Massachusetts Health Information Technology Council Meeting

December 8, 2010
3:30 – 5:00 pm

Matta Conference Room
One Ashburton Place
Boston, Massachusetts

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Attendees:

Council Members:
JudyAnn Bigby, MD – (*Chair) Secretary of Health and Human Services*
Terry Dougherty – *Director of Medicaid*
Deborah Adair – *Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*
Meg Aranow – *VP and Chief Information Officer, Boston Medical Center*
Karen Bell, MD – *Chair of the Certification Commission for Health Information Technology (CCHIT)*
Lisa Fenichel, M.P.H. – *E-Health Consumer Advocate*
James Ermilio, *Special Counsel to Secretary Gregory Bialecki, representing* EOHED

MTC:

Mitch Adams
Rick Shoup
Carole Rodenstein
Judy Silva
Kris Cyr
Bethany Gilboard
Donna Nehme
Elizabeth Elfman

Other:

Wendy Mariner - *Boston University*
Leon Goldman - *Chief Compliance and Privacy Officer, BIDMC*
Foster Kerrison – *Royal College of Surgeons of Edinburgh (RSCEd)*
David Szabo - *Edwards, Angell, Palmer, & Dodge*
Gavi Wolfe - *ACLU Massachusetts*
John Halamka, MD, *BIDMC, Harvard University and NEHEN*
Manu Tandon, *Executive Office, Health and Human Services*
Jackie Raymond – *Partners*
Karen Grant – *Partners*
Steve Witter – *Folio*
Lorllyn Allan – *Lahey Clinic*
Timothy Masse – *Barry Dunn McNeil & Parker*
David Houle - *Barry Dunn McNeil & Parker*

Ellen Janos – *Mintz Levin*
Jessica Long – *Conference of Boston Teaching Hospitals (COBTH)*
David Smith – *MHA*
Karen Walsh – *CMS*
Claudia Boldman, *A&F* (for Marcie Desmond)
Adam Delmolino – *MHA*
Steven Weiner– *Mintz, Levin*
Seth Hedstrom – *Barry Dunn McNeil Parker*
Charles Leadbetter - *Barry Dunn McNeil Parker*
Deb Schiel – *EOHHS/Office of Medicaid*
James Daniel – *MDPH*
Louis Kaczmarek – M*DPH*
Steven Brusie, MD – *Valley Eye Physicians*
Michael Lee, MD – *Atrius Health*
Henry Och – *Lowell Community Health Center*
Diane Stone – *Stone & Heinold Associates*
Andy Patstone – *HHS*
Debra Deblo

The thirtieth meeting of the Massachusetts Health Information Technology Council was held on December 8, 2010 at One Ashburton Place, Matta Conference Room Boston, Massachusetts.

Secretary Bigby called the meeting to order at 3:35 pm.

I. Approval of the November 15th minutes

The Secretary made the motion to approve the minutes

After motions were made, seconded, and approved with no abstentions, it was agreed to accept the draft minutes as the official minutes of the November 15th meeting.

II. Ad Hoc Workgroup Updates:

Legal Policy sub-group of Privacy & Security and HIE Workgroup Presentation on Governance:

1. Legal Policy Presentation on Governance given by Wendy Mariner

Wendy commented: the group worked very hard and were very giving of their time for this task.

Previously presented conclusions:

- Chapter 40J, as amended by chapter 305, does not directly address the governance of a statewide health information exchange (HIE).
    - It does not require or forbid the HIT Council, MeHI or MTC to be the governance entity.
- The law allows flexibility to identify or develop the most suitable governance structure for Massachusetts.
    - Two options: 3a and 3b
      Evaluation of 3a and 3b based on the following Principles for HIE Governance:

        - Treat HIE as a public good
        - HIE as exclusive mission and function
        - Membership of stakeholders with domain expertise
            - Patients
            - Public and private users/subscribers
        - Transparency, fairness and openness in policies and operations
        - Authority to establish and implement all policies and operations
        - Remain bound by privacy and security requirements of federal and State law (including chapter 305)
        - Independent and self-sustaining with private and/or public funding

