**Meeting Minutes**

**Health Information Technology Council Meeting**

**May 6, 2019**

3:30 – 5 p.m.

**One Ashburton Place
Boston, MA 02108**

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| Name | Organization | Attended |
| **Lauren Peters**  | *Undersecretary of Health and Human Services* *(Chair – Designee for Secretary Sudders)* | Y |
| **Daniel Tsai\*** | *Assistant Secretary, Mass Health* | Y |
| **Vivian Haime** | *Manager of Care Delivery Transformation and Partnerships, Health Policy Commission* | 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* | Y |
| **Juan Lopera** | *Vice President of Business Diversity, Tufts Health Plan*  | N |
| **Linda McGoldrick** | *CEO and President, Financial Health Associates International* | N |
| **David Whitham** | *Assistant Chief Information Officer for Health and Eligibility* | Y |
| **Laurance Stuntz** | *Director, Massachusetts eHealth Institute* | Y |
| **Manuel Lopes** | *Chief Executive Officer, East Boston Neighborhood Health Center* | Y |
| **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 of Massachusetts Center for Health Information and Analysis* | Y |
| **Frank Gervasio** | *Project Manager, Executive Office of Administration and Finance* | N |
| **Naomi Prendergast** | *President & Chief Executive Officer, D’Youville Life and Wellness* | y |
| **Damon Cox** | *Assistant Secretary for Technology, Innovation and Entrepreneurship, Executive Office of Housing and Economic Development* | N |
| **Michael Miltenberger** | *Vice President Healthcare Team, Advent International* | Y |
| **Nancy Mizzoni, RN** | *Practicing Nurse and Clinical Instructor at Northeastern University* | N |
| **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.* | N |

**HIT Council Members**

Note: The above list provides the HIT Council Members at the time of the May 6, 2019 meeting.
\*Monica Sawhney attended as Dan Tsai’s designee.

## Discussion Item 1: Welcome

Undersecretary Lauren Peters called the meeting to order at 3:35 p.m. The Undersecretary welcomed the Health Information Technology Council to the May 6, 2019 meeting.

The February 4th HIT Council meeting minutes were approved.

## Discussion Item 2: Query and Retrieve Discussion

*See slides 5-10 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.*

Bert Ng discussed how to leverage functions of organizations such as CommonWell and Carequality when thinking about strategic end goals for the HIway. Ng outlined the implementation and transition from paper-based queries (fax, telephone, etc.), to the electronic format (chart on slide 6). Ng discussed the benefits of using electronic solutions versus paper-based operations (tracking down correct providers, figuring out needed forms, all streamlined using electronic format).

Ng discussed whether these tools are valuable to the HIway and how they should be used as the HIway continues to grow. Ng provided overview of two services that offer query HIE: CommonWell and Carequality. He outlined the specific uses of each service and how they differ from each other.

Ng asked the Council for opinions on how the Council should consider being involved and leveraging these services, and what we can do as a council and as a state to help facilitate adoption within the Commonwealth.

Manuel Lopes asked if there was a cost involved in participating. Ng said that Commonwell/Carequality doesn’t know, so they could not disclose to us, if their member vendors charge an additional fee to providers. As a state, there is a potential to become members of the group and have voting rights. Right now, he said they want to consider whether it is worth investing resources.

Laurance Stuntz added that individual members have told MeHI that they are not charging, but that may change in the future. MeHI always tries to find out what the costs are upfront, Stuntz said. Largely, he thinks they are not charging for query/retrieve service and that this is built into the overall cost of the EHR product.

Michael Lee said that since they are already paying for the framework, they are not charging by transaction. It may be built into the overall cost. Michael Miltenberger agreed.

Lee shared a relevant situation from the Department of Children and Families (DCF), where Boston Children’s Hospital is having difficulty getting information and indicated this may be an opportunity to implement query/retrieve. Most of the use cases will be outside the large acute care environment. He expressed concern that this would be much harder than HIway implementation.

David Whitham said he can see the role of the Commonwealth as an enabler to help healthcare providers become successful. Deborah Adair asked how we would do that, what the costs would be. What do we have to do to get this in place? Ng reiterated that the biggest downfall is that there is not a high adoption rate, so we need to be leveraging our ability to go out and inform providers about the availability of this service.

Lopes and Adair were unsure whether their instances of Epic allowed for easy access of query and retrieve services, and again questioned cost. Peters said it is a matter of the state endorsing or helping to promote these services through the HAUS program, to increase access points where providers are learning of these solutions.

Stuntz agreed that HAUS and newsletters could help make the community aware of and understand the benefit. Any payment decision would be for the provider to make. He said there could be an interesting use case with DCF for the state, querying to get appropriate medical information on patients they’re seeing.

Whitham agreed that could be a great way to expand clinical gateway. Lee said the biggest need is to help people understand what the requirements are.

Naomi Prendergast said a lot depends on how broad or narrow the query might be. If you get 20 years of medical history, trying to get relevant information might be more trouble than it’s worth. She asked about the timeframe, how long it takes to get information back. Lee said it’s almost instantaneous, but they do retrieve a lot of “stuff,” a lot of information going back years, which may not be what the provider wants.

