Meeting Minutes
Health Information Technology Council Meeting
June 6, 2016
3:30 – 5:00 P.M.

One Ashburton Place, Boston, MA 02108

	Name	Organization	Attended

1.	**Alice Moore**	*Undersecretary of Health and Human Services (Chair- Designee for Secretary Sudders)*	Y
2.	**Daniel Tsai**	*Assistant Secretary, Mass Health*	Y*
3.	**David Seltz**	*Executive Director of Health Policy Commission*	Y
4.	**Deborah Adair**	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Y
5.	**John Addonizio**	*Chief Executive Officer, Addonizio & Company*	Y
6.	**John Halamka, MD**	*Chief Information Officer, Beth Israel Deaconess Medical Center*	Y**
7.	**Juan Lopera**	*Vice President of Bussiness Development, Tufts Health Plan*	Y
8.	**Karen Bell, MD**	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Y
9.	**Kristin Madison**	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve College of Health Sciences*	Y
10.	**Laurance Stuntz**	*Director, Massachusetts eHealth Institute*	Y
11.	**Manuel Lopes**	*Chief Executive Officer, East Boston Neighborhood Health Center*	Y
12.	**Michael Lee, MD**	*Director of Clinical Informatics, Atrius Health*	Y
13.	**Patricia Hopkins, MD**	*Rheumatology & Internal Medicine Doctor (Private Practice)*	Y
14.	**Sean Kay**	*Global Accounts District Manager, EMC Corporation*	Y
15.	**Aron Boros**	*Executive Director of Massachusetts Center for Health Information and Analysis*	N
16.	**Daniel Mumbauer**	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	N
17.	**Katie Stebbins**	*Assistant Secretary of Innovation, Technology, and Entrepreneurship, Executive Office of Housing and Economic Development*	N
18.	**Lauren Peters**	*Associate General Counsel & Director of Healthcare Policy, Executive Office for Administration & Finance*	N
19.	**Margie Sipe, RN**	*Assistant Professor, MGHIHP and Nursing Program Director at Brigham and Women's*	N
20.	**Normand Deschene**	*President and Chief Executive Officer , Lowell General Hospital*	N
21.	**Robert Driscoll**	*Chief Operations Officer, Salter Healthcare*	N

HIT Council Members

** Ipek Demirsoy*

***Attended via phone*

Guests

Name	Organization
Carissa Mann	Berkshire Health Systems
Lisa Fenichel	Consumer Advocate
Gary Sing	EHS
Ipek Demirsoy	EHS
Julie Creamer	EHS
Kathleen Snyder	EHS
Michael Chin, MD	EHS
Nick Hieter	EHS
Ratna Dhavala	EHS
Erika Scibelli	Health Policy Commission
Kate Barrett	Health Policy Commission
Jennifer Monahan	MAeHC
Len Levine	MAeHC
Mark Belanger	MAeHC
Micky Tripathi	MAeHC
Brendan Abel	Mass Medical Society
David Bachand	NEQCA
Ryan Thomas	Orion Health
Pam May	Partners
Sarah Moore	Tufts Medical Center
Joe Heyman, MD	Wellport HIE (Whittier IPA)

Discussion Item 1: Welcome

The meeting was called to order by Undersecretary Alice Moore at 3:34 P.M.

Undersecretary Moore welcomed the Health Information Technology Council to the June 2016 meeting. New members of the HIT Council were introduced: Manuel Lopes, Chief Executive Officer (CEO) at the East Boston Neighborhood Health Center (EBNHC) and Sean Kay, Global Accounts District Manager at

EMC Corporation. Two additional new members, Lauren Peters Associate General Counsel and Director of Healthcare Policy at the Executive Office for Administration & Finance (ANF) and Katie Stebbins, Assistant Secretary of Innovation, Technology, and Entrepreneurship at the Executive Office of Housing and Economic Development (EOHED), were not present at the meeting.

The April 4th 2016 meeting minutes were approved as written.

Undersecretary Moore noted that the focus of the meeting will be a continuation of where HIway is going, what direction it will take, who it will serve, and how to make that happen. Ms. Moore thanked the Executive Office of Health and Human Services (EOHHS), MassHealth, Massachusetts eHealth Institute (MeHI) and Health Police Commission (HPC) teams for facilitating many of the collaborative discussions, all of the working groups that have weighed-in along the way, and the stakeholders who are important to the success of the HIway as we discuss transforming it by determining what the priorities are moving forward. MeHI will also be submitting its operating plan for discussion purposes here as well. The regulations that will be focused on today are works in progress, so they are not being formally presented, but really conceptually presented today for discussion here at the Council.

Undersecretary Moore introduced Sharon Boyle and Gary Sing to give an update on the HIway regulations.