      Comments based on the principles:
        - No existing entity satisfies all the necessary governance principles
        - Does have advantage of public instrumentality and money
        - 3a is not a recommended option

        - The recommended option is 3b: New Entity as Governance Entity
          Advantages of 3b
            - Exclusive focus on HIE
            - Includes private stakeholders with domain expertise
            - Can attract private revenues
            - Could be converted to public instrumentality
            - Authority and accountability
            - Transparency

    - Governing Board membership is key
        - Recommended both public and private members
        - Public
            - Secretary of HHS

        - Director of Office of Medicaid
        - Director of Department of Mental Health
        - Director of Department of Public Health
        - Other official, e.g., Auditor
    - Private categories
        - Academic medical centers
        - Community hospitals
        - Community health centers
        - Long term care facilities
        - Large MD group practices
        - Small MD practices
        - Pharmacies, laboratories
        - Health benefit plans
        - Patients (at least 2)
        - Financial/other expertise
    - Note: no HIT vendors

- Governance level responsibilities
    - Policy making; strategic planning
    - Operational, financial, and legal accountability
        - Revenue sources and budget approval
    - Approval of vendor and/or contracts
- Management level responsibilities
    - Business and financial operations
        - Vendor contracting
        - Subscriber/user acceptance/certification
    - Technical operations, security, privacy, efficacy
    - Outreach, communication and education

Wendy added the group found 3b to be universally acceptable, it builds in accountability, and it will create trust among patients and other stakeholders.

A report was handed out to the Council outlining a legal overview of governance. Wendy indicated the report is lengthy and suggested to read both for backup and explanation

The group recognized it may be difficult to put together a new organization in the timeframe needed. Need an interim solution.

Dr. Bigby commented:

The Legal Policy Workgroup has been very responsive to the Council.

Dr. Bell commented that she read the materials and that she thought it was very elegantly done.

Question: How long would it take to put a permanent structure in place?

Answer: It potentially could be done within a year, probably by 2012. Also, depends on the willingness of people to work together and to link up.

Question: Is it correct that the 3b option does not acknowledge its creation by the HIT Council or suggest for it to report to the Council?

Answer: The HIT Council can be the initiator and specify what the new entity must consist of – ultimately it will be an independent entity and will not be reporting to the HIT Council. There is the possibility of oversight by the State.

Question: Who is ensuring that the HIE is for the public good if the private sector is not tied to the public?

Answer: Ultimately it will be a public entity, but there could be some concerns by patients about privacy via a State agency. The Commonwealth already has in place State networks. The challenge is how to get the private sector to participate.

2. HIE Workgroup: Short-term Governance Recommendation: Presented by Dr. John Halamka

- We have to move forward
- Not a year from now but tomorrow
- Ensure that there is the trust for/by all the stakeholders, protect the public interests, and engage the government (State)
- Trustworthy organization – HIT Council – too small
    - The HIT Council cannot be expanded without legislative change.
    - Add a multi-stakeholder Advisory Group to the HIT Council until legislative change enables us to evolve Governance into an independent public/private body
        - HIT Council plus the Advisory Group equals the "HIT/HIE Steering Committee
    - The HIT/HIE Steering Committee is likely to require workgroups of additional experts from the public and private sector.
        - The HIT/HIE workgroups will need professional facilitation and domain experts to support their activities. MeHI, the contracting authority, can procure this support.
    - Management

        - Need a network of networks unified by a single program management office, common standards, implementation guides for content/vocabulary/ transport, directory services, and certificate management.
        - To operate this network, need a single program management office staffed with domain experts who can execute the priorities of the Governance body (HIE/HIT Steering Committee).
        - Certified vendors will offer their services directly to payers, providers, and patients.
    - If the HIT Council is supplemented by a multi-stakeholder Advisory Group and the HIT/HIE Workgroups which are supported by a workgroup project management office and day to day operations of the HIE are performed by the HIE project management office, then the MA HIE can begin to function now.
    - When legislative change is completed, a permanent governance body can take the place of the HIT Council.

Question: In the short-term will this combined body of HIT/HIE be overseen by the MTC Board?

