**Meeting Minutes**

**Health Information Technology Council**

**August 5, 2019**

3:30 – 5 p.m.

**One Ashburton Place  
Boston, MA 02108**

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| Name | Organization | Attended |
| **Lauren Peters,**  **Chair** | *Undersecretary for Health Policy, Executive Office of Health and Human Services*  *(Chair – Designee for Secretary Sudders)* | Y |
| **Daniel Tsai\*** | *Assistant Secretary, Mass Health* | Y |
| **Kelly Hall** | *Senior Director of Care Transformation and Innovation,  Health Policy Commission* (Designee for Executive Director Seltz) | Y |
| **Deborah Adair** | *Director of Health Information Services/Privacy Officer,  Massachusetts General Hospital* | Y |
| **John Addonizio** | *Chief Executive Officer, Addonizio & Company* | Y |
| **John Halamka, MD** | *Chief Information Officer, Beth Israel Deaconess Medical Center* | N |
| **Juan Lopera** | *Vice President of Business Diversity, Tufts Health Plan* | Y |
| **Linda McGoldrick** | *CEO and President, Financial Health Associates International* | Y |
| **Laurance Stuntz** | *Director, Massachusetts eHealth Institute* | Y |
| **Manuel Lopes** | *Chief Executive Officer, East Boston Neighborhood Health Center* | N |
| **Michael Lee, MD** | *Medical Director, Children’s Hospital Integrated Care Organization* | Y |
| **Pramila R. Yadav, MD** | *Private Practice Obstetrics & Gynecology,  Beth Israel Deaconess Medical Center* | Y |
| **Sean Kay** | *Global Accounts District Manager, EMC Corporation* | N |
| **Ray Campbell\*\*** | *Executive Director, Massachusetts Center for Health Information  and Analysis* | Y |
| **Frank Gervasio** | *Project Manager, Executive Office of Administration and Finance*  (Designee for Secretary Heffernan) | Y |
| **Naomi Prendergast** | *President & Chief Executive Officer, D’Youville Life and Wellness* | N |
| **Damon Cox** | *Assistant Secretary for Technology, Innovation, and Entrepreneurship, Executive Office of Housing and Economic Development*  (Designee for Secretary Kennealy) | N |
| **Michael Miltenberger** | *Vice President Healthcare Team, Advent International* | N |
| **Nancy Mizzoni, RN** | *Practicing Nurse and Clinical Instructor, Northeastern University* | Y |
| **Dicken S. C. Ko, MD** | *Chief Medical Officer / Vice President of Medical Affairs, St. Elizabeth’s Medical Center, Steward Healthcare* | N |
| **Diane Gould** | *President and Chief Executive Officer, Advocates, Inc.* | Y |

**HIT Council Members**

Note: The above list provides the HIT Council Members at the time of the August 5, 2019 meeting.

\*Monica Sawhney attended on behalf of Daniel Tsai for Mass Health

\*\*Emma Schlitzer attended on behalf of Ray Campbell for Massachusetts Center for Health Information and Analysis

## Discussion Item 1: Welcome

Undersecretary Lauren Peters called the meeting to order at 3:37 p.m. The Undersecretary welcomed the Health Information Technology Council to the August 5, 2019 meeting.

The May 6th HIT Council meeting minutes were approved.

Peters shared an update regarding the Digital Health Advisory Council. The group is composed of individuals from the public and private sectors who provided recommendations to the Governor. The council recently established a collaborative sandbox, developed a proposal to establish the Distributed Data Network to provide patient access to healthcare data, and more.

Laurance Stuntz elaborated that the sandbox was recently expanded, and more information regarding the initiative can be found at [www.massdigitalhealth.org](http://www.massdigitalhealth.org). The website makes core resources available to the public, including job postings for ~1,700 jobs across 350 companies that are updated in real-time.

Kathleen Snyder of the legal team is departing EOHHS.

## Discussion Item 2: Connection requirement/attestation update

*See slides 5-12 of the presentation. The following are explanations from the presenter, and comments, questions, and discussion among the Council Members that supplement the content on the slides.*

Chris Stuck-Girard reviewed the Connection Requirement, which is phased-in over four years. Stuck-Girard outlined the cohorts of provider organizations subject to the requirement. In anticipation of this year’s attestation, there were multiple improvements made to the forms and the process. A majority of organizations from each cohort have submitted their required attestations. Though the deadline has now passed, there is upcoming outreach planned to encourage provider organizations that have not done so to submit attestation materials.

