Meeting Minutes
Health Information Technology Council Meeting
April 6, 2015
3:30 – 5:00 P.M.

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

Meeting Attendees

Name	Organization	Attended
Marylou Sudders	*(Chair) Secretary of the Executive Office of Health and Human Services*	*
Darrel Harmer	*Acting Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
Bill Oates	*Chief Information Officer, Commonwealth of Massachusetts*	Yes
Daniel Tsai	*Assistant Secretary for MassHealth*	**
David Seltz	*Executive Director of Health Policy Commission*	***
Áron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	Yes
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Yes
Patricia Hopkins MD	*Representative from a small Physician group Practice Rheumatology & Internal Medicine Doctor (Private Practice)*	No
Meg Aranow	*Senior Research Director, The Advisory Board Company*	No
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	*Chief Information Officer, Beth Israel Deaconess Medical Center*	Yes
Normand Deschene	President and Chief Executive Officer , Lowell General Hospital	No
Jay Breines	Community Health Center	No
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Yes
Michael Lee, MD	*Director of Clinical Informatics, Atrius Health*	Yes
Margie Sipe, RN	*Performance Improvement Consultant; Massachusetts Hospital Association (MHA)*	Yes
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	No
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	Yes
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Yes
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Yes

*Alice Moore	*Undersecretary of Health and Human Services* *Sitting in for Secretary Sudders*	
** Rick Wilson	*Chief Operating Officer, MassHealth*	
*** Iyah Romm	*ANF Commonwealth of Massachusetts,* *Policy Director, System Performance and Strategic Investment*	

Guest

Name	Organization
Jessica Costantine	AARP
Marilyn Kramer	CHIA
Lisa Fenichel	Consumer healthcare
Bala Burra	EOHHS
David Bowditch	EOHHS
Kathleen Snyder	EOHHS
Nick Hieter	EOHHS
Ratna Dhavala	EOHHS
Robert McDevitt	EOHHS
Claudia Boldman	ITD
Jennifer Monahan	MAeHC
Mark Belanger	MAeHC
Murali Athuluri	MAeHC
Ryan Ingram	Mass Dental Society
David Smith	MHA
David Bachand	NEQCA / Tufts
Karen Latta	Orion
Kary Nulisch	Orion
Pam May	Partners
Pat Rubalcaba	Partners
Christine Griffin	PHS
Venkat Jegadeesan	BIMDC
Sarah Moore	Tufts

Meeting called to order – minutes approved

The meeting was called to order by Alice Moore at 3:35 P.M.

The Council reviewed minutes of the March 2, 2015 HIT Council meeting. The minutes were approved as written.

Discussion Item 2: Participant Update – Partners HealthCare (4-12)

See slides 4-12 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.

An overview of Partners HIway Implementation was provided by Pam May and Christine Griffin.

(Slide 5) Partners Approach to MA HIway Implementation - At the outset Partners decided to focus on the Direct implementation and gearing up to meet Meaningful Use. Another focus area was the Provider Directory (PD), and early on Partners made the decision to publish providers individually on the HIway. The last piece was the patient consent process, which came with a big operational component. Newton- Wellesley Hospital and Massachusetts General Hospital are rolling out Epic right now and the goal is to keep the two systems synchronized.

(Slide 6) Technology Progress- Currently Partners can receive a Continuity of Care Document (CCDA), incorporate it into the EHR and notify the provider. They also have the ability to send Transition of Care (TOC) documents and patients are able to view, download and transmit their clinical summaries.

- Question (Larry Garber): Is that incorporation part of the HIway directory automated or manual?
    - Answer (Pam May): We have started to automate it, but it's a manual process with the errors.

The last piece was sensitive data management. Partners wanted to ensure they were not sending out information regarding things like HIV medications or drug and alcohol treatment. There is an enterprise level clinical rules service which scans documents for any sensitive information and stops it from leaving the door.

(Slide 7) Communication with hospitals & physician organization - Partners needed to make other hospitals aware of what they were doing with the HIway. An HIE Committee was formed last year to give governance and structure to the HIway implementation. There is membership from five different Partners hospitals and physician groups. The goal is to have consistent forms, policies and processes across all of Partners. Each site also has a hospital Meaningful Use committee that looks at the metrics, including HIway use for the summary of care measure.

