MINUTES

Massachusetts Health Information Technology Council Meeting

May 3, 2010

3:30 – 5:00 pm

Matta Conference Room
One Ashburton Place
Boston, Massachusetts

MINUTES
MASSACHUSETTS HEALTH INFORMATION TECHNOLOGY COUNCIL

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Attendees:

Council Members	JudyAnn Bigby, MD - *(Chair) Secretary of Health and Human Services*
	(Jay Gonzalez - *Secretary of Administration and Finance)***
	Represented by: Marcie Desmond
	(Terry Dougherty - *Director of Medicaid)***
	Represented by: Philip Poley
	Karen Bell, MD - *Chair of the Certification Commission for Health Information Technology (CCHIT®)*
	Lisa Fenichel, M.P.H. - *E-Health Consumer Advocate*
Other	David Martin (EOHHS)
	Claudia Boldman (ITD, CoMA)
	Bert Ng (Healthcare Finance Committee)
	Jessica Long (Conference of Boston Teaching Hospitals)
	Karen Welsh (CMS)
	Barbara Klein (Concordant)
	Foster Kerrison (Edinboro University)
	Michael Gilbert (Arcadia Solutions)
	Jan Roce (ML Strategies)
MTC Staff	Mitchell Adams
	Dr. Richard Shoup
	Judy Silvia
	Bethany Gilboard
	Glen Comiso
	Angelia Lewis
	Carole Rodenstein
	Barbara-Jo Thompson

The twenty-third meeting of the Massachusetts Health Information Technology Council was held on May 3rd, 2010, in the Matta Conference Room at One Ashburton Place in Boston, Massachusetts.

As Secretary Bigby would be joining the meeting late, Dr. Richard Shoup called the Meeting to order at 3:34 p.m.

AGENDA ITEMS

As the secretary is running late, we will defer voting on the minutes.

I. Review of Proposed Regional Extension Center (REC) Business Model

Dr. Shoup mentioned that Carole Rodenstein of the Massachusetts eHealth Institute (MeHI) had worked hard on the REC Business model with Angelia Lewis, Bethany Gilboard and the team. He then asked her to update the council on the REC Business Model.

- 20,000 providers means physicians
- Priority vs. non priority.
  We can service as many as we wish of non priority providers – for a fee --, but only have funding for priority.
- Proposed MeHI Value Added Services (slide not in handouts)
  - Hiring Clinical Relationship Managers (CRMs)
  - Need to be aware of changes in regulations and law
  - 2 packages: Initial and ongoing
- Initial REC Services
  - Expectation is that MeHI staff will provide services to providers and their staff
  - Working with Implementation Optimization Organizations (IOOs) to get certification to get to meaningful use
  - Role of REC is to do due diligence on IOOs and vendors. We know the providers should practice medicine not search through vendors to determine what they need so we will assist.
- Additional services include what we will do for the provider in his own community.
  - We will do a readiness assessment with the providers to help them determine where they are and where they need to be.
  - We will help with language with contracts and negotiating
  - These services will help get them to meaningful use

(Secretary Bigby arrived at 3:41.)

- Ongoing REC Services
  - Work to provide education, outreach, techniques of communication, etc…
  - From a Community of Practice angle it is important to work with them to get physicians talking to physicians
  - Working with Medicaid for certification program
- Other ongoing services
  - We know that Meaningful use has 3 stages and that HIPAA changes over time.
  - The REC working with the Health Information Exchange (HIE).
  - Things are changing that we might not even be aware of at this time
  - Not only do we need to get them to meaningful use but we then need to help them sustain their systems.
  - Leverage on Computer Physician Order Entry. (CPOE)

- Working with Massachusetts Broadband Institute (MBI) to get broadband services to underserved areas.
- Collaborate with Department of Public Health not only implementing but also helping them improve quality of care.

Council Members posed a few questions and discussion points regarding the REC.

- Huge amount of work and a wonderful approach
- Our goal with regard to priority types: Curious if there are goals in what you are hoping to achieve in regards to those areas
- Many are in large delivery systems. Even though we may see them as independent are they getting other services?
- Great idea of marrying the REC with "Patient Centered Medical Home"

We are bringing together a group to find out how to link the medical home with the Regional Extension Center.

In regards to the statement of Priority types, that is a topic we have spent a lot of time on, part of what we are currently doing is to work through a prioritization model to be sure we are targeting the right people. It is not to get 2500 providers, but that we get the right 2500.

The conversation continued:

- Regarding meaningful use guarantees, getting there is only 30%, but there is a piece that is the physician and he may not have done the work to get to meaningful use in time but hopefully the self assessment will help show where he is. But concern about giving guarantees, not just regarding the REC or the IOOs but the physician. Shouldn't we be careful about guaranteeing?

Response – in the contractual language we are going to be sure we are fair to the vendors. For example, here are the exact things you need to do to get there… and they need to do it. But the CRMs should be able to recognize and identify providers that are struggling.

- What if there is a person that just does not look like they are going to get there or they don't have staff buy in and just won't get there, do we make allowance for that?

Response – it would be worse to bring someone part way forward. It will be necessary that we have those conversations at the onset. They may need to do something to get ready to sign up.

- Does this mean you will help with the negotiation?

Response – The goal is to negotiate up front to design a few packages, but also allow flexibility for the provider to adjust as needed.