Stuck-Girard outlined the issue regarding classifying the size of ambulatory practices given the HIway’s unique counting of “licensed providers” (MDs, DOs, NPs, and PAs). There are no other entities that use this definition to count provider organization size; therefore, the HIway is leveraging two data sources: the state’s Registration of Provider Organizations Program (RPO), and MeHI’s contact database. Using these tools, the HIway will flag practices with 8 or 9 MDs/DOs, given the likelihood of enough mid-level clinicians (NPs and PAs) also being present to bring them to 10 providers or more, and thus medium practices per the HIway’s definition.

Juan Lopera asked if there was confidence that these two resources will give us the required information, given that not all practices are required to file a submission with the RPO.

Stuck-Girard acknowledged that only organizations with revenue greater than $25 million and a panel greater than 15,000 are required to register with RPO. Leveraging the MeHI database will help fill in gaps, given the high threshold. Additionally, there will always be a lag-time between the data being available and what is happening in real-time on the ground. The final number of 553 is robust and is more than likely capturing most of the necessary population.

Laurance Stuntz explained that the MeHI data comes from a variety of sources. It’s a list of all the Meaningful Use incentive payments that have been paid out to date. There are a couple of outliers that did not take payouts, but they are larger organizations and are likely to be included in the RPO data. The list has been developed over the past 7+ years.

Undersecretary Peters added that this is the best proxy we have at the current time. Given the purpose of this definition and that this current approach is somewhat conservative, then organizations not included in the list most likely would not be too small to meet the definition of a medium or large practice anyway.

Michael Lee explained that the number of urgent care sites is growing and they are looking to connect, but they are likely never to fall into any of these groups. These organizations should be considered when revisiting the requirements and setting new deadlines.

Peters acknowledged Lee’s point and stated urgent care is being considered in the re-evaluation of the regulations.

## Discussion Item 3: HIway 2.0 migration and HIway 1.0 shutdown

*See slides 13-18 of the presentation. The following are explanations from the presenter, with additional comments, questions, and discussion among the Council Members.*

David Whitham announced that the HIway team successfully migrated all of its participants to the new HIway 2.0 environment in early June. This moves the HIway from a legacy server environment to the latest 2.0 platform, leveraging Software as a Service (SAAS). Orion had both the 1.0 and 2.0 environments up and running at the same time for a smooth transition of participants.   
  
January through June 2018 saw the migration of the Clinical Data (CG) nodes. By starting with the CG nodes, it ensured there was no issue with data sharing between HIway 1.0 and HIway 2.0. All 252 participants were migrated by June of this year. This was a great accomplishment for only 18 months of work. As our migrations grew, so did the transactions on the new environment, and HIway 2.0 supports our transaction volume well. The longest hang-up in the migration process was the Declaration of Identity (DOID) form, as they needed to be notarized by the organization. The onboarding process for new participants is streamlined with the new environment. Whitham thanked all those involved in the migration process.

**Discussion Item 4: Market-based ENS Initiative – Regulatory update**

*See slides 19-25 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 reviewed the Market-based ENS Initiative, where the approach was shifted last fall. Draft regulations were published in early July, and the public comment period is now closed. The HIway is currently reviewing comments and feedback received through the public hearing and comment process. The goal is to issue final regulations this fall. Comments are welcome on the proposed timeline. The goal is to provide access to these services for all provider organization types, but without redundancy of contracting with multiple vendors. With admission, discharge, transfer (ADT) notification “reflection” (sharing among vendors), vendors are encouraged to compete on quality of service and not the quantity of data available.

Bert Ng explained that the HIway will use a combination of regulations and vendor certification criteria to accomplish the initiative’s goals. The key is the data sharing among the vendors, which allows organizations to send and receive from a single vendor. We’ve learned that there are currently many data silos built today that result in multiple contracting on both ends, (1) in order to be a good steward to the community, a submitting organization must currently provide data to multiple vendors, and (2) not knowing where your patients may land, one needs to access data from multiple vendors. The draft certification process ensures that we better understand how these vendors work. The HIway is targeting Q1 of 2020 to have certifications live.

Ng outlined the feedback received at the Public Hearing:

* Certification criteria development should be done transparently in a public setting (Ng confirms this will be done).
* What happens when privacy-breach notification is required? Who is responsible for notifying the various required entities?
* Request to delay the framework going live, as technical and contracting issues could affect timeline.
* Precise definitions of what data has to go in, and what data can be excluded.