(Slide 8) Enrollment – The team reached out to Chief Medical Officer (CMO) and Physicians Organization (PO) for permission to do this. Physicians were given information about closing the loop on referrals by

using the HIway which explained things like how they would be alerted, how they can access documents and how to send CCDA's for referrals and TOC. Provider Directory lists from each of the hospitals were generated from the EHR team and sent to Pam May, the Access Administrator for Partners, to credential each individually.

- Question (Mike Lee): Are you going to publish Direct addresses for all providers including the hospital?
    - Answer (Pam May): Within the providers address it designates where he or she is located; when we publish addresses we also publish their primary office location. The domain is still just Partners, but we were sensitive to the fact that people may not realize they are going to a Partners owned facility for their health care. We wanted to make sure that we represented where the physicians practice and how patients know them.
- Question (Laurance Stuntz): Is the Direct address like david.smith@partners.org and then he would be listed in the directory as David Smith at Newton Wellesley?
    - Answer (Pam May): Yes, we have another designation before the @ sign to help route the messages to the right place.

(Slide 9) *Outreach to Practices* –Partners Community HealthCare (PCHI) is the management services organization for Partners. PCHI has a support team that has relationship with each of the practices which was hugely helpful. Pam May is the Partners Access Administrator, but the practices may not know her. The team started by dividing practices in tiers, and contacting them via letter with information about the HIway. PCHI also started to join Meaningful Use meetings to help them plan for the HIway.

(Slide 10) Communication between Partners and MA HIway – A HIway team was started which includes two HIway Account Managers. There are weekly meetings to talk about opportunities and challenges. There are also weekly meetings with PCHI which are attended by a HIway Account Manager. This sounds like it is tied neatly with a bow now, but it took a while to get the communication approach nailed down.

(Slide 11) Partners Enrollment Numbers to Date - A little over 3,000 providers are enrolled, including physicians and non-physicians. A breakdown of enrollment across Partners was provided.

(Slides 12) Identifying Trading Partners – One obstacle is getting patients to consent; the other is ensuring the receiving organization is on the HIway. In order to meet the TOC thresholds for Meaningful Use using the HIway the team analyzed one year of discharge data to identify the top 10 trading partner organizations.

- Question (Karen Bell): I know we are working on connecting with other HIE's, but do you have any idea how many of those discharges go to other states, and do we need to look at accelerating that interstate exchange effort?
    - Answer (Christine Griffin): We do have a lot of physicians on bordering states, not sure what the number is, we really only looked at Massachusetts during the study.

  - Comment (Mark Belanger): We can bring that statewide transaction data to the next HIT Council meeting.
- Question (John Halamka): In the last few weeks we have seen a lot of regulations blooming, and of course all of these proposed bills point at evil vendors, saying they are blocking transactions and the standards are not ready, but the excuses ignore the cultural and economic issues. I would be interested to hear what your impression is? Is this workflow, incentive and process related, or is it just those darn IT people moving slowly?
  - Answer (Christine Griffin): It is more of a time and capacity issue and the trading partner summit will help with that. From a resource perspective we do not have time to track down who is in charge at in each department and coordinate who to talk to. We are still in the midst of that challenge.
- Question (Larry Garber): If we were an opt out state, instead of opt in, would you be further along?
  - Answer (Christine Griffin): Yes, absolutely.
  - Comment (Deb Adair): We have been talking about how to educate patients and consumers, we feel strongly that if patients and families knew more they may be more willing to ask their providers about it. We are planning to put consent information on the patient portal, when patients have more time to read information. I know we talked about doing a big statewide campaign with this group year's back, but the education issues are not going away.
  - Comment (Mike Lee): We have roughly 80,000 people consented and documented in Epic, about two times that number not scanned in, and then four times that number have been given the consent forms. Our decline rate is now around 10% which is higher than anticipated, we figured people would just throw it out instead of actually declining.
  - Comment (Larry Garber): It's challenging because education is needed for such a large group of people; families, nurses, front desk staff etc.
  - Comment (Christine Griffin): Social media does help, we have tried doing some of that. if staff have to sit and answer questions in detail there are registration backups.
  - Comment (Lisa Fenichel): It sounds like everyone is supporting the opposite of what was said regarding opt out. The push for education would not be as much of a priority if it were the other way around.
  - Comment (Mike Lee): When we finally get some volume up with the physician to physician transactions we will have a story to tell. Right now we are doing a lot of Public Health reporting , but that stuff is not as touchy feely. I also do not think that it is a bad thing this is taking so long; it's giving us time to work through the issues.
  - Comment (Larry Garber): I had a HIway story last Friday – a patient was discharged from the hospital and I had the CT scan, but they did not bother mentioning that there was a abdominal aortic aneurysm. If I did not have the full summary with the scan I would have not picked that up. These lifesaving stories must be happening with others.