Discussion Item 2: HIway Regulations: Opt-In & Opt-Out Mechanism

See slides 3-8 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 the opt-in/opt-out regulations was presented by Sharon Boyle, Chief MassHealth Counsel and Gary Sing, Director of Delivery System Investment at MassHealth.

(Slides 4 & 5) *Background for Opt-In/Opt-Out*- The 118I statute establishes that there must be an opt-in and opt-out mechanism. At the last meeting,the opt-in and opt-out mechanism was discussed, feedback was reviewed and the draft approach was tweaked a little bit.

(Slides 6 &7) *Proposed Opt-in/Opt-Out Mechanism*- Right now, focusing on the opt-in/opt-out mechanism for function 1 on the slide, which is a secure mode of transmission commonly called Direct messaging, the HIway does not store any information – it is really analogous to a fax machine or a phone call. We are distinguishing that function from the other functions of the HIway which are what we call 'HIway sponsored services' – those include things like the Relationship Listing Service (RLS) and the Event Notification Service (ENS) where the HIway does store information.

Comment (Gary Sing): One thing to add here is that the Relationship Listing Service exists on a pilot basis and the Event Notification Service does not yet exist but it is something that the state is interested in looking at soon.

For function 1, which is direct messaging, federally HIPAA and 42 CFR are absolutely enforced and control the use and disclosure of information. With those in mind, providers may transmit over the HIway with direct messaging just as though it were a fax. That is consistent with the way other state HIEs operate and promotes the use of the HIway in a way that we think is consistent with the way providers generally communicate with each other through fax, phone and chatting over lunch as appropriate. That is our function 1 approach.

For the other functions, the thinking is that the state will provide notice – so it will be notice-based opt-in, every provider will need to give written notice, or there are various other ways we are conceptualizing that providers could educate patients on the functions of the HIway such as posters, banner on a web portal, a letter or email. We do leave it up to you but we do want to provide a sample notice so that folks have some idea of what we think is the best way to approach the subject. Then we are proposing that we will operate a centralized opt-out mechanism, like a do not call list, where individuals can notify us that they are opting-out and we will be able to manage that centrally. Of course for those who want to do more, that would be permissible as well, you could have a local opt-in/opt out.

- Comment (Deborah Adair): On the first function where you say "direct messaging" – just looking at this change for some clarification, I would suggest adding at the end of the sentence where it says: "same way they are permitted to fax the information, *without the patient having to opt-in."*
    - Response (Alice Moore): That's fine, and this is just a presentation. This is not the actual regulation language.
    - Response (Deborah Adair): Yes, just a suggestion. If this is presented to broader audiences it just clarifies it.
    - Response (Sharon Boyle): And there will be, as the Undersecretary has alluded to, a formal regulatory process. This construct, once we settle on it, after gathering input from all of you, will be part of that. We will have a public comment period.
- Question (Juan Lopera): A question about the centralized opt-out mechanism- that would mean that the patient would be opting-out completely, not from a specific system?
    - Response (Sharon Boyle): Correct and I am hoping that David Whitham can leap in if you have other specific questions.
    - Response (David Whitham): Yes, it would be centralized opt-out for those additional functions.
- Question (Kristen Madison): Just to clarify, by centralized you mean not only is it going to be one place to go, but also a universal opt-out with respect to all providers for both RLS and ENS?
    - Response (David Whitham): We haven't gotten into the weeds there. We are envisioning that at some point in the future it would be centralized opt-out for the service that is in question. At that point the service would contain a repository of identifiers that we would be able to control and say 'this identifier no longer wishes to participate in this service and we will be able opt-out.
    - Comment (Gary Sing): You can imagine from an ease of implementation perspective, having a single decision govern someone's participation will be easier to implement initially so that is a consideration we are taking into account. Obviously from a functionality perspective

being able to have site-specific opt-outs increases the complexity of an implementation significantly, despite the benefits.

- Question (Kristen Madison): Do you expect the regulation to specify the structure of the opt-out process?
    - Response (Sharon Boyle): We have not drafted our regulation language yet but yes, I would expect that we will describe how individuals can opt-out in the scope.
- Question (Laurance Stuntz): And then, just to clarify, if an organization had a local opt-in/opt-out, would that apply locally, or would you be expecting that to be promoted to the centralized location?
    - Response (David Whitham): We do not know that at this point. The initial assessment we are looking at envisions a centralized opt-out, whether or not we can promote that locally is not a place we have delved down yet.
    - Response (Laurance Stuntz): And you may not want to – certain people may only want to opt-out of one provider as opposed to everything.
- Comment (David Seltz): Madam Undersecretary, I am very supportive of the overall approach and I think that was the consensus from the last meeting. I have said this before and I will say it again, and I understand the ease of implementation, and I do think maybe 5 years down the road if we could get to functionality where people can opt-out for certain providers or provider types that would be great, but understand that this is the initial approach and that makes sense. The other thing I want to raise is the idea of an additional local opt-in mechanism, and I think it is the right approach to provide the flexibility for providers to put in place their own opt-in mechanism if they think that is the best for their system and their patients. But I also wanted to reflect that these systems work best when all patients and providers are participating in them. I would suggest that maybe as we go through this we are keeping track in some way of what some of those local opt-in mechanisms are and to the extent that we have entire provider systems that are just not getting their patients opting-in and many other provider organizations are, that we are just monitoring and keeping track of that. We do not want it to be so differential across the Commonwealth, but I also understand the flexibility and I think it is the right approach to begin with – something maybe to just track.

