MINUTES

Massachusetts Health Information Technology Council Meeting
September 30, 2009
4:00 – 6:00 pm

Matta Conference Room
One Ashburton Place
Boston, Massachusetts

MINUTES
MASSACHUSETTS HEALTH INFORMATION TECHNOLOGY COUNCIL

September 30, 2009

Attendees:

Council Members	JudyAnn Bigby, MD - *(Chair) Secretary of Health and Human Services*
	(Terry Dougherty – *Acting Director of Medicaid)***
	Represented by: Philip Poley
	Deborah Adair - *Director of Health Information Services / Privacy Officer Massachusetts General Hospital*
	Karen Bell, MD - *Senior Vice President of HIT Service at Masspro*
	David S. Szabo - *Partner with Edwards Angell Palmer & Dodge*
	Lisa Fenichel, M.P.H. - *E-Health Consumer Advocate*
Other	David Martin (EOHHS)
	Kimberly Haddad (Committee on Health Care Financing - Senate)
	Bert Ng (Committee on Health Care Financing - House)
	Cathleen McElligott (DPH – Office of Rural Health)
	Adam Delmolino (Mass Hospital Association)
	Maria Tinsly (VA Medical Center)
	James Fuccione (Home Care Alliance)
	Jessica Long (Conference of Boston Teaching Hospitals)
	Larry Garber, MD (SAFEHealth)
	Lorllyn Allan (Lahey Clinic)
	Whitney Patterson (Regis College)
	Kevin Schwartz (Concordant)
	Bob Strong (Pro Caseo, Inc)
	A representative from Microsoft (*he didn't sign in*)
MTC Staff	Glen Comiso
	Bethany Gilboard
	Judy Silvia
	Barbara-Jo Thompson
Deloitte Staff	Doug Beaudoin
	Michael Marino
	Eric Finocchiaro
	Lisa Sherwin
	Kevin Carr, MD
	Alex Contreras
	Jyotin Gambhir
	Hussein Jaffer
	Giao Le

The fifteenth meeting of the Massachusetts Health Information Technology Council was held on September 30, 2009, in the Matta Conference Room at One Ashburton Place in Boston, Massachusetts.

Secretary Bigby called the Meeting to order at 4:04 p.m.

AGENDA ITEMS

I. Approval of September 2nd and September 15th Minutes

After motions made and seconded, it was unanimously agreed to accept the draft minutes as the official minutes of the September 2nd and the September 15th meeting. (with one minor edit to the Sept 15 minutes)

Secretary Bigby stated, "Excitement for us now." We are going to walk through the preliminary final recommendations of the HIT Strategic plan.

Since Mr. Adams would be delayed and Dr. Shoup was unable to attend, Secretary Bigby turned the meeting over to Dr. Kevin Carr of Deloitte to walk through the preliminary final strategic plan.

II. Updates on Strategic Plan:
   a. High-level overview of Key Recommendations

Dr. Carr started with a brief overview of the strategic planning process. He further expressed that once all are in agreement; the HIT Council will have the opportunity to review and comment – prior to removing "preliminary."

He explained that the Council had two things in front of them, the first he referred to as a "place mat" due to the size. The second was the standard meeting packet.

The reason for printing the document so large was because these two components are key. It was printed larger than life to give the Council a chance to look back to see how the presentation on the screen links back to the preliminary application. On one side of the place mat are MeHI Key Activities the other side is a diagram of the MeHI Stakeholder Engagement. (pasted on page 2)

