MINUTES

Massachusetts Health Information Technology Council Meeting

December 22, 2009

3:30 – 5:00 pm

Matta Conference Room
One Ashburton Place
Boston, Massachusetts

MINUTES
MASSACHUSETTS HEALTH INFORMATION TECHNOLOGY COUNCIL

December 22, 2009

Attendees:

Council Members	JudyAnn Bigby, MD - *(Chair) Secretary of Health and Human Services*
	Deborah Adair - *Director of Health Information Services / Privacy Officer at Massachusetts General Hospital*
	Karen Bell, MD - *Senior Vice President of HIT Service at Masspro*
	Lisa Fenichel, M.P.H. - *E-Health Consumer Advocate*
	Meg Aranow - *VP & Chief Information Officer, Boston Medical Center*
Other	Deb Schiel (EOHHS – Office of Medicaid)
	Kimberly Haddad (Senator Moore's office)
	Bert Ng (Committee on Health Care Financing - House)
	Sue Kaufman (Dept. Health Care Finance and Policy)
	James Fuccione (Home Care Alliance)
	Adam Delmolino (Massachusetts Hospital Association)
	Alan McDonald (South Shore Hospital)
	Henry Och (Lowell Community Health Center)
	Karen Welsh (Student)
	Foster Kerrison
	Janie Tremlett (Concordant)
	Barbara Klein (Concordan)
	Kevin Schwartz (Concordant)
	Michael Gilbert (Arcadia Solutions)
	Luanne Kimler (Arcadia Solutions)
	Jan Rose (ML Strategies)
	Helen Luce (Blue Cross Blue Shield of Massachusetts)
	Brian Lenagham (Intel)
	Bill Burns (Oracle)
	Bob Strong (Pro Caseo, Inc)
	Steve Goldblatt (Suffolk Group)
	Stacia Talberta (Atlantic Associates, Inc)
	Linda Cavanaugh (Marke?) (Atlantic Associates, Inc)
	Monica Cunningham (Independent HIT Consultant)
	Gary Murad (O'neill / Navinet)
	Brian Gildea (Arcadia Solutions)
	Owen Pollock (Rasky Baerlein)
	Skip Best (Cousint)
	Roger Lambert (Cousint)
	Natasha Greco (NaviNet)
	Claudia Boldman (CoMA, ITD)
	Marci Sindell (Atrius Health)

MTC Staff Mitchell Adams
Dr. Richard Shoup
Judy Silvia
Barbara-Jo Thompson

The eighteenth meeting of the Massachusetts Health Information Technology Council was held on December 22nd, 2009, in the Matta Conference Room at One Ashburton Place in Boston, Massachusetts.

Secretary Bigby called the Meeting to order at 3:34 p.m.

AGENDA ITEMS

I. Approval of November 10th Minutes

After motions made and seconded, it was unanimously agreed to accept the draft minutes as the official minutes of the November 10th meeting.

II. HIE/REC/WFD update

Dr. Richard Shoup started with an update of the various funding opportunities from the Office of the National Coordinator.

Key opportunities pursued by the Massachusetts eHealth Institute:

- HITECH Regional Extension Center to support implementation of electronic health record systems in 2500 physician offices: applied for approximately **$15 M** for Massachusetts (MeHI)

Things have changed at the Office of the National Coordinator, and they have combined cycles 2 and 3. The new date for a decision to award is scheduled in January. Dr. Shoup reminded the Council members that there is core support and direct assistance. We would support a number of providers in the state.

- Summary of Funding – Total $640 Million (Average Award is estimated to be $8.5 Million)
- Awards are anticipated to range from $1 Million to $30 Million
- There will be approximately 70 awards
- Award length = 4 year project – two separate two-year budgets.
- Estimated start date is January 15, 2010
- Award of 4 year cooperative agreements. Initial preliminary application was due on September 8th with matching requirements as follows:

FY2010 = 90/10
FY2011 = 90/10
FY2012 = 10/90
FY2013 = 10/90

It is expected that each Regional Center will provide federally supported individualized technical assistance to a minimum of 1,000 priority primary-care providers in the first two years of the four-year cooperative agreement project period – which must represent at least 20% of primary care providers in the "region"

- HITECH Statewide Health Information Exchange with collaborative governance and sustainable funding model: applied for $ 945K in planning funds out of total of **$10.6 M** for Massachusetts (MeHI)

  Awards to states and qualified State Designated Entities (SDEs) to develop and advance mechanisms for information sharing across the health care system
  Total funding is $564M with grants in the $4M - $40M range over 4 years – est. start date: 1/15/2010

  Grants to establish and implement appropriate governance, policies and network services within the broader national framework to rapidly build capacity for connectivity between and among health care providers

  Areas of focus include the following:
  - Governance
  - Finance
  - Technical Infrastructure
  - Business and Technical Operations
  - Legal/Policy

- ARRA Workforce development grant through Department of Labor for health information technology training: EOHHS applied for **$4.9** on 10/5/09 and MeHI may need to provide some support.