Discussion Item 3: HIway Regulations: Connecting to the HIway

See slides 8-19 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 the connection requirement of Chapter 118I was presented by Sharon Boyle, Chief and Gary Sing.

(Slide 9) *Background* - The other statutory requirement to address through the regulations includes the requirement to connect to the HIway. Chapter 118I establishes a broad requirement that we're going to interpret: "*all providers in the commonwealth shall implement fully interoperable electronic health records systems that connect to the statewide health information exchange by January 1, 2017."* There is a lot of room in there for interpretation, and that is one of the things to focus on today.

(Slide 10) *Three Key Questions about Connecting* - Some of the things we must define in regulations are: who must connect, how we define providers, what does it mean to connect to the HIway, when providers must connect, fees and penalties, and collecting information regarding interoperable

electronic health records. This is the start of the regulatory process we are going to discuss today- we will be looking to gather your initial thoughts and input today.

(Slides 11&12) *Who Must Connect?* - The state will look to develop some provider definitions and define what provider organization types are required to connect, which is something they are still working on. There is a need for taxonomy so that everyone has the same understanding of what we are talking about when we establish the requirements. I (Sharon) have MassHealth expertise and we have some quirky ways of thinking of providers and I bet others do to. I am sure we all do not refer to each other in the same way. That is something we need to work out and where we will need this Council and others to help us define.

(Slides 13-15) *What does it mean to Connect*- Current thinking is that you need to be an active user of HIway services. For example, acute hospitals are an example of a provider organization that we can anticipate will be required to connect and must submit Admit, Discharge, Transfer messages (ADTs) to the state sponsored statewide Event Notification Service (ENS).

(Slide 16) *When must Provider Connect*- What are the deadlines – that is probably causing some anxiety out in the field. Anticipating a phased in approach so that certain provider organizations will be ready to start in January 2017, and then we will roll out the rest over a period of time. This is where we are looking for feedback regarding what is feasible and what makes sense but also keeps us moving forward.

Current thinking will be to look at provider organizations not individual providers. This may be too burdensome for a single doctor to do this. Regulations will require new provider organizations connect to the HIway, while others will have a roll out period where there will be specified dates for provider types and unspecified future dates for other provider types. We may use sub-regulatory guidance to implement over time so that we do not have to keep amending the regulations but we are expecting that we would always give at least a year of notice so that there would be plenty of time for ramp-up. Again, looking to the Council for feedback on whether that is an adequate amount of time or too much time – it would be helpful to hear your thoughts.

- Comment (Patricia Hopkins, MD): In regard to provider organizations, some providers belong to more than one organization and there are all different types – contracted organization, hospital organizations, professional organizations like the Massachusetts Medical Society- I am not sure what is appropriate here.
    - Response (Sharon Boyle): That is a good comment – I do think that is one of the challenges we will need to confront - how to define provider organizations so that it is meaningful for all users.
- Comment (Juan Lopera): I was going to suggest, in regard to the sister organizations that have come through this process already in terms of reporting quality data to the state, such as CHIA and the Health Policy Commission (HPC), the work already done that can be leveraged because that was a significant lift.
    - Response (Sharon Boyle): That is great to hear, thank you.

- Comment (David Seltz): In terms of notice being provided at least one year prior to the requirement to connect, and I apologize for jumping ahead, but in terms of the regulations being promulgated here towards the end of the year, who are we thinking is actually going to be part of that first cohort? And maybe we do not have an answer yet, but something to think about.
    - Response (Sharon Boyle): I am not sure we are ready to say that yet, but you're right.
    - Response (Alice Moore): I will say that there will be no surprises- those who will be required on January 1 probably already know who they are, and those new folks that have not necessarily participated in the same way will likely be given some leeway. But, it will be important to define each group and be very clear in the expectation so that the expectation can be met.