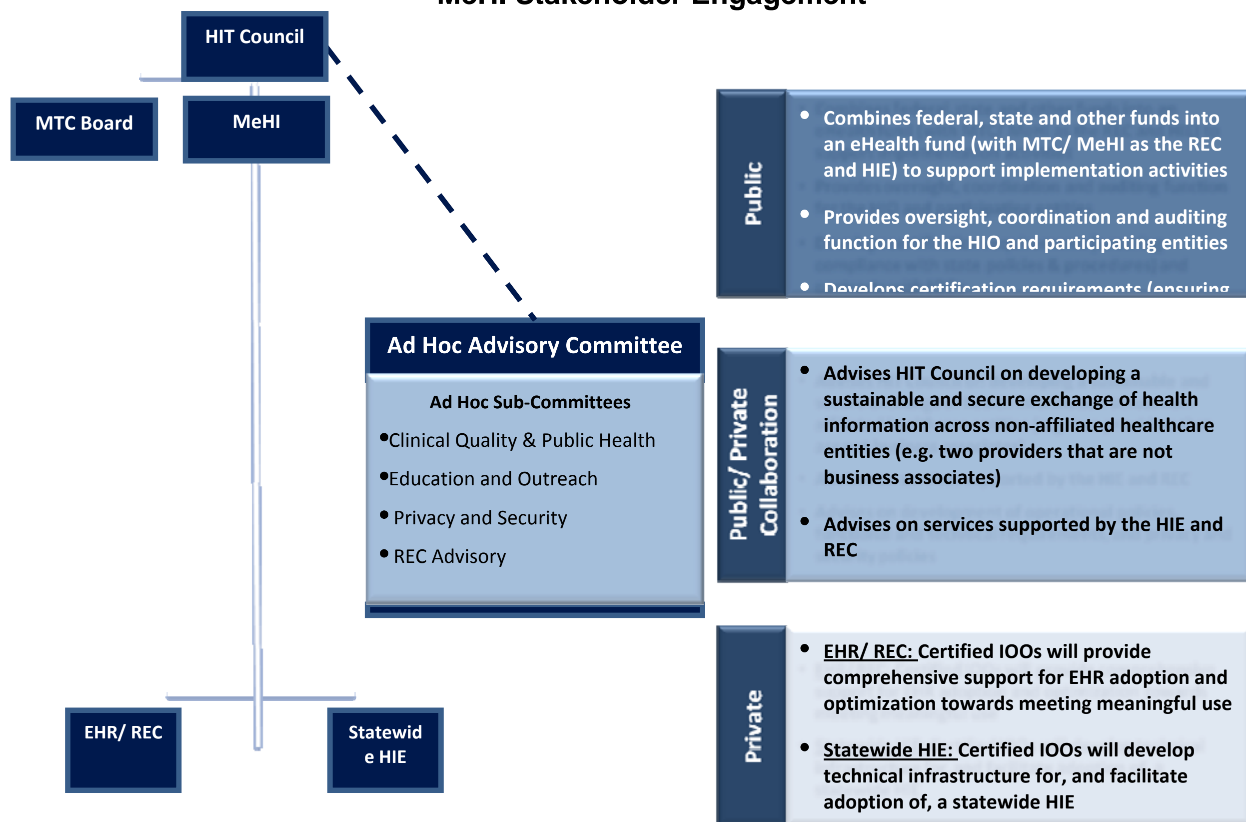
Dr. Carr started with the time line explaining all the work to date. He went on to show all the meetings that have occurred since this project began.

Governance

MeHI is always actively involved with the private sector. It aims to promote a public private partnership.

The HIT Council is key for driving principles of the plan. The Council will prioritize for MeHI and determine which activities to fund.

In addition, Chapter 305 specifically states that the Council and or MeHI should reach out to gather additional expertise if necessary. That is where advisory ad hoc committees would come into play.



MeHI needs to file with the Ethics Commission prior to adopting any advisory committee.