Laurance Stuntz asks the council, what was the rationale for the delay? Deborah Adair clarifies that given how contracting processes ensue, the timeline is not realistic. Stuntz states that his assumption is that all acute care hospitals are already contracted with a vendor. Peters explains that there is no contract with the state, only a certification, and all vendors will be notified of their status by the end of the calendar year.

Adair asks, where do the breach notifications and other administrative questions get outlined and between whom? Peters explains that certification criteria will outline the “rules of the road.” To be certified, you are agreeing with the data sharing requirements set forth. Adair asks what if vendors don’t share data as required? Peters says that in that case, the state would take action as outlined in the certification requirements. Adair provides an example of a provider organization passing data to their vendor, and the primary vendor sends that data to a secondary vendor per the regulations. That secondary vendor breaches the data. In that case, who is responsible?

Ng explains that it is a less formal “contractual process,” as there is no true negotiation between the parties. It is more of an “adhesion contract,” which gives opportunities to the state to take action against a vendor that does not adhere to the rules, and even “kick them out.” Adair shared that the contracts established between the vendor and the provider organization could conflict with the rules of this certification process. Peters explains that the regulations address the described scenario, as the organization is no longer liable once data is transferred to “vendor B.” At this point, the state takes over the liability of the data transfer between the vendors given that it is a state requirement that vendors share the data.

Michael Lee explains that breach and notification requirements are a big deal. Many of these vendors have been involved in the process, are aware of the latest proposed regulations, and are likely already working on this. If we delay a year, these issues are not going to be resolved. Peters asks, if we announce the certified vendors in December, would that hinder the ability to meet the timeline? Lee continues, if vendors come back with a technical issue, then the timeline will be affected, however the other issues (breach and process) are well-known and shouldn’t affect the timeline.

Diane Gould asks how the number of vendors will be determined. Ng explains that the HIway knows of three major players in the state and two others that play large roles in other states. There is another handful of vendors, bringing us to about ten nationally. However, the HIway is not limiting the number of vendors.

Stuntz asks whether certification will be a rolling process. Ng states that the next slide will explain that further.

Linda McGoldrick asks what the budget to manage the program is. Ng explains that the HIway is leveraging the market itself and the existing teams that are already in place for project management. McGoldrick asks if we can put a number to this process at a certain point. Peters states, yes, we can quantify labor costs, which is the primary cost to the state, given the state is not contracting and providing a service outright.

Stuntz asks whether all ADTs, or only Acute Care hospital ADTs, must be reflected. Stuntz thinks that all ADTs should be reflected regardless of setting, though the HIway only has regulatory authority over Acute Care Hospitals. David Whitham states that the HIway has authority over Acute Care Hospitals for submitting ADTs, but perhaps there is leverage with the vendors to reflect all ADTs, particularly from a MassHealth ACO perspective where the goal is to expand the care settings.

Ng explains that the initial certification is to get the details outlined around the different HL7 message types, versions, what sort of backward compatibility is required, etc. Future certification will allow for accommodating changes in the technology landscape. Ng said the HIway needs to be flexible to move toward new standards. Each two-year term will provide opportunity to address these changes moving forward.

Stuntz says it seems strange to not take any new vendors to the market for at least another two years. Whitham explains that the thought was to provide a stabilization period with the initial roll-out. Adair states that given the volume of data sharing, we should start small. Peters says that this ensures that new vendors to the market build their client base up during these two-year gaps. Stuntz asks how the HIway will encourage innovation through the certification process to serve other populations, while balancing the need for stabilization. Ng replies that the HIway should take that into consideration.

**Discussion Item 5: HIway Success Story**

*See slides 26-37 of the presentation. The following are explanations from the presenter and comments, questions, and discussion among the Council Members that supplement the content on the slides.*

Phill Argyris from Tufts Medical Center (TMC) presents on external communications with other provider organizations, including the use of the Mass HIway. TMC first adopted an EHR in 2006. TMC’s vendor said that they would need to hard code each fax number, but instead TMC created an internal Provider Directory, which has grown over time and now includes the Mass HIway as a channel for outbound communications. Once Meaningful Use came along, TMC needed to be able to do more, thus the creation of the WebServices hub, which includes HIway Direct Messaging and routing of received messages to Tufts’ secure email.

Laurance Stuntz asks, how often is TMC adding new recipients? Argyris explains that they are still working on new recipients in groups.

David Whitham adds that the new Provider Directory standards will potentially allow us to roll out new services to organizations to support the addition of recipients.

## Conclusion

The next meeting of the HIT Council is **November 4, 2019**.

Undersecretary Lauren Peters adjourned the HIT Council at 5:02 p.m.