Peters asked Lee if there is a service that he can think of that would be more useful. Lee said not at this time. Stuntz added that there is an emerging standard that allows for data-level query, but is not widely adopted. A few companies are starting to explore that, and it should be tracked in the next few years. But currently, it is more of a “tell me everything you know about this patient.” One difference between CommonWell and Carequality: whereas Carequality will give you everything, CommonWell will say they know of information at “these places,” and the provider can say they only care about specific visits and then go look at those individually. Stuntz added that one thing they could do is think about those differences and what is useful, and help providers understand what they need it for.

Adair asked if there was an idea of how many providers might need this service. Prendergast said it could be helpful if they could get the pertinent information. Prendergast said she sees the service as complimentary, not replacing anything. She said they should look and see at how many places depend on this service, not use it to augment other available services. Stuntz added that he sees it as another tool that can be made available, not replacing any current services.

Ng said he would like all council members to think about it, bring it back to their teams, and think about whether or not there’s any applicability for this service. Stuntz volunteered to run some numbers through Salesforce to see what potential need there might be, and report back to the council.

## Discussion Item 3: Market-led ENS Initiative – Regulatory Update

*See slides 11-18 of the presentation. The following are explanations from the presenter, with additional comments, questions, and discussion among the Council Members.*

Peters and Ng provided an update on the ENS Initiative. Ng discussed the purpose of the initiative and how it is supposed to work. He discussed the transformation of the model from previous meetings to the current model, with the second tier of vendors, and using a reflective model.

John Halamka talked about some issues he discussed with vendors. They said they know there will not be a monopoly, it would be technologically complicated. You’ll end up with three silos of routing unless you figure out some “magic” where each silo knows about the other. Vendors said that when they get a transaction, they will go to other vendors and ask if they can route the information to others. If there is no subscriber to receive that information, it will be gone. Vendors have offered to do this for free, and they are already doing some of it already.

Adair said they have talked about it with Partners, and it’s fine if you’re going to delete the data, but you need to make sure that it’s getting deleted immediately and isn’t stored.

Lee added that just sending the notifications is not enough; it allows the vendors who want to engage to build up services around it. Some receivers don’t need all the services. There can be layers of cost and the market will choose what is most important. The best way to get the vendors on board is to hold them harmless, Lee said. We should allow primary care providers (PCPs) to give all patients, and let them determine who should be on their rosters.

Peters said that not all that much would change from the current process. When you are a PCP organization, you have a process now for defining who your patient roster is when you go into that contract. We don’t want to interfere or change the definition of those patient rosters. Just take the process today and if there is a match, that PCP can take it and go with it. If there is not a match, the vendor needs to delete those ADTs. Where there’s going to be some complexity is with CPs, as the CPs are getting off the ground and working with ACOs, they will be generating new patient rosters. It’s on the provider, not on the vendor, to define who is on their patient roster.

Lee asked if it would help to define what you are getting notified about. Peters said her only concern with defining it is that if you look at subscribing providers, they may have different needs. Use cases are different, so we don’t want to prescribe a one size fits all definition.

Halamka commented on different definitions. One hospital may define active patient as seen in the last 2 years, another may say in the last 10 years.

Adair commented on privacy issues. Ng said these will be issues that they will be determining as they continue to develop the process.

Peters commented that the three functions (slide 16) will all remain in the framework; there could be a use case that fits more squarely in one over the others. Adair expressed confusion over 2 and 3 that seem to contradict each other. Peters reiterated that the slide is to show where they were initially going, and where they are now. Miltenberger said the approaches make sense.

Stuntz said he would like to see data about transaction flows, where the data is being used, that would be informative about the underlying metadata but without risking protected information. Peters said they should continue to think about a way to balance privacy and limiting use cases. We don’t want to create a framework that opens up the use cases beyond ENS.

**Discussion Item 4: HIway 2.0 Migration Update**

*See slides 19-22 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.*

Whitham updated the council on the migration. The remaining 20 migrating participants is now down to 13.

**Discussion Item 5: Connection Requirement/Attestation Update**

*See slides 23-26 of the presentation.*

This agenda item was skipped in the interest of time. If there are any questions about the connection requirement/attestation, please contact Chris Stuck-Girard.

**Discussion Item 6: HIway Success Story**

*See slides 27-33 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.*

Andrew Massey from the Home for Little Wanderers shared a success story about using the Mass HIway to support CANS reporting. Stuntz provided more background: MeHI provided a grant to vendors to develop the interface to support CANS data being submitted to the CBHI program. Four grants were awarded to vendors and each vendor implemented these interfaces in multiple pilot sites. Now the standard has been tested and rolled out, and there are a couple more vendors in the process of implementation.

Campbell asked about other opportunities to implement this workflow. Massey said they have been looking at other services where it could be beneficial, and there are a lot of ways they can use this workflow.

## Conclusion

The next meeting of the HIT Council is **August 5, 2019**.

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