  (Slide 17) *Implementing a Fully Interoperable EHR* - We are expecting that providers who are required to connect- and we know we need to clarify what it means to connect and be an active user of the HIway- that there are a couple of different approaches outlined in the presentation in regard to direct messaging over the HIway and the statewide Event Notification Service depending on the type of provider. We are trying to think about what we can do to establish reasonable requirements to get people using and interacting with the system. [Examples of the current thinking were provided on the slide and Ms. Boyle offered to walk the Council through them.]
- Comment (Mike Lee, MD): The problem we need to keep in mind is the Meaningful Use issue- everyone is sending and no one is receiving transactions which is a consistent problem now so it would be nice for active participation to require receiving. I know that is a different kind of burden, but otherwise it makes it useless.
    - Response (Sharon Boyle): Thank you, that a really great suggestion in terms of everything going outbound.
    - Response (Mike Lee, MD): Our federal government did the exact same thing and they got exactly what they asked for.
- Question (Kristen Madison): With respect to second bullet point where it says provider organizations can satisfy the requirement for direct messaging outside of the HIway. I am concerned about the possibility that it would lead to the exclusion of a group of providers from using the HIway and it wouldn't encourage them ever really to join.
    - Response (Sharon Boyle): Could you say more about what you are thinking?
    - Response (Kristen Madison): It basically says that you can sort of communicate within your own system and as long as you are doing that, and not connecting to the HIway more broadly like everyone else is, that that's sufficient. I do not know enough about the technology involved here to say more than that, other than to say that the possibility that you don't have to use the HIway concerns me.
    - Response (Sharon Boyle): That is helpful to hear – I think the thinking is that the HISP was sort of a bridge to get you so that you are still using the HIway but you are going through this intermediary step. With that thinking does that make sense?

  - Response (Kristen Madison): Yes, as long as they are able to fully transact with everyone on the HIway that's fine with me.
  - Response (Gary Sing): I think the rationale behind that particular bullet point was because one of the most important things the state cares about is increased care coordination between different provider organizations and across different systems. Let's say System A is communicating with System B, and they already have that capability, and are already doing that over HISP for example, and that isn't going over the HIway, we are currently thinking it does not make sense to force that connection, essentially forcing them to use a different pipe. But to your point, we want to make sure that even if you are using that 'off-HIway HISP' as an option that you would still have that ability to transmit and receive messages over the HIway.
  - Response (Kristen Madison): So to be able to send and receive from System C or D and E as well as B, and like to see evidence that they actually do that on the theory that if you have the technological capability and the systems capability of doing that it might encourage you to participate in the HIway more broadly in the future.
  - Comment (David Whitham): In the appendix on page 40 we list the 22 HISPs the HIway is already connected to. One of our goals is to provide as much connectivity as possible throughout the state.
- Comment (Mike Lee, MD): Again you run into a single network, a hospital with community physicians that are essentially on the same electronic platform and they can send to each other and that will qualify for sending and receiving transactions without ever essentially leaving their organization, but they may in fact be different organizations – one might be a PHO and one is a hospital. They will meet your criteria without sending anything over the HIway or in fact enhancing care coordination with anybody except their own company. So I do agree that you are going to need to do something here that requires connecting to a HISP that is outside of their greater organization. It is going to come down to your definition of organization- that really going to challenge you as you write this. That is going to be a very important attribute. You could send something Epic to Epic within the same organization with a direct message without leaving that scenario. Or you could send something Epic to Epic from Atrius to Partners, which would I think be an acceptable use of an electronic exchange without using the HIway. But we still want to get everyone on the HIway because of the connection to the providers that are not in those larger organizations. I think the right approach would be to require a connection to the HIway for a use case, you may not need a volume threshold of transactions, but you still need to be connected. I think you will shoot yourselves in the foot if you allow HISP to work for this. Maybe for the first year that's allowed, but by the second year it's not – so you are not forcing somebody. You don't want to dump something that works, but you still want everyone to be connected- that's why we built this in the first place.
- Comment (Laurance Stuntz): We ran into this as one of our milestones with the eHealth eQuality grants- the reality is that not everyone is on the HIway yet and people are using HISPs- which 'the bits' never have to go over the HIway. Where we came down was basically to require grantees to show us how they could send messages over the HIway even if the use case doesn't necessarily exercise it in the exact example of attestation. There is all sorts of weird stuff going

on with behavioral health organizations, like [those who use the EHR] NetSmart. Half of the behavioral health agencies in the state use Netsmart and communicate to each other. They have a product called Care Connect which uses their HISP and is one of the HIway HISPs, so they have the capacity to do it, but in their use cases they will not exercise that. Part of our due diligence is just making sure that the folks using that Netsmart HISP are communicating outside of their organizations. I am not sure how to write that into regulation, but maybe you make note just as guidance.