Answer: Yes, but adding different and necessary components.

Question: Will those components be complementary, serving ad hoc to the Council?

Answer: Yes, but they would be advising the HIT Council as representatives of their communities/organizations/sectors, not as ad hoc groups.

Steve Weiner then commented:

- It's astonishing how much work has been done since the last meeting
- I agree the work that the Legal Policy Workgroup put forth is very elegant
- Cannot assume that the HIT/HIE Steering Committee will be a quick fix because the role of the Council and MeHI and the guidelines of the Federal grant make it more complicated.
- There are reasons why this must be done more rapidly.
- Could Dr. Halamka's proposal work? Yes it can.
- One challenge is how to create legislation to allow for State participation
- Longer term challenges – this legislation may not be the highest priority to address in the legislature so it may take longer than a year.
- Urgent is the term - how do you move more immediately while the longer term objectives are being achieved with the 3b option?

Question: Could this proposal work and is there any State conflict of interest issues?

Steve Weiner answered:

- 268A needs to be addressed
- Very viable approach
- Also to clarify, MTC board does not have final authority – MTC board and HIT Council have equal authority
- Depending on how long the processes of getting the committee in place, we should address issues of how it functions.
- Build in stages to address questions around how the HIE functions.

Question: If the MTC Board and the HIT Council are equal – do both have to agree if something does not get approved?

Answer: Yes, under 305 both have to be approved by MTC board and the HIT Council on all key decisions.

The Secretary and the Council issued a charge for the following to be reported back to the Council: (Judy Silvia and David Martin are to oversee this task)

The Secretary and the Council recommended that an advisory committee be formed that they would call the HIE/HIT Advisory Committee that would make recommendations to the Council on implementation and management of the HIE.

1. Pursue a strategy for expanding stakeholder involvement in the HIE
2. From the recommended stakeholders (in the Legal Policy Workgroup presentation), determine who should sit on this advisory group
    a. No vendors on the committee or anyone with conflict of interest.
3. Also request MeHI to come back with a budget proposal for the staff management part and for this steering committee.

Comment: The budget is a small part of the work. The bigger issue is how to create the public instrumentality that is responsible to the public. If there is a need for HIE Federal funding, the funding is available at 90/10 through Medicaid.

Karen Bell made a motion to approve the recommendation presented for MeHI to move forward with a proposal to create a governing body (HIT/HIE Steering Committee), and development of a project management office to support the HIT/HIE Steering Committee which would be a governing body moving forward and to include the membership the Legal Policy Workgroup recommended in their presentation.

All approved, none opposed

The Secretary issued a charge to create a workgroup who would come up with a process for selecting the members of the Advisory Committee and recommended that Meg Aranow lead, and asked that she include staff from MeHI to assist. She also asked for other volunteers and Lisa Fenichel accepted.

Presentation on Consent Policy Framework: Jackie Raymond and Michael Lee, MD
Jackie acknowledged her team who has worked many hours on this difficult task.

Secretary Bigby thanked the Consent group for doing the work, which is such an important process and commented it really does require getting it right and conveying it to the public in a way that engenders a lot of confidence.

Presentation: Jackie Raymond

Consent Policy Workgroup

- The Consent Policy Workgroup focus was on the "Opt In" policy, which is dictated in Chapter 305.
- Development of informational materials, marketing tools and media to engage and educate consumers was not our focus
- We recognized there is a significant need to describe these policy components at a literacy/understandable level for all types of consumers and providers.
- Important information we anticipate will be needed for consumers/patients:
    1. A fact sheet about the HIE
    2. A very explanatory permission/consent form (Opt In/Opt Out)
    3. Frequently asked questions (FAQ's)
    4. Definitions and some patient scenarios

Consent Policy

- The patient decides to "Opt In" to the HIE per provider/group/healthcare organizations
- Provider definition reviewed
- Three important Statues
    1. Chapter 305 "Opt In" and "Opt Out"
    2. Genetic Testing – patient consent
    3. Disclosure of HIV related information requires per event consent
- It was necessary to balance the above for the HIE to be useful and effective
- We recommend that a full and complete summary of clinical information from each Provider be transmitted through the HIE
- Partial or filtered information is not consistent with the quality and safety needs of the community
- We acknowledge there are statutory constraints for transmissions such as:

1. Sensitive information
2. Genetics testing and HIV testing
3. Licensed provider mental health and substance abuse notes

- Patients have the following choices to participate in the Commonwealth of MA HIE:
  1. Decline to participate in the HIE
  2. "Opt In" to the HIE
  3. "limited ED Opt In" to participate in the HIE only for ED visits
- Information needs to be complete as possible, and do not filter.