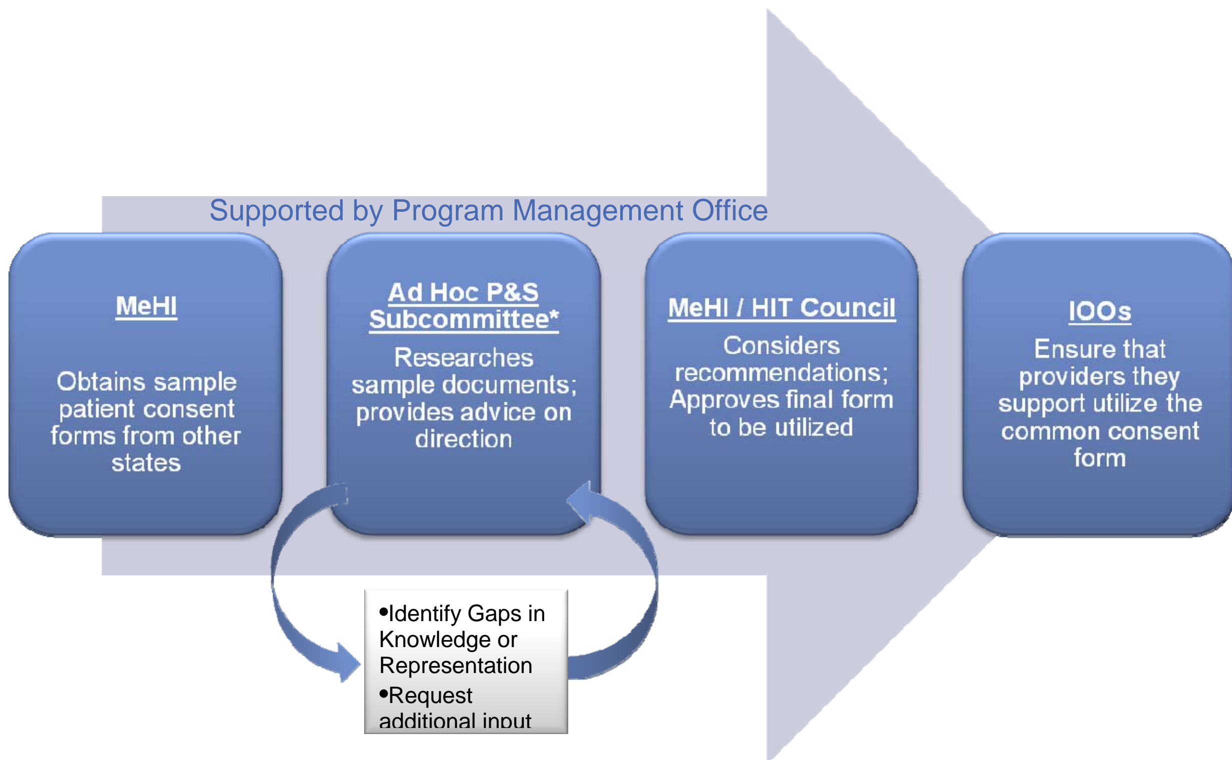
Ms. Fenichel asked if the Ad Hoc Committees are seen as stable or ever changing. How are they chosen? What is the incentive for people to give of their time? Answer – if you are a beneficiary, you can not have oversight on how those funds are utilized. You cannot write an RFP to give funds to your-self. The Council can choose members of the committees as needed.

Dr Bell suggested that in that light of this maybe best not to name them. Then it will be clearer that this is not an on going process. Judy Silvia indicated that MeHI will be filing this structure with the Ethics Committee, we must be sure we do it correctly. Dr. Bell added that as an on looker, MeHI is very engaged with private stakeholders and current ethics laws.

Ms. Fenichel asked if there are any problems, and that is why you file with Ethics Commission. Judy Silvia explained that we need to be sure that no one is precluded from bidding on projects. Ms. Fenichel asked if the structure was being put to the Ethics Committee or is it the individuals. It is the structure and the individual roles.

Dr. Carr then walked through an Example of how MeHI with the help of an advisory ad hoc committee may put together a consent form.

Example 1: Develop a Common HIE Patient Consent Form



Secretary Bigby added that this demonstrates the narrow nature of a task. Once it is done, it is done, it goes away. The Council then determines if there is a new question the group can work on or are they done. This is the beginning of the strategic plan. You will need to engage additional stakeholders outside the HIT Council.

Ms. Fenichel asked about consultants that were vetted early on. Is this not a role that they could play? Answer – the Council determines the areas where expertise is needed. There will be ad hoc advisory groups, if the group doesn't feel qualified to make a suggestion or to vet an issue then the Council may decide if outside consultants are necessary.

Ms. Adair asked Dr. Carr to talk more about what would be "Supported by the Program Management Office". There needs to be someone there providing support, or even creating a deliverable. For example, we need a consent document, and then we need them to come back with one.

Regional Extension Center-REC

Dr. Carr - MeHI has applied to be the REC for the state.