Discussion Item 2: Future Policy Issues Discussion (Slide 14)

See slide 14 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.

A discussion on policy issues related to the HIway was led by Mark Belanger.

(Slide 14) Future Policy Discussion Topics -

At the last meeting there was a request for a deeper dive into some of the consent policy issues. The goal of the discussion today is to collect a list of all of those issues for discussion at later meetings. A starter list was provided; almost all issues are consent based hurdles.

- (Larry Garber): An advanced directive registry may be in our future which might require us to revisit and modify consent.
- (Mike Lee): Access to information over the HIway. We recently had requests from two major Massachusetts insurers asking us to send all encounter based CCDs to them for their populations. All of the HIway specific complaints from patients are almost exclusively insurance related concerns. We should consider what type of access is reasonable. The insurers have the ability to audit for payment, but does that really extend to all of the information contained in the CCD? That is really where the difference in opinion resides and I would like to hear from this group regarding what access is reasonable.
- (John Halamka): If we look at some of the regulations that have come out over the last few weeks there is an emphasis on payment and Patient Centered Medical Home. The CEO at Fenway Health thinks we should all have an electronic medical home that collects all of our health information in one place. If a lab is done elsewhere, it should 'auto-magically' appear in the EHR at Fenway. It is a complex consent issue; did Fenway order the lab test? No, but you have a primary care record there. We can all agree that EHR's do not support this kind of workflow; CCDA's can go back and forth, but not lab orders.
    - (Larry Garber): We do this right now with provider based subscriptions, we subscribe to patients that have identified us as their provider so I get their discrete data, even imaging. That is what we should all strive for – the hassle free HIE.
- (John Halamka): If we look at the value add with HIE, as we know sometimes the economic incentive is not enough. It's what can we do to enable the patient centered medical home- I can send a list of my patients to the HIway so that the HIway can get that information to me. We can easily send a list to the HIway of patients that have consented.
- (Karen Bell): I think as we discuss this there will be more and more opportunities for data exchange outside of direct clinical care which made me think about social services. Right now takes a long time for organizations to make disability determinations, might we want to think about use cases for the benefit of the patients in terms of decreasing administrative burden.
- (Deb Adair): I wanted to add the Department of Mental Health (DMH) locations to that list. A lot of these are laws that either need to be changed or reviewed; with the technology limitations, something has to give for us to do this.

- (Larry Garber): I would love to see us change to opt out, but right now we do have the technology to make it easier for patients to opt in, but I think we should try to come up with a way that does not require that at every site.
- (Laurance Stuntz): As an extension of that, a patient's ability to manage their own consent and seeing where they have opted out. They are going to end up receiving treatment in two different places and have two different answers; they should be able to rationalize it themselves.
- (Iyah Romm): We have spent a lot of time with Laurance and his team looking at other states, it strikes me that as opposed to generating a list and talking about it later, we should dive into these issues a little deeper. Whether that is the EOHHS IT staff, or MEHI, we should dedicate the resources needed to come to grips with the spectrum of opportunity out there. Everyone I talk to is interpreting and applying the rules and regulations of 42 CFR differently. I think we need to understand that as much as the policy lens in which people view it.
- (John Halamka): Another topic to add, should the HIway join Direct Trust? Direct Trust is a mechanism of getting a trust fabric that goes beyond geographies. There are some benefits to joining, you can easily connect to others, but there is cost and complexity- do we want to buy into that?
- (Mike Lee): I would like to know if we have any role in discussing the impact of some of the regulations imposed on us. It seems vague as to how some of the rule making gets done. It would be helpful to understand why and how this process takes place from a legislative perspective.
- (John Halamka): Chapter 224 was the classic example; it was designed to make HIV testing easier, and more ubiquitous. Now it's almost denying those patients from participating in the HIE and improved care coordination.
- (Mike Lee): The American Medical Association (AMA) also just recommended HIV tests be performed for all adults. What would we do if we couldn't release anyone's results?
- (Larry Garber): It gets worse if you have to document verbal approval and it's free text in the note that you did the HIV test, the law is written so vaguely it sounds like the existence itself needs to be hidden.
- (Alice Moore): It sounds like we should put a subgroup together to study these issues and report back to the Council, potentially at the next meeting. Please let me know if you are interested in joining the group. We can certainly explore the legislative processes, but it does have a certain calendar to it. It is probably more of a longer term project to make legislative changes. I will say that feedback on the laws is always encouraged.