- Comment (Alice Moore): We have a ways to go before we draft the regulation – we look forward to all of your comments, assisting us in that endeavor
- Comment (Ipek Demirsoy): I want to invite more discussion about the receiving end of this and about how critical that is. I participate in discussions in various settings and I think there is a spectrum in the sense that, to what extent, if I am receiving, and say, under an alternative payment and I have an incentive to really reduce re-hospitalizations and care coordinate for my patients- is that sufficient incentive to enough to figure out the clinical workflow that is necessary to be on the receiving end of an ADT. I think that's one philosophical view, I think the other one that seems to be in the regulation is we need to specify who needs to do this. So, can you maybe describe in more detail your particular organization and the MU requirements? I think there is a context that is slightly different now, versus the federal requirement for Meaningful Use in the context of how the state is moving to alternative payment methods – so I think it is worth having further discussion.
    - Response (Mike Lee, MD): Sure, and I don't want to bog anyone down with Meaningful Use which is so overwhelmingly complex and ever-changing. For example for Meaningful Use more than 10% of the time you must send a summary of care electronically to another provider, but a vast majority of providers in our state do not receive any of our transactions and the ones that do actually discard them, so they are not actually incorporating any of that clinical data anywhere. Currently Beth Israel is sending transactions, Children's Hospital is sending transactions, Partners is sending transactions, all of which we incorporate electronically, but that has been relatively new over the last couple months. And there are glitches in that as we are all learning from each other as we go through this, but the ability to receive is not inherent on whether or not we are going to send. To have us send something to a provider and not have them actually use it when we used to have a postal letter which sometimes at least we hope they read. What we don't want to do is confuse ourselves and think that we are actually doing something more clinically when we are not. That is what worries me – we get into a standard where sending the electronic transaction is easy and it's working but some people are not taking them at all- that means they are actually practicing blind where at least they used to have a postal letter- and do we have to do both in order to meet with our clinical community. We deal with specialists and dozens upon dozens of communities in the state - we want to make sure that at least if people are required for their licensure to be connected that they at least at some point be able to receive a message. Whether they use it or not is their own clinical judgement. It is hard on that end, not all EMRs can do that right now and that's why I think the timing piece may be

how you get at it, but at some point people need to be able to receive an electronic transaction and I do not think that's so far beyond the realm of possible for most EMR vendors. Does that help answer your question?
    - Response (Ipek Demirsoy): Yes, I think so – and I was kind of thinking about the intersection of this versus transitioning to alternative payment methods. Is putting this into the regulation the best way to promote that because really the system is moving in that direction and if I were a reasonable provider I would want to be able to receive that and incorporate that into my clinical flow – I think that is a tradeoff I just wanted to bring up here.
    - Response (Mike Lee): Right, you do not want to mandate that a small provider change their EMR because they cannot receive messages – that's a situation I do not think we want to be in. From an alternative payment model standpoint people are going to do anything they can, if you are really taking on that kind of risk like we are, to really try to figure this out so I do not think these regulations will impact that in any way unless they are receiving.
    - Response (Alice Moore): I'd like to move us along, thank you.
    - Response (Manuel Lopes): If I may, there was one point in the discussion, without getting too far into the regulations that we should at least conceptually agree on the point around 'what does it mean to connect.' I think what I heard was that we should consider is the interoperability between provider organizations as opposed to just within your own system. You could in theory meet the criteria by talking within your system, but to be interoperable I'd expect that you'd probably want to consider talking outside of your system especially with the leakage that happens outside of your system – and you want to keep the care integrated. I feel like that is an important conceptual consideration for us, but I think what I heard Dr. Lee mention, is that it should be at least communication with one other system outside of your own.
    - Response (Mike Lee, MD): I think that is where defining an organization is going to be a huge challenge.
- Comment (Alice Moore): So the process for continuing to take comments as you are drafting – is that through the working groups of this Council? How would you like to receive comments?
    - Response (Sharon Boyle): Yes, I think that is a really good way to get the best possible product before formal publication.

The slide provides additional examples of current EOHHS thinking based off of recent discussions. For example, provider to provider communication would be an example of active use and further examples would be a hospital sending a discharge summary to a skilled nursing facility or a rehab facility, or a primary care provider sends a referral notice to a specialist. Everything up here is about sending so that was a great point. Other examples could be a hospital emergency department requests a patient's medical record from a primary care provider, the primary care provider sends what I believe is called a CCD -

- Comment (David Whitham): A Continuity of Care Document, it is a national standard.

The document contains things like problems, medications and immunizations. That is one set of examples being explored. The other is payer case management where an Accountable Care Organization (ACO) for example, sends quality metrics to a payer or a provider sends lab results to a payer, or a provider sends claims data to a payer for purposes of case management. Quality reporting, communicating with a provider, communicating with a business associate for data analytics for quality purposes. And finally public health reporting- there are number of reports required to go to the Department of Public Health (DPH) which is another way the connection could be demonstrated. Those are the thoughts so far.