Regional Extension Center Implementation Approach

- MeHI considered the four approaches to implementing the Regional Extension Center
- Each approach had varying state procurement process implications
- Option 4 was selected because it struck the appropriate balance between MeHI's roles and responsibilities and those of the IOOs

Option 1: MeHI staffs Regional Extension Center PMO and provides minimal "feet-on-the-ground" services, which are largely contracted out to IOOs.

Option 2: MeHI provides direct grants to Providers that can only be used to contract for services with certified IOOs.

Option 3: MeHI staffs a fully-functional Regional Extension Center or creates a separate REC Organization to provide full EHR implementation and optimization services.

Option 4: MeHI staffs PM / Practice Liaisons to serve key client-facing, project management roles on each MeHI-funded implementation.

Dr. Bell added a possible option 5, the current option 4, seemed very administratively heavy. The one that NY City adopted is a customer management organization, but work is done by IOOs. Dr. Carr stated that was in the discussion and our intent. You don't want to duplicate, you want the face of MEHI. MS Gilboard explained that MeHI would act as an agent for the provider and assist in identifying the best match for a provider and IOO. Dr. Bell added we must be specific about the MeHI role. Dr. Carr added that we will go back and revisit the wording to be sure that it accurately reflects the intent.

Mr. Szabo asked boots on the ground, audit, owner's rep; overlay of management, how scalable is this? Is it spilling ink on glass that will spread fast? Will 2-5 FTEs do it?

Dr. Carr, from a strategy perspective, will MeHI have a relationship or no relationship. They selected to have a relationship, but a thin relationship to insure they are involved in the front end. Let the IOOS do what they do well. We all know 2-5 FTEs depends on relationship at the front end, as providing assistance has a lesser role. It is linked to the services. Dr. Carr asked Bethany to comment. Bethany answered. If an IOO has been certified and has been vetted by MeHI a provider can be assured that the process will be handled properly. The client is provider and not the consumer.

Ms. Adair so we all agree what the intent is. It just needs to be wordsmithed.

Dr. Bell stated that MeHI is funding more than implementation, we need to fix that language.

Ms. Adair, stated why couldn't any consumer issue be applied to the model here? If we determined it to be an issue we can add a committee to address it.

Secretary Bigby stated we need to think what structures already assist, and how should they be involved in this? There is already a consumer protection group at the Attorney General's (AG) office. Do we educate our colleagues at the AG's to be aware if this activity?

Ms. Fenichel added that there should be a large education piece. Secretary Bigby responded that could be one of the Ad Hoc committees.

Doug Beaudoin from Deloitte stated that the Connector Authority proactively communicated with media and educated the public.

Ms. Fenichel stated that there has to be a feedback loop. Perhaps it could be an additional subcommittee on how to reach out to consumers. This needs to be addressed sooner vs. later

Interoperability

MeHI will implement and want to follow federal standards

Patient-Centric	• Provide each individual in Massachusetts a record of their health history and care information
Adoptability	• The MA HIE conforms to standards, policies and regulations
Adaptability	• MA HIE can be modified and expanded to integrate with newly introduced architecture components, additional services, interfaces and features that will cater to the needs of increased users, systems and networks
Maintainability	• MA HIE standards and requirements for participation are not onerous or overly complex, allowing greater participation by the MA community.
Systems Integration	• Adapters and connection mechanisms are defined and developed for all MA HIE participants to use.
Extensibility	• Enables addition of new functionality or updates to existing functionality with minimal impact to existing functions.
Data Aggregation	• Provides the ability to collect, transmit and aggregate required information in standardized formats

Privacy and Security

We discovered that additional work needs to be done. There are multiple stakeholders that need to be involved. Privacy – Consent Management. Security – Technology.