A motion was made by Alice Moore to create a subgroup of the HIT Council to work on the consent policy issues. The Council voted unanimously to carry the motion.

Discussion Item 3: HIway Operations Update (Slides 16–38)

See slides 16-38 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.

An update on HIway operations was provided by Darrel Harmer.

(Slide 16) 2015 Mass HIway Incident Summary Dashboard – There was a slight format change to the uptime/downtime metrics dashboard based on suggestions from Orion.

(Slide 17) 2015 Mass HIway Incident Summary Dashboard – The six week stability sprint was a collaborative effort between EOHHS, Orion and Logic Works to really dig into what was causing stability issues and attacked them at the source.

(Slide 18) Stabilization Sprint Overview- A list of the stabilization sprint activities was provided. The goal of the sprint was to increase system reliability, performance and participant confidence.

(Slide 19) Stabilization Sprint Highlights – A list of key activities that lead to increased monthly uptime was provided. There were software and hardware upgrades as well as tuning and optimization activities- it was a real substantive effort.

(Slides 20&21) Improvements to the Clinical Gateway and Overall Infrastructure – Clinical Gateway improvements and modification activities were provided. The Clinical Gateways is used for the Public Health Registries.

(Slides 22&23) 2015 Mass HIway Incident Summary Dashboard February and March 2015 – The results of the sprint were provided. February uptime was dramatically improved and continued to improve into March.

(Slide 24) 2015 Mass HIway Incident Summary Dashboard Dec. 2014 to Dec. 2015 – The incident summary dashboard was provided.

(Slides 25) HIway Availability Trends – Availability is trending in the right direction now. The goal is to have the total monthly availability no lower than 99.9% (downtime no more than 44 minutes/month) and the days with outages no higher than 3% (1 day).

(Slide 26) What's Next? - The operations team will continue working on stabilization as the system evolves and grows, but can now go back to some of the activities that were put on hold. There are plans to do a full performance load test of infrastructure, increase documentation and complete the development and implementation of key system management processes. To further increase transparency, the uptime metrics are going to be published on the HIway website. The team will also look at how to improve and simplify connections and start an analysis of future infrastructure options. One of the options being looked at is moving off the Direct Gateway and onto the multi-tenant Direct Secure Messaging (DSM) solution. The Council would be involved in those decisions.

- Comment (John Halamka): One of the challenges with Meaningful Use Stage 2 is that we offer too much optionality with vendors. You can connect to HISPs in a variety of different ways, but now the complexity is versioning and flavors. The customer is thinking it's the HIway's fault for being too complicated, when it's really not. I would suggest we make a template onboarding guide by vendor – what are you running; here is what you can expect.

- Question (Áron Boros): There is a small improvement in March, and I see that the goal is 99.9%, but usually you see 99.999% uptime reliability for Google for example. I guess my question is, when was the sprint started and do you feel like we have made progress since the number has not really moved? Are we going to see that at 99.9% in April 2015?
    - Answer (Darrel Harmer): I think we have made a lot of progress if you look back at December. We want to keep that line moving up with a goal of 99.9 in April, we are willing to take it up as high as we can go, five 9's would be great.
    - Comment (John Halamka): I would caution that you pay exponential dollars for every 9 you add. I have run all BIDMC applications at 99.9 except the code paging system which is at 99.99%. We have never achieved five 9's.
- Question (Áron Boros): So should we be using this as a checklist and ask you about how these are going in three months?
    - Answer (Darrel Harmer): Yes.

(Slides 27 & 28) HIway Participation – A list of new Participation Agreements and connections completed in March was provided.

(Slide 29) Setting New Targets - There are three categories being tracked – Signed on, connected and actively using. In the fall targets were set high, and for the reasons listed on the slide those targets were not met. The team expected a large number to come in via the eClinicalWorks HISP and unfortunately that did not happen in large part because eCW wanted to start using Direct Trust. The team is confident that targets will be met for organizations signed on and connected, but are dropping the goal to 100 actively using.

(Slide 30) Setting New Targets Cont. – The methodology and confidence factors behind the revised targets were explained.