- Comment (David Seltz): I know we want to keep moving here, but if care coordination is really a goal here I don't know, and I know this is very important and is the biggest source of volume over the HIway, but I don't know that public health reporting- just sending data to DPH is moving us down the line on care coordination.
    - Response (Sharon Boyle): Fair enough, that is good feedback, thank you.
    - Response (Ipek Demirsoy): I would agree with that statement from a payer point of view- I think that is the ultimate goal. Really making sure the HIway enables care coordination and innovative care delivery across physical health, behavioral health, long-term services and I would take it as far as social services. So I think that is the nirvana but it is going to take us awhile to get there- overall that is the best use of the HIway.
- Comment (Patricia Hopkins): Part of the problem is, so when the patient trips an ADT, if you are the coordinator of care and you want to take charge of that switch and bring the patient back out it is absolutely impossible. The ER will not allow it, the hospital will not allow it, the physician assistants will not allow it, the patient will not be seen by another doctor because it trips another switch. We have been working on this at South Shore, we are overpopulated by 100 patients every day and the ER will not discharge to a primary care doctor's office. It must go all the way through the system and loop around through the inpatient services department, all while people are trying to get in touch with specialists. To really change and respond to alternative payment systems you have to have someone bright enough to make the decision that we are going to reverse the utilization of care or draw it back into a lower cost environment – right now it is an impossible train to stop.

A few additional points were made about what the state hopes to accomplish. They will seek to clarify that provider organizations, which will also be defined, must send transactions over the HIway for at least one direct messaging use case and the state will define those use cases and give some examples and absolutely think and address the concern about not just sending, but also receiving. They anticipate requiring acute care hospitals to send ADT messages to the statewide ENS once it has been launched – that is similar to how other state HIEs have implemented ENS. The state believes that is very doable for hospitals. The state will establish through these regulations, in accordance with Chapter 118I, that the HIway is the statewide HIE and, based on comments today, think more about the HISP connections.

(Slide 18) *Proposed HIway Regulations Timeline*- The state is anticipating that there will be a roll-out with certain types of provider organizations required to connect for direct messaging purposes in January of 2017, while they are anticipating others will come in January 2018 and 2019 – again those are dates that the state is suggesting and is looking for feedback on. Even after that, if there are some provider organizations that are not going to be ready yet, or need a 'sometime in the future' expectation as they gear-up. The state plans to leave enough room for sub-regulatory guidance to be issued to tell folks when they may be subject to these requirements. In every case the state expects to give at least a year notice and they do expect that acute care hospitals will be required to connect to the HIway and use the ENS within a year of our launch. In regard to fees and penalties the state will address those in the regulations as well.

- Question (David Seltz): Sharon, just to clarify, for the ENS that is within one year of launch of the ENS service?
    - Response (Sharon Boyle): Yes.
- Comment (Laurance Stuntz): This seems to lay out that, at some later time, which since we are moving out to 2017-2018-2019, basically means 2020 or later we are going to – I guess I would encourage us to say 'all others' or something like that for 2020, because leaving it open always leads to an inclination to let it slide and not push it- particularly because three years should be pretty sufficient to get everyone on the HIway, especially with the EHR requirement you have to connect. We are not saying you have to buy an EHR, we are just saying you have to have the capacity to exchange information electronically is long enough.
- Question (Deborah Adair): Do we have an idea of when the ENS launch will be?
    - Response (David Whitham): No, not yet.

Another thing the state will be dealing with is the 118I requirement for provider to use a "fully interoperable electronic health record system." As many in the room know there is no national standard for what that means so the state is proposing to define it themselves as meaning the ability to send direct messages using the HIway. However, the state does expect that national standards will evolve over time and the state will do its best to stay up with those. The state is expecting to have a mechanism to tweak standards so that they come up to par with whatever the national guidance may be – likely through sub-regulatory guidance.

There will be an attestation requirement in order to keep track of use and how it is going out there – MeHI will assist the state with this.

It is an ambition plan, but EOHHS is working to develop a draft for June- more realistically for July. They will be engaging stakeholders in advance of the formal engagement process. There will be a public hearing and comment period in the fall and the final recommendations will be promulgated by Christmas.

Discussion Item 4: MeHI Operating Plan Overview

See slides 20-28 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.

