and Human Services IT Division, and then we have this body- but I've sat on this body for three years and I think the number of times I've seen a budgets come across this body is maybe once in three years or something like that, so we are really not a governance body. I think there is a really important conversation for maybe the next one on how is the HIE governed – and I mean not just decisions, investments, strategic planning, and which use cases we are going after first. I think the administration has done a nice job starting that conversation in a way that hadn't started a year ago, and I really commend the administration for getting that conversation going, but I think there has to be change with how this is governed in order to move upwards over the coming years.

- Comment (Normand Deschene): Similar to what Aron said, if we look back at the graph at the participation from hospitals small and large, that bottom tier of all those ambulatory sites, there are over 5,000 ambulatory sites not participating. They need a voice at the table, because clearly the message is not resonating with that group or there are major impediments and it's difficult to interpret that when we sit here, and many of us represent large monolithic systems where the organization bears a lot of the costs.
- Comment (Aaron Boros): I think that can happen at the board level. Laura Adams, who is the President of the Rhode Island Health Quality Institute, sits on my Council and part of her job is to go check with all of those people, affirmatively go out talk to them, and then to be the face of the HIE, to build those relationships and identify opportunities. Today that happens with a number of different people at the state. There is no single person strategically doing that at the state.
- Comment (David Seltz): Since the Assistant Secretary was looking at me while asking this question, I will affirm from Health Policy Commission standpoint around conversations with providers of varying sizes and sophistication in this area, I think the value of ENS and being able to have more real time information about where patients are and where they are receiving care is a real important piece of infrastructure for population health management. I think we have heard also, and I am not a lawyer so I will step aside from the legality and what it will take to move from opt-in to opt-out, but it appears to have both the value of reducing the administrative burden for the people participating in the system, while increasing the value of that system because you will have more people in. It touches both sides of the value statement as far as thinking about getting more people involved here. I would just add that the Assistant Secretary and our organization are both making investments into the healthcare system, and when we think about those investments, I'd like to make those investments in ways that are going to be connecting to and supporting the sustainability of the HIway. I would rather not make investments that are sidestepping the state infrastructure. The sooner we can think about this, I think it will help us align investments across the commonwealth to better support those providers.
- Comment (Daniel Tsai): From a funding efficiency standpoint, for a health information exchange to work, there is a very attractive federal match rate, a 90% match, versus anything else we want to do if we are trying to create capability as individual payers, whether on the private sector side, or it's a governmental agency, it is a very different set of dollars that are available with different constraints- I think that is another thing for us to keep in mind.
- Question (Patricia Hopkins): Do you have a community EHR for health centers?
 - Response (Daniel Tsai): No.
 - Response (Patricia Hopkins): So to go to your point, how you are going to scale the 10 and under system, the level of which they know nothing that is happening around them is incredible, because it is done for them, it's just there. They cannot even think about putting paper on a table then using a pencil. In terms of scale, we need to put it in the hands of what they have already invested in and put the responsibility on the vendors to

facilitate. The state should say we are not going to let you be an EHR system we approve unless you come to the state and make those processes happen. Community health centers are in the same situation with all of the disparate physicians sitting out in the community with different vendors. This is the only answer, so really the 5,206 probably needed more than any other organization.

- Comment (Karen Bell): Very briefly getting back to Rhode Island for a moment, they do have the ADTs, they do have opt-in and they've also done very nice thing where the doctors who have signed up and are receiving ADT notifications actually have patients with a statistically significant readmission rate. So that fits in with many of the other funding opportunities in Rhode Island. The point I wanted to make is that here we are in Massachusetts, one of the six states that received a big original SIM grant years ago, and we have many other grants coming in, but in many ways it feels like our HIE is sitting out there alone; it's not automatically baked in, it is part and parcel of some of the others things we are doing. I would just point out one thing to spend a little more time on here, how does what we do here relate to all of the other efforts here around healthcare reform.
 - Response (Daniel Tsai): I should also mention, and Ipek is leading most of this process, in our payment reform ACO development work for MassHealth, the SIM grant is a stabilization model and testing grant that we received from the federal government – it will be a large part of how we are thinking about this. Precisely because of the extent to which we want to help move our healthcare delivery system forward, all of these questions that require infrastructure and support for providers are coming up. As I mentioned before, this will be a strategic thing - either here is a path with reasonable timeline that is credible, or we will have to consider other strategies. The funding leverage thing is important- anything we do here I think has the benefit of public utility, especially for those smaller providers. It also comes at a significant federal match versus other funding sources we would be taking away from.
- Comment (Mike Lee): I mentioned this briefly last time – insurance companies are very interested in the clinical processes. When you have conversations around HIE this comes up as the first thing. Self-funded employer health plans. Relatively rare that information is going from Larry to Mike and most patients think this is happening already. We should have more open discussion around all participants as part of the governance and be very transparent. I answer all of the patient questions that our staff cannot answer and so far insurance companies having access to data is the main concern.
- Comment (Daniel Mumbauer): For the behavioral health population we would prefer to manage consent on our side versus having to call a 1-800 state number to manage it - otherwise the comfort level for some of our folks may be a bit skittish. I think it's important to try to bring as Behavioral Health providers that are clients into the mainstream systems.

Discussion Item 4: Conclusion

Alice Moore provided closing remarks before adjourning the meeting

Undersecretary Moore stated that we are at a fork in the road with the Mass HIway and that this has been an effort to really connect the HIT Council with MassHealth, EOHHS IT and others to understand what the priorities should be, what the challenges are, and design a path for the future.

The HIT Council meeting was adjourned at 4:58 pm.