Dr. Shoup explained that MeHI has applied for these grants and the expectation is that we will hear something from Washington in January.

Ms. Fenichel asked Dr. Shoup to reiterate what we are expecting to hear in January. Dr. Shoup responded that we have been told that there should be an announcement in January as to who will be receiving funds and the amounts of the awards. Secretary Bigby added that we have heard some feedback, and all has been positive.

Next Dr. Shoup explained that there are a few new funding opportunities. The first is regarding training. We are not leading this effort but we are teaming with 13 other participating Eastern states to apply for this grant.

Community College Consortia for HIT Training

- 5 regions created by pairing contiguous HHS regions
- NE and Mid-Atlantic with potential for $ 17.25M in funding for 2 years
- Community College educational programs to begin by 9/30/2010 and be completed within 6 months

- Focus on 6 skills supporting EHR implementations
- MeHI coordinating 13 states:
  - NE status plus VA, MD, PA, NJ, NY, W.VA and DEL
- LOI due 1/6/10 and full application 1/22/10

Dr. Shoup stated that earlier in the day the eastern states held the second conference call to discuss this opportunity and another call is scheduled for next Wednesday. Then as a combined effort we will submit the letter of intent by January 6, 2010. Currently it appears that Pennsylvania will take the lead with the input from the other states. The group will decide how to distribute the funds. We have not worked through all the details to date.

Ms. Adair asked a question in terms of skills, is that something that has been agreed upon. Dr. Shoup responded that there is another funding opportunity that is about developing curricula for HIT training, and using funds to provide the Community Colleges with the curricula to train the workers. For the grant opportunity just discussed this has not been determined. The full application is due on January 22nd, 2010.

It was at this point that Dr. Shoup explained that it may make sense to change the order of the agenda slightly and discuss the Beacon Communities opportunity and then come back to the HIT Plan.

III. Beacon Communities

Dr. Shoup walked through a power point presentation explaining the Beacon Communities funding opportunities and what will occur. (That presentation has been posted on the MeHI website www.maehi.org)

Basically this is an opportunity to shine a light on communities that have advanced HIT capabilities, and for Massachusetts it is an opportunity to showcase our leadership in this area. The objective is to show what a state may look like in five years, or where we think we want to be in five years.

It will target a community that has at least 30% of physicians with installed EHRs (urban setting) and we have communities that meet that threshold. It will be up to the Beacon Community to determine the quality outcomes they wish to measure, but the community must also demonstrate a public / private partnership. This grant opportunity will provide funds to advance Meaningful Use criteria at it will show how it can be a "beacon" for the rest of the country.

Use of Funds:

- **IT and Exchange Infrastructure**
- **Integration of HIT Into Care Delivery**
- **Evaluation, Performance Monitoring and Feedback**

The Letter of intent is due on January 8th with a full application due on February 1st. As with many other grants, this is a great opportunity with very short time lines. The City of Boston working with Aligning Forces (50+ organizations in Eastern Massachusetts) will lead the effort in applying for this grant.

Rick is involved as the Director of MeHI and as the state HIT Coordinator. Medicaid and others are also involved. The level of participants is comprehensive and reflects many organizations in the greater Boston area. The slide in the presentation of the Proposed Participants represents more organizations than are expected to participate.

Aligning Forces is at the point in their evolution where they can demonstrate many of the key items described in this funding opportunity. Other stakeholders have been noted and a discussion ensued about what specifically needs to occur for the letter of intent.

Much of the project has yet to be determined but it will be presented in the context of supporting healthcare reform. For this opportunity, HIT is not a driving force.

Massachusetts will support multiple applications as long as they meet the grant criteria and coordinate with the state.

Lisa asked a question about the details of the project and Dr. Shoup responded that the "LOI is still in development."

Massachusetts Health Quality Partnership is drafting the Letter of Intent and they will share with the broader project group prior to its due date.

Debbie asked how we see the funds being aligned with the work we are trying to do and how would we be able to align ourselves and prioritize without getting in each other's way.

Dr. Shoup responded that there will be coordination through MeHI and the Ad Hoc workgroups; aligning all efforts while ensuring that we are working closely together. It is a lot to manage.