Massachusetts Laurance Stuntz provided an overview of the MeHI Operating Plan

Mr. Stuntz noted that the Operating Plan and supporting documents were sent out in advance for review prior to the meeting. As a reminder, as part of MeHI's governance under legislation, this body, the HIT Council, has a responsibility to review and comment on the MeHI Operating Plan and our expenditure of the eHealth Institutes budget. For new folks this is something that we do every year, but if at any time you are interested or have questions or comments please reach out. MeHI also worked very closely with the Executive Office of Health and Human Service MassHealth and stakeholders across the community to guide the MeHI Operating Plan and use of the budget.

From a timeline perspective we have vetted this plan with an advisory group MeHI put together, a first pass with the Mass Tech Executive Committee, which has responsibility to approve, and are going back to the Executive Committee June 30th to ask for final approval of our operating budget for next year, which starts the following day (July 1st).

(Slide 21) *Strategic Context and Positioning* – To set context around the MeHI initiatives and the various activities going on - a couple of things they are kicking-off, or already have kicked-off, and some of the folks in this room have been engaged in trying to figure out where MeHI can grow their involvement and understanding of how consumers engage with providers. MeHI is initiating some research in this area and some activity around basically understanding more, we are going to focus research in the area of care giving and caregivers after a conversation with a bunch of stakeholders, in particular the Secretary of Health and Human Services, to try to understand how to better use technology to reach caregivers and to give them more support – whether that is caring for elders, for children, or for people with a disability. That is something MeHI is initiating now and will continue into next year.

MeHI is growing and investing in the area of digital health cluster development with something you may have seen come out recently in news reports. On January 7th the governor launched a digital health initiative and has charged MeHI with basically acting as the states arm to push that forward. It is in the governor's economic development bill and a piece of that was actually in the jobs bill that was passed last session as well. Last week MeHI announced its investment, but with a whole bunch of other folks, in a new and expanded space that will be run by MassChallenge out of the Landmark Building and have cross-space with an Accelerator called Hatch – so it is pretty exciting and interesting. From a maintaining perspective the programs you see on here are things that MeHI had in existence for the last few years and they are basically continuing them. Included are things like the Connected Communities Program. Those grants have kicked-off and on June 14th MeHI will have a launch event and the announcement of those grants. eHealth eQuality grants are continuing along, and the Medicaid Meaningful Use Program MeHI manages on behalf of MassHealth will be continuing. Two areas that will be taken off of the list, are because the federal grant for the Regional Extension Center ended and the eHealth Services area where MeHI was providing hands on support. Just looking at the budget, our capacity, and the fact that we are a state agency and wanting to be able to provide free resources to anybody who needs them, the eHealth Services model did not work particularly well in that model so MeHI has decided to discontinue that.

(Slides 22&23) *Operating Plan Design Principles and Themes* – In terms of the initiatives that MeHI has going, and this remains in the context of the strategic plan that was finished up in June 2014, we initiated about a year prior with a focus on digital health cluster development and the broader digital health initiative. We are really trying to tie together the various activities that we have in encouraging innovation and adoption of electronic health records to capitalize on Massachusetts' position as the most connected and the most digital, from a healthcare perspective, state.

As mentioned MeHI is transitioning the hands-on support being done prior, to a broader based model. From a financial perspective and the planning horizon, and for folks that don't know, most of MeHI's work is funded through a fund called the eHealth Institute Fund, which you can see in the financials that were distributed to the Council. This was initiated in 2008 and re-upped in 2012, but will likely be exhausted in 2019. MeHI will obviously be looking to change that and discuss plans for that with stakeholders this year. There are also proposed plans to balance the eQuip budget.

Laurance invited questions about the proposed initiatives.

- Question (Ipek Demirsoy): As part of the grant programs you have taken a pretty hands on approach in terms of working with providers and making sure they can really do care coordination and the provider to provider communication that we need them to do, so I am curious – in the state, I kind of look to MeHI as one of the Subject Matter Experts (SMEs) on that topic, and a lot of other provider organizations are doing that on their own to a certain extent – but if you were to guess what percentage of the market in terms of technical assistance does MeHI currently own and how do you see that vs others participating in that activity. There is a lot of learning, what is the value of adding that with regards to others also kind of participating in that activity and the reason I am asking again is that there are a lot of little learnings from that thread and what is the value more broadly as more and more providers are moving in that direction and does it make sense for every single provider organization do that versus MeHI playing a more central role potentially?
    - Response (Laurance Stuntz): I am not sure I will hit all the points of the question but one of the things we looked at for next year, form a resource perspective, was being able to provide hands on support. It costs way more money than we have available to do it. So what we decided to do from a leverage perspective was, and it made the most sense, is to provide learning groups and learning collaboratives to develop best practices around particular areas of interest. For instance, one that has been identified is around behavioral health integration and working to develop best practices for centers that want to integrate behavioral health with physical health. I have no idea really what the market for technical assistance is. One data point that we found was from the Regional Extension Center, which had to focus on primary care providers. We ran out of people to sign up which was a good thing, we just could not find anyone out there that had not yet adopted an EHR. So the market or the need for technical assistance, at least for basic EHR adoption is decreasing dramatically. One of the things we are doing this summer is to really try to codify and get to real numbers on how many more providers are left to