MeHI convened a stakeholder meeting on September 24, 2009 to discuss Privacy and Security

- Many questions remain concerning the appropriate consent approach
- Policy and technical questions were often discussed together
- Discussion topics vary by stakeholder (Policy vs. technical), so MeHI will pursue more targeted discussions in the future
    - Privacy: Focused on consent management
    - Security: Focused on technical requirements
- MeHI will ensure appropriate 'bridging' of the two stakeholder groups

Requirements for Patient Consent/ Authorization from Chapter 305

- Establish a mechanism to allow patients to opt-in to the health information network and opt-out at any time
- Give patients the option of allowing only designated health care providers to disseminate their individually identifiable information
- Keep sensitive patient information confidential by exclusively utilizing electronic health records products that are certified by the Certification Commission for Healthcare Information Technology
- Inform individuals of what information about them is available, who may access their information, and the purposes for which their information may be accessed.

Patient consent is EXTREMELY important. Development of consent model extremely important when developing a HIE model. Develop a Consent model approach before going out and develop an HIE. We need to define how patients opt in to a HIE and how the information is exchanged.

Ms. Adair stated that we have to nail down what we want to do before we engage in a discussion on the technical side. There is a lot of room for discussion.

Ms. Fenichel added that this presentation says "bridge the two groups" – but thought it was one. Dr. Carr responded, maybe one group but with different conversations: policy and technical, policy drives the technical.

Consent management is more state specific. We need to insure it is more fully developed.

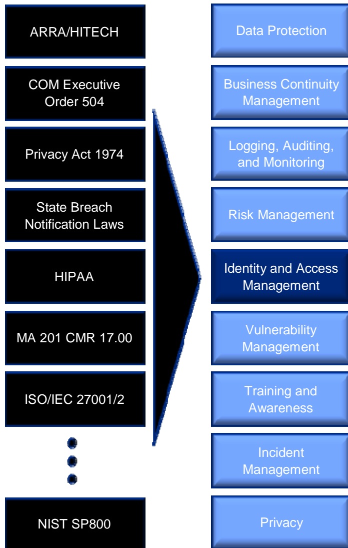
Mr. Szabo added that the whole interaction between privacy requirements and technology is iterative. Chapter 305 was written with assumptions of communities of data, not around point-to-point data. Especially filters around data flows. This is very important. You cannot have procurement until it is perfected.

Dr. Carr, I completely agree. Then he talked about other states with opt in and opt out.
You must define entire scope and prioritize.

Security Architecture

Our approach to securing the HIE begins with an “end to end” security framework for enabling integrated risk and compliance management and through the use of rationalized requirements linked to the various legal and regulatory requirements.

Baseline Requirements & Standards (Federal, State)



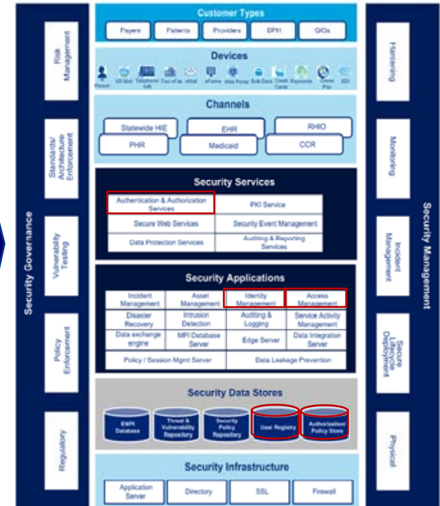
Regulatory Domain – regulation and standards applicable to State HITECH

Requirements Library

Authorization	
Requirement	**Source**
Ensure that only authorized users have access PHI.	HIPAA, FISMA, MA 201 CMR 17, EO 504
Authentication	
Requirement	**Source**
Implement procedures to verify that a person or entity seeking access to electronic protected health information is the one claimed.	HIPAA, FISMA, MA 201 CMR 17, EO 504
User Access Management	
Requirement	**Source**
Restrict logical and physical access to PHI by users in accordance with the defined access control policy.	HIPAA, FISMA, MA 201 CMR 17, EO 504

Requirements Library- as inputs into a Security Architecture

End to end Information Security Architecture



Secure SOA (sustainable, repeatable, and scalable controls)

Security Services: Identity Management, Access Management, Data Protection, Web Services Security, Security Event Management.