- Question (Claudia Boldman): Does the eClinicalWorks strategy change mean we need to revisit their HISP Agreement?
    - Answer (Murali Athuluri): Yes, we are revising the agreements now.
- Question (Áron Boros): What is the point of not hitting the target and revising the target to make it look better? I am not in favor of changing the target, I would be more in favor of saying we did not hit the target and explaining why. Changing the target makes it look like you are giving yourself a better grade.
    - Answer (Darrel Harmer) : We are looking at it as more of a re-baseline exercise.
    - Comment (Áron Boros): I think we can do that in 2016, but we set a target and missed it. Changing it now just obscures that fact.
    - Comment (John Halamka): Given that the market has evolved and continues to change, rather than changing the targets maybe we revisit how we set the target – what is the right number and how do we count it.
- Comment (Iyah Romm): I agree with both comments, another metric is actively using and how we define it. Do we need a subset of that goal to look at Public Health reporting versus provider to provider exchange in a meaningful way?

- Comment (Darrel Harmer): I also want to remind everyone that through design decisions we only have a very limited set of data to study.

(Slide 31) Progress Relative to SFY'15 Revised Targets – The revised dashboard was provided.

(Slide 32)Transaction Activity- The HIway transaction volume continues to increase, averaging over one million a month since January.

(Slide 33) HIway Transaction Analysis – The HIway production transaction trends by use case type were provided.

- Comment (Iyah Romm): Do we know how many organizations are represented in each category?
    - Answer (Darrel Harmer): We would have to look into the data further; we can bring those numbers next month.
- Question (Larry Garber): Do you know where the specialized registry reporting for Meaningful Use is categorized?
    - Answer (Darrel Harmer): That would fall under Public Health.
- Question (Laurance Stuntz): As we expand out our reporting and start understanding the raw numbers, what about looking at reporting on distinct Direct addresses? For example Partner's shows up as one.
- Comment (Iyah Romm): If we can get those TOC numbers up and create more of a value statement with goals and targets around each it will be easier to promote. Quality reporting is valuable to a CIO, but providers are not particularly banging down doors to join the HIway.

(Slide 34) DPH Registry Update – A list of the currently available Public Health Registry connections was provided. The Children's Behavioral Health Initiative (CBHI) is on target to go live April 12th. Efforts are starting for the Prescription Monitoring Program (PMP), the HIway is working closely with The Department of Public Health on that effort.

- Comment (Laurance Stuntz): There is a ton of experience in this room around the appropriate implementation of e-prescribing and prescription history and all of that. I would encourage tapping into this room, not just DPH. The PMPs do not meet the standards for prescription history so we need to think about how to handle that.
- Comment (Iyah Romm): For the context of others, The Massachusetts Hospital Association (MHA) and others are interested in pushing this forward quickly. It will be important for this group to know that folks want to implement this outside of the Health Information Exchange, which could be a place for us to capture that energy and push it into the HIway.

(Slide 35) HISP to HISP Connectivity – An update on the HISP connections was provided.

(Slide 36) Query and Retrieve Pilots -

Beth Israel Deaconess (John Halamka): Coding is complete for consent online, close!

Atrius (Mike Lee): in test system right now, there are still some glitches, 350k patients on right now,

Tufts (Sarah Moore): Testing has gone well, but we found a glitch with the opt out. If a patient opts out you can still see them in the Relationship Listing Service (RLS). We are working with Orion on that right now.

Partners (Deb Adair): We are moving right along!

(Slide 37) HIway RLS Unique Patients – The RLS volume was displayed.

(Slide 38) Communications & Outreach – A list of webinars was provided.

Discussion Item 4: Wrap-Up (Slide 40)

See slide 40 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.

Wrap-up presented by Darrel Harmer.

- Comment (Karen Bell): In terms of targets and measures, it might be a good idea for us to revisit the deliverables for the CMS Implementation Advanced Planning Document (IAPD) program.

The schedule for the 2015 HIT Council Meetings was provided.

2015 Meeting Schedule*

- ~~*No meeting scheduled in January 2015*~~
- ~~February 2 – *Cancelled*~~
- ~~March 2~~
- ~~April 6~~
- **May 4**
- June 1
- July 6
- August 3
- September 14 *(1st Monday of September is Labor Day)*
- October 5
- November 2
- December 7

** All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21st floor*

The HIT Council meeting was adjourned at 5:00 P.M.