adopt an EHR. That is a long way of saying I do not know the exact answer to that, but it is definitely diminishing. We see our role as, or at least the need in the state, as getting away from technical assistance and more into educational on what's coming, which may lead to more technical assistance, for instance as more folks get into alternative payment models we anticipate needing to provide more education and potentially hands on assistance. Also, a lot of the calculus is a resource constraint. The Regional Extension Center was a federal grant given to us for about $10.5 million dollars over only a few years. That is more than the resources we have to support all of the rest of the stuff we have to do. Does that help answer your question at all?

- Response (Ipek Demirsoy): Yes, sorry it was somewhat of a loaded question.
- Response (Laurance Stunts): And I think trying to figure out how best to leverage those resources will be important, and trying to get information out to those providers in an effective way.

(Slide 24) *Digital Health Initiative*- MeHI has divided its efforts into three key areas based upon what folks told us what was most needed:

A Digital Health Marketplace Program to try to bring together start-ups to get their ideas vetted more quickly and bring them to market more quickly in a viable way. MeHI is working with stakeholders, providers, payers and investors to design a program right now that would effectively do that and bring needs from the community across all provider types to entrepreneurs so that those entrepreneurs hopefully can discover those needs and more quickly develop solutions .

The Digital Health Hub and Cluster Convening initiative is really about networking and bringing together the entrepreneurs, the companies and the providers. The Pulse at Mass Challenge is a huge part of that.

The Health Data Initiative brings together stakeholders both from the public side to provide greater access to health data, as well as to the private side and non-profit side to try to bring together folks who can analyze that data in different ways. For instance, what if there were a standard way of getting access to private data, bringing folks to a standard agreement which entrepreneurs could sign, or a certification that they could go through that would give providers a sense of confidence that this entrepreneur or organization really knows what they are doing and can interact with my data in a safe, secure and reliable way. Coming up with standardized agreements is on MeHI's list of things to do within the Health Data Initiative.

(Slide 25) *Connected Communities* – Within the Connected Communities, MeHI is managing community grants. They are kicking-off consumer engagement with a focus on caregivers and they continue working with and trying to organize conversations with vendors so that vendors have a good understanding of provider requirements around interacting with the various Massachusetts electronic systems.

(Slide 26) *eHealth eQuality* – Right now MeHI does a lot of work with the vendors in the Behavioral Health and Long term Post-Acute Care (LTPAC) space and will continue that as well as trying to categorize the way people are connecting to each other. MeHI is developing educational materials and

update on consent will be added to that once finalized. They are also starting to work with the Massachusetts Coalition for Serious Illness Care and have a vision around putting together a group of stakeholders to define what would really work in terms of capturing Advanced Directives and making sure they are accessible at the point of care. There are a lot of issues to be uncovered there but those are the key things MeHI will be working on.

*(*Slide 27) *Education and Outreach* – MeHI will continue to provide webinars and learning activities to educate providers. If folks have any announcements or messages to share with the provider community, particularly around state activities let me know – MeHI has the infrastructure to support getting that out to the world.

(Slide 28) *Medicaid Meaningful Use Incentive Application Program* – MeHI continues to support Medicaid Meaningful Use contract. One observation was that the applications are taking longer to complete and review so MeHI is increasing assistance to applicants and working with MassHealth on how to streamline internal operations.

- Comment *(*Karen Bell, MD): You brought up the whole concept of care integration, which is very different than care coordination, and I am wondering to what extent are you thinking about how can we as a community think through how we can use the HIE to push more into this effort of more integrated care that really focuses on continuing care for the patient, rather than the providers just exchanging information.
    - Response (Laurance Stuntz): Yes, and I think the Behavioral Health Integration Workgroup is an example of that. I think integrated care and sharing of information, whether that is through integrated case management or integrated care management. From my perspective MeHI can help support those as they bubble up from the community. There are so many different examples of that. For instance, the Connected Community grants are designed to take projects that are really about integrating care management and providing them with some funding to try it out and see what outcomes we get and that we can take out to a broader community across the state. I think that we can help by providing some seed money and sharing those effective examples.

Conclusion

See slides 29 and 30 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.

Alice Moore provided closing remarks before adjourning the meeting

The next meeting of the HIT Council is August 1, 2016 3:30-5:00 PM.

The HIT Council was adjourned at 4:54 PM.

Note: The regular operations slides (slides 35-41) were provided for review offline due to meeting time constraints.