In order to meet federal and state requirements (including Chapter 305) AND support health care reform initiatives, the HIE technical architecture must support:
Statewide HIE Key Concepts

Patient Consent	The patient consent approach will be core deciding which technology will be selected for the HIE (e.g. patient consent applied universally vs. by provider/ geography/ provider group/ other)
Public Health Reporting	Current ESP pilots have successfully transmitted data to an HL-7 gateway, but additional investment is required to scale the solution to small office providers
Quality Reporting	The HIE must facilitate routing of appropriate data to appropriate reporting tools and support the possible linkage to registries in the future
Bi-directional Data Exchange	HIE participates must be able to contribute data, allowing others to retrieve data from the HIE (with consent applied)
Provide Robust Clinical Data	The patient consent approach must align with the EHR/ HIE integration approach in order to provide clinicians with actionable data at the point of care (integrated with provider EHRs); data must be more robust than available in current organization-specific EHR implementations
Support Stakeholder Needs	Given federal funds will not support the entire HIE infrastructure, the HIE must provide value to stakeholders willing to support it financially

Dr. Carr explained that this is implying there is the ability to push data to HIE, and others can pull the data.

When the EMR provides data that is more robust that the HIE, the adoption is low. HIE must be what it promises to be.

Dr. Bell questioned what was meant by bi-directional, is it robust multipoint-to-multipoint? Dr. Carr responded, yes, it is multidirectional – not bi-directional.

Mr. Szabo added; remember we are here to support health care reform. The bar is low for 2011, 2012. Arguably you don't need the full HIE to meet Meaningful Use, but there is a progression. Public health and quality reporting are imbedded in 2012 reporting.

Dr. Bell, when you are in a delivery system, you do need a very robust HIE. On the other side, if you are not in that environment, you would need a summary report. You should only share what is appropriate.

Next Dr. Carr reviewed the pros and cons of centralized vs. federated model.

None of the stakeholders sounded like they wanted a centralized HIE. Dr. Carr stated one of the reasons for a federated approach is the concept that data resides at providers' data center. Provider may choose to disconnect and take their box home.

Consent Management.

Consent can be managed at multiple levels by a provider. It is so important to have multiple levels.

Dr. Bell added, if we are developing a strategic plan, we are looking in the future through an HIE. Yes – this is a doable model in 3-5 years. Instead of linking in to Surescripts you link into HIE. Consent management is important.

There are multiple ways to link into an HIE. ASP model, if you are a REC in existence and the community wishes to support you in the future, it could be a hub, more scalable ASP models.

Mr. Poley asked how updates are handled in this model. If things change or do they only get it when someone joins the HIE. For example, if I am a patient and I have multiple physicians and I change my address; do the other providers receive my updated data? It isn't a technical issue, but how is it updated if we receive new data? He added that he did like the centralized model. How do we handle changes? We need to make sure there is some data that gets pushed to other users.

Dr. Carr stated there is clearly going to be times when data is not presented in a standard format. Maybe my data is not in a CCD format. It will take the information, and put it in standardized format.

Ms. Fenichel asked if the standard format is defined. Dr. Carr explained that the CCD document is standardized.

Certified Program Objective

MeHI will develop a certification program to help Massachusetts providers meet meaningful use criteria by:

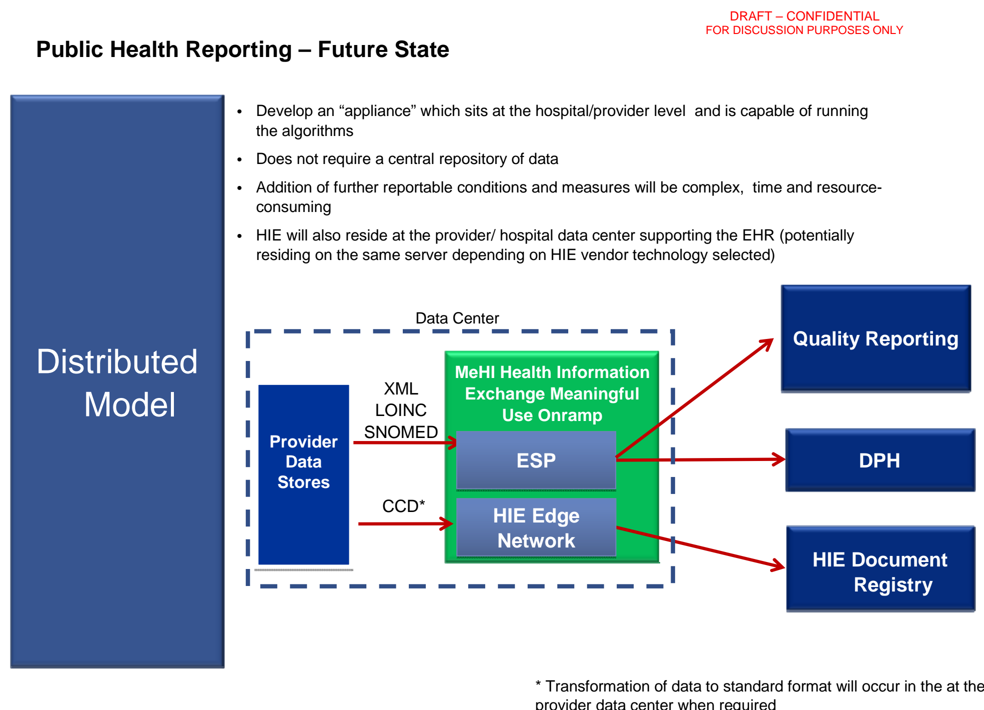
- Ensuring providers are supported by IOOs with vendor-specific knowledge
- Ensuring providers receive the highest value from their implementations
- Ensuring EHR implementations are able to link into the statewide HIE in a secure, value-adding manner

In order to do accomplish the above through a robust yet flexible certification program, MeHI will:

- Certify IOOs to perform provide implementation support (IOOs must demonstrate vendor-specific knowledge
- Certify EHR implementations directly (if not performed by a certified IOO)
  - Certification will focus not only on the technology implementation, but also the workflow / use of that technology
- Leverage existing federal vendor certification programs where appropriate

Dr. Bell stated that the care management process needs to be consistently brought forth in these discussions.

Mr. Szabo stated there will be IOOS that will help with implementations. The institute will enter into contracts with the IOOS, and there are others we will certify. Dr. Carr, MeHI is not going to fund all the IOOS. It will only provide contract for services, you must be certified and audited through MeHI if you receive funds.. The IOO can be certified, or the implementation itself can be certified.



Public Reporting will be defined in the operational plan.

Workforce development

Healthcare Awareness, Clinical Experience, Communication, and Generalist skills emerged as the most in demand and hard to find skills across the jobs.

Required Skills for Prioritized Healthcare IT Roles

	Implementation Specialist	Project Manager	Practice Consultant	Data Manager / Analyst
Healthcare Awareness	**X**	**X**	**X**	**X**
Clinical Experience (RN, MA)			**X**	**X**
Written and Verbal Communication	**X**	X	**X**	X
General Business Skills (MBA)		X	**X**	**X**
Critical Thinking & Analytical Reasoning (Problem Solver)	X	X		X
Big Picture / Systems Thinking (Knowledge of Workflow)	X	X	X	
Systems Testing / Data Validation	X			X
Orientation to Detail			**X**	X
Vendor Knowledge			X	**X**
Consulting Skills (Listening/ Customer Service)		X	X	
Team Player		X	X	
Others Specific to the Role	• **IT Expertise** • **Technical Writing** • **Strategic Planning** • Integration Tools • Interface Awareness • Quality Control	• **PMP Certification** • Time Management • Change Management Skills • Governance Models	• Ability to conduct assessments • Self-Driven • Quick Study • Executive Presence • Flexibility	• **Pay for Performance** • **Biostats/Epidemilolgy** • Metadata Knowledge • Methodology • Programming (SQL)

NOTE: **Highlighted Skills** are hardest to find.

MeHI is working with Health and Human Services on the grant application for workforce development. It will be filed on October 5th.

Following there was a brief discussion regarding funding. Dr. Carr discussed the carious funding mechanisms including: Chapter 305, Federal Government, Bonding, Payers / Employers and Providers.

III. Other

With no other items to discuss, the meeting adjourned at 6:07 pm.