- There is a lot about clinical information being robust and that the REC would be the vetting organization to be sure that information would be good information, but how would that play out?

Response – We did not feel we could do that ourselves, but as we see some of the responses from the IOOs, the short answer is we don't know yet. In our ongoing updates to you we will get more information.

- You have done a great job to tell the story of what the REC will do.

REC Business Model:

- The REC receives $5000 per provider. The model will pass those funds ($4500 - from Paper and $2500 from currently installed EHRs) on to the IOOs. We are going to charge the provider an initial fee ($600 for Priority and $800 for non-Priority Providers)
- We are looking at the value of the services
- We have 4000 estimated Medicaid eligible providers and MeHI would be the certifying body for those funds
- Chapter 305 also has assumptions, it assumes MeHI will certify. As a REC member as they reach meaningful use, they will also receive their Chapter 305 certification.

Proposed fees:

- Fees would continue until they reach meaningful use, then the fees would drop to $100 per year.
- The funds are not buckets of money but what they receive at various milestones. We do not receive the funds until they reach those milestones.
- The providers: Medicaid and Medicare incentives exceed what they would receive from the REC.
- Provider fees in comparison to Medicaid – Medicare providers. There is no money that goes directly from Physician to IOO. However, the physician can pay for extra services to the IOO.
- We did extensive validation with other states and Massachusetts has lower provider fees than most states
- When having dialogues with delivery organizations we heard that we have good options
- We want to help give an incentive so they get to meaningful use quicker
- Revised revenue implications, bring back to a model that is sustainable to be sure we are making thoughtful assumptions
- We have to realize not everyone will get there in one year

Council member comments:

- What about the consumer?

Response – this is not a portal for the consumer

II. Updates

- **REC Supplemental Funding Opportunity**

Dr. Shoup walked through slides "Critical Access Hospitals and Rural Hospitals Funding Opportunity" this will add to our existing REC award.

- **Ad Hoc Workgroups**

So far we have very strong co-chairs.

Health Information Exchange (HIE)
- John Halamka, MD, BIDMC and NEHEN
- Phil Poley, COO, MassHealth

Clinical Quality and Public Health (CQPH)
- Jim Daniel, CIO, DPH
- Barbara Rabson, CEO, MHQP

Privacy and Security (P&S)
- Dave Szabo, Edwards Angell Palmer & Dodge
- Louis Kaczmarek, ISO, DPH

Consumer Engagement
- Georgia Simpson May, Office of Health Equity
- Martha Hayward, Partnership for Healthcare Excellence

Workforce Development
- Judy Burke, Middlesex Community College
- Ray Campbell, Executive Director, Massachusetts Health Data Consortium

The REC / EHR workgroup will meet tomorrow. We have a comprehensive plan that the dependency between groups is monitored closely and we have already started the process.

Council Comments
- The ONTRAK tool is very helpful, but sometimes not.
- One issue is that you can't pick and choose your ad hoc group to send things to.
- It is overwhelming – not easy to navigate
- It is static – does not promote collaboration

Response - we could post a document that lists Ad Hoc members' email, also will consider a different tool.

- **Governor's National HIT Conference**

Dr. Shoup started the update on the conference by asking everyone in the room, "What do you think of the Governor's conference?" The response was applause.
- Very Successful
- Still waiting on reimbursement requests
- Right now in the black
- No follow-up participant survey planned

Secretary Bigby would like to acknowledge Dr. Shoup, Ms. Silvia and all the others at MeHI; also David Martin who kept pushing to ensure that everything happened.

Secretary Bigby added a few comments and feedback

- Had people tell her they had never attended a conference to learn so much
- Two areas that we need to focus attention - Workforce Development (there are a lot of jobs coming on line and a lot of people who need those jobs) and the PHR. We said we were going to put off the PHR and the hybrid model but if we are going to take this seriously we need to do it now (from the Governor's panel)

Council Comments:

- We keep thinking of HIT as a delivery system but we need to recognize that it is important for everyone (ie, biotech and workforce)
- There is clearly a lack of and desire for more collegial exchange of information and a fear there is a redundancy that is going on and developing. People didn't want conversation to end during breakout sessions and many were admitting what is not working. Is there a way to continue after the conference?
- There were plenty that said "see you next year!"
- All kidding aside we noticed that there is a hunger for it to occur yearly
- We need to hear the physician voice. People trust their physicians and we need to hear from the physician regarding Privacy and Security. Patients trust the physician as he is the one holding the information.
- Attendees from the Western States didn't even know one another. The questions we gave were a bit over reaching. We had to prompt them to get to areas of collaboration
- Many were very interested in Workforce.

Response – workforce is the only area we have not received funding for, however the Office of the National Coordinator has set up some collaboration tools. We have met regularly with the New England States which we can leverage. Also, we intend to have a follow up with MHDC to put as much as possible on the MeHI website and to be sure we give contact information to all attendees so they can contact one another. So people not only had a good experience there but also great take aways.

Secretary – we have the minutes from April 5th to approve – accepted.

III. Approval of April 5th Minutes

After motions made and seconded, it was unanimously agreed to accept the draft minutes as the official minutes of the April 5th meeting.

IV. Other

Dr. Shoup distributed hard copies of the HIT plan.

With no other business to discuss, the meeting adjourned at 4:30 p.m.