Consent Policy Framework Presentation Continued: Mike Lee, MD
System operation status or flags

Consent System Implementation

- System "flags" or authorization statuses
  1. "Opt In"/Not "Opt In"
  2. "Opt In" only for sharing information with an ED, patient unable to consent
  3. The presence or absence of HIV related information
     - Disclosure around whether you have HIV and disclosure of the information
       - challenging
       - won't allow them to participate – discriminating
       - decided to not exclude them

  Note: Many states have "Opt Out" only.
- Phase 1 (2011) Push Model is basically the current model
- Phase 2 (2013) Pull Model is the future model

Question: If an individual does not opt in and then arrives at the ED comatose, and now plans to "Opt In", do they have mutually exclusive options?

Answer: This has been hard to explain to people and "opting in" for ED complicates things.

Question: What about psych notes, are they excluded?

Answer: Massachusetts law stipulates you cannot send notes from a licensed provider, only diagnoses and medications are able to be exchanged. When patient gives information to their primary care provider, then it becomes part of their record and can be transmitted. Genetic testing can be a part of the consent to "Opt In". If patient does not want it, then s/he does not have to choose it.
Comment: What constitutes the flag for the HIV patient disclosure in the case of both providers knowing – no disclosure – exchange would take place.

Comment: Would be helpful to have these exclusions addressed at the legislative level.

Comment: Did incredible work, a lot to grapple with. You have to be careful about the language used because it does not mean the same at other organizations and in other states.

Question: what is the time frame once you have "Opted In"?

Answer: Five day response time and have to be done by a provider; indefinite once you "Opted In" and need to go to each provider to withdraw.

Comment: Have to be careful that patients understand that they are not "Opting Out" of HIE entirely.

Secretary Bigby stated that she assumed the Council will be getting some sort of report? She suggested waiting until the report is received and reviewed before making a motion for approval of their recommendations.

III. Updates on HIE and REC (Rick)

- Feedback on HIE strategic and Operational Plans
  - Plan approved awaiting approval of revised budget submitted on 11/30
  - Excellent plan with no revisions needed.
- New HIE Funding Opportunity
  - Challenge funding basic information
  - Requirements/restrictions
  - 5 Themes
    1. Achieving health goals through HIE
    2. Improving LT and post-acute care transitions
    3. Consumer-mediated information exchange
    4. Enabling enhanced query for patient care, and
    5. Fostering distributed population-level analytics
  - Award Information
    - Approximate amount of funding available - $16,296,562.00
    - Award $1,000,000 to 2,000,000
    - 10 awards
    - Starting February 1, 2011 and ending on the end date of the applicant's State Health Information Exchange Cooperative Agreement
  - Main activities
    - Identify aligned funding opportunities
    - Prioritize and choose optimal opportunities
    - Align appropriate stakeholder support

- Write and submit grant for #2 and possibly # 3
- Leverage MassHealth Data Consortium to help with application

Question: What do you have to put in the Letter of Intent?

Answer: Nothing, just that we will be submitting an application.

REC Update (Rick)

- Reviewed slides – Provider numbers by City/Town
- Patient-Centered Medical Home Initiative (PCMHI)
    - Enrolled 14 practices (out of 46 total), 298 PCMHI providers.

Year to Date Totals - REC

- 1195 Primary Care Providers
- 1282 In-house total
- 364 December Pipeline
- 64 Specialists signed up
- 1700 by end of December

Question: Are you enrolling dentists?

Answer: Dentist cannot receive REC direct assistance.

With no further questions.

Meeting adjourned 5:03 p.m.