**Meeting Minutes**

**Health Information Technology Council**

**November 2, 2020**

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 |
| **John Addonizio** | *Chief Executive Officer, Addonizio & Company* | Y |
| **Damon Cox** | *Assistant Secretary for Technology, Innovation, and Entrepreneurship (Designee for Secretary Mike Kennealy)* | Y |
| **Frank Gervasio** | *Project Manager, Executive Office of Administration and Finance* | N |
| **Diane Gould** | *President and Chief Executive Officer, Advocates Inc.* | Y |
| **Vivian Haime** | *Manager of Care Delivery Transformation and Strategic Partnerships, Health Policy Commission* | N |
| **John Halamka, MD** | *President, Mayo Clinic Platform* | N |
| **Sean Kay** | *Global Accounts District Manager, EMC Corporation* | N |
| **Dicken S. C. Ko, MD** | *Chief Medical Officer/Vice President of Medical Affairs, St. Elizabeth’s Medical Center, Steward Health Care* | N |
| **Michael Lee, MD** | *Medical Director, Boston Children’s Hospital*  | Y |
| **Manuel Lopes** | *Chief Executive Officer, East Boston Neighborhood Health Center* | N |
| **Linda McGoldrick** | *President and CEO, Zillion* | N |
| **Michael Miltenberger** | *Vice President Healthcare Team, Advent International* | Y |
| **Nancy Mizzoni, NP** | *Professor and Nurse Practitioner, Middlesex Community College* | Y |
| **Naomi Prendergast** | *President and Chief Executive Officer, D’Youville Life and Wellness Community* | Y |
| **Monica Sawhney** | *Chief of Staff, MassHealth (Designee for Assistant Secretary Daniel Tsai)* | Y |
| **Emma Schlitzer** | *Manager, External Affairs, CHIA (represented by Lisa Ahlgren)* | Y |
| **Laurance Stuntz** | *Director, Massachusetts eHealth Institute* | Y |
| **Pramila Yadav, MD** | *Private Practice Obstetrics & Gynecology, Beth Israel Deaconess Medical Center* | Y |

**HIT Council Members**

Note: The above list provides the HIT Council Members at the time of the November 2, 2020 meeting.

## 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 November 2, 2020 meeting.

Undersecretary Peters called for a motion to approve the minutes of the August 3, 2020 HIT Council meeting. The minutes were approved.

## Discussion Item 2: HIway Connection Requirement and 2020 Attestation

*See slides 5-11 of the presentation. The following are explanations from the presenter, with additional comments, questions, and discussion among the Council Members.*

Undersecretary Peters introduced the connection requirement section and added that EOHHS will be extending the ENS/ADT requirement to April 1, 2021. The announcement of this extension date will be coming soon.

Deb Adair commented that there are federal requirements that need to be met by states, and asked if it is possible for the state to align their ENS requirements with the federal requirements. Undersecretary Peters asked if this discussion could continue offline so that she could revisit the federal requirements before providing a response. Adair replied that the federal requirements are more detailed than the state’s, so it would make sense to adopt the federal ones. Undersecretary Peters said that they will take that back and do a cross walk to understand if there are any areas of misalignment between the two.

David Whitham added that the assumption is that by fulfilling one requirement, you fulfill both, and that the state requirement is not additive.

Chris Stuck-Girard then presented an update on the 2020 HIway connection requirement and attestation, showing where the HIway is in the attestation cycle and highlighting last year’s attestation numbers.

Lawrance Stuntz asked whether exception forms indicated that an organization was not meeting the requirement as well as the reason for not meeting the requirement. Stuck-Girard clarified that that was the case and one of the most prevalent reasons for not meeting the requirement is a provider organization implementing a new EHR system. In some cases, organizations need assistance meeting the requirements in which case the HIway can connect them with Account Managers to help them get back on track.

## Discussion Item 3: Consolidated Clinical Gateway Update

*See slides 12-14 of the presentation. The following are explanations from the presenter, with additional comments, questions, and discussion among the Council Members.*

David Whitham presented an update on the Clinical Gateway, and moving the seven Clinical Gateway nodes from private hosting to Amazon Web Services, which will allow the HIway to control costs and allow scalability.

There were no questions during this discussion item.

**Discussion Item 4: Query HIE and FHIR Update**

*See slides 15-24 of the presentation. The following are explanations from the presenters, and comments, questions, and discussion among the Council Members that supplement the content on the slides.*

Undersecretary Peters asked members to think about use cases while these slides were discussed, and introduced Kevin Mullen and Julie Creamer. Mullen and Creamer presented on Query HIE and provided an update.

Mike Lee commented that they are using CommonWell as a Cerner enterprise and connecting to Carequality. From his experience, it does work, they’ve used it many times, but it is much harder from the CommonWell side to access the information and that it is more work for the CareQuality folks to know what to expect. He explained it was bit clunky and more effort than he thought to get the whole

thing up and running. He emphasized it does work however. He doesn’t believe it will be avidly used until they improve the workflow. Mullen agreed that he had heard similar feedback and that they have come to understand that depending on the EHR system there is a varying degree of integration capability.

David Whitham asked if Lee would be willing to follow up offline to talk about what “clunky” means. Lee replied that sometimes to request these documents takes a number of steps, and then once they are received they are “foldered” in a way that you could open them and have no content, so it can be frustrating from an end-user point of view. Lee added that the structure can be confusing, and having to grab a whole bunch of information and then sort through it can be challenging for providers. He reiterated that it does work, however, and it will improve many things.

Laurance Stuntz commented that it is encouraging that almost 90% of providers are using an EHR that could enable query HIE. There’s still some work to be done, but if 90% of providers can already do something, then it’s perhaps time to start pushing and encouraging this as a core piece of what is done at the HIway.

David Whitham agreed that it shows that there’s a lot of “market momentum” here, and a lot of opportunity. The potential is really encouraging.

Mullen said that for some of the smaller vendors it may be cost prohibitive or there may be technical barriers to integrating with CommonWell or Carequality. One solution may be to look at data integrators. He stressed that there are options out there for those 10% vendors that are not yet connected.

Creamer presented on next steps to promote Query HIE, including educational webinars and targeted outreach beginning in 2021. The focus will be on providers and other administrators and clinical staff, though there could be some need to educate or inform some of the technology professionals as well. There were no questions on next steps.

Mullen then shifted to a FHIR API update, including the results of an HIE survey scan, examples of a use case, and Mass HIway initiatives.

Stuntz said that he was interested in a process to evaluate what they do next: what’s first on the list, next on the list, and the reason for that priority. He would be interested in thinking through with the Council or with a workgroup how to prioritize the steps. Bert Ng commented that that was the goal of all of this, and as the FHIR research continues, they will get closer to setting the FHIR priorities and deciding where it should go. He added that the principal goal of the HIT Council is to get some of the technical expertise in before getting to the business discussion around HIT.

Lee commented that one of the things they’re exploring is bulk FHIR exports, which could help a lot with quality reporting, and may be a beneficial HIway service. He doesn’t understand the technology side enough to identify what role the HIway would play but it would make sense from the gateway architecture. Adair said she would want to hear some of the use cases Lee was thinking about. Mullen echoed the need to identify use cases first, and adding to Lee’s comment, identified bulk data access as an emerging FHIR requirement but noted that regulations are focused on the EHRs who are the regulated entities. The challenge with the HIway is that there is nothing in the middle; with the exception of the provider directory and Clinical Gateway Nodes, so there’s nothing for the HIway to expose. He stated it’s more about providing services that help the exchange and the traffic which is where the biggest opportunities lie. Mullen agreed with Adair that identifying use cases is the next step and it’s important to dig a little deeper with stakeholders to identify where the interest is and where the use cases are and how those use cases translate to some of the technical requirements of the HIway.

Whitham told Lee to reach out to him for a brief call to brainstorm and reiterated that that is the kind of engagement they’re looking for. There’s a lot of opportunity here. Undersecretary Peters clarified that not all these use cases have to be leveraged for using the HIway infrastructure. The HIway’s role could be in facilitating; similar to its approach to ENS. Lee agreed to connect later to discuss more.

**Discussion Item 5: eMOLST Initiative**

*See slides 25-28 of the presentation. The following are explanations from the presenters, and comments, questions, and discussion among the Council Members that supplement the content on the slides.*

Undersecretary Peters introduced this section, explaining that there have been changes from eMOLST to ePOLST, which aligns with the federal initiative.

Bert Ng presented on the eMOLST initiative.

Adair commented that this initiative is valuable and wishes the council could do it sooner than the current timeline.

Stuntz brought up the Blue Cross Blue Shield foundation/Coalition for Serious Illness Care pilot program and added that it would be good to get a “lessons learned” overview from that program to be considered by the HIway. Stuntz asked if is this going to be a HIway service contract with a vendor. Ng said yes, due to the need to have a more centralized data source. A sponsored service may have fewer hurdles verses the alternative as far as getting information.

Diane Gould commented on people who can be left out of programs like this: behavioral health patients and the disabled population. Gould asked that EOHHS please include these communities. Ng replied that that was a good idea and asked Gould to reach out to them. Gould said she would do so.

Undersecretary Peters said that they will keep everyone updated along the way as the initiative rolls out and would love to receive feedback, so if anyone thinks of anything they want to share or additional questions, please reach out.

## Conclusion

The next meeting of the HIT Council is scheduled for **February 1, 2021**.

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