Mr. Adams added that Dr. Shoup will be an informal presence as no state employee can be involved in decision making. Everyone will be aware of all that is going on. One way to ensure coordination is to have a MeHI staff member on each Ad Hoc workgroup.

IV. HIT Strategic Plan Update

Before Dr. Shoup presented the update on the HIT Strategic Plan, Dr. Bell mentioned that one approach for managing the goals of the strategic plan is to prepare a matrix demonstrating how they all work together. Dr Shoup added that once we have come to agreement on the vision and goals then that will inform the process.

Dr. Shoup then began that the HIT Council hired Deloitte to develop a supplemental Strategic Plan (to the first one from Boston Consulting Group). Secretary Bigby interjected that the BCG document was never a plan, but we are in the process of developing a plan.

Dr. Shoup continued that there was a draft of a written plan submitted on October 16 that Deloitte provided to us for the HIE grant application. Unfortunately, it was not what we needed. What we require is less technical and includes the vision for the future: a strategic and not an operational plan.

We then asked Deloitte to redraft the plan and once there is consensus within the council, the final draft strategic plan will be posted on the MeHI website for public comment.

We are well into drafting this second version and we have received feedback from the council. This is a good place to get consensus.

Secretary Bigby pointed out that our plan is not about putting technology in health care but using technology to support health care delivery.

Ms Fenichel asked for an explanation of the process. Dr. Shoup responded that we received feedback from the Secretary, Dr. Bell and Ms Adair on the discussion for today. We did not want to waste council time reviewing ongoing HIT plan drafts unless the process was at a place to confirm the vision and goals allowing us to move forward.

Deloitte has been drafting chapters and they have even brought in professional writers. They are doing it the right way and then once we get a consensus on the vision and goals then we can proceed to next steps.

Ms. Fenichel responded that there is a lot to comprehend in one hour and come to agreement on.

Secretary Bigby explained that we are not signing off on the four goals today.

Mr. Adams added that this is not a document to approve but a conversation around goals.

Dr. Bell thanked the Secretary for turning everything around because there were no goals in the first draft plan. Secretary Bigby stated that we need good solid goals first. Dr Bell continued that the attempt today would be to get the ship in the right direction.

Ms. Fenichel responded that it is a process that isn't clearly understood. She added that there should be transparency around who is part of these conversations and why.

Dr. Shoup then discussed the goals.

Goal 1: Improve access to person-focused healthcare: Each individual has a unique combination of health-related risks and/or conditions. Therefore, the Commonwealth will continually strive to support access to the best care for every person seeking care. In addition, consumers and patients will have increased opportunity for well-informed and personal choices through use of technology.

Objectives:

- Improve adoption of HIT by all caregivers in the Commonwealth, supporting efforts to improve clinical outcomes.
- Improve provider use of technology that will support patient centered medical homes and the use of technology to transform practice as appropriate
- Improve provider use of technology to manage chronic disease and improve health outcomes.
- Provide access to personal health information for all individuals who desire access.

Dr. Bell pointed out that this is focused on healthcare, what would others think of broadening to a personal focus?

Ms. Fenichel responded, but what about health and wellness, not just sickness?

Secretary Bigby stated there is a goal on health.

Ms. Aranow asked for clarity regarding goals.

Secretary Bigby directed everyone's attention to the third bullet that addresses chronic disease. The first bullet is generic and then the third, a bit more specific.

Ms Fenichel expressed that 'adoption' is one thing as in the first bullet, but the third bullet states, 'use'. We need to use language clearly and consistently.

Goal 2: **Improve the quality of health care across all providers:** The quality of care should be predictable. Data from EHRs, claims, and other sources will be available as more providers adopt HIT. These data should be used to identify areas that need improvement at the individual provider level and across systems of care.

Objectives

- The Commonwealth will adopt a common set of quality measures across all payers and providers
- The Commonwealth will adopt meaningful use measures as defined by the federal government for reporting purposes
- Support patient-centered care coordination that results in fewer preventable hospitalizations, readmissions and other indicators of poorly coordinated care.
- The state will collect and report quality measures for all providers and track progress on reaching quality improvement goals.

Dr. Bell stated that Goal One is to improve access; Goal Two is to insure that it is measurable. She then stated that she had missed this distinction originally.

Goal 3: Improve efficiencies in the health care system and slow the growth of health care spending: The Commonwealth has several opportunities for improving efficiencies in the delivery of health care. As the state explores payment reform as a mechanism for slowing costs HIT must support the transformation of the payment system to a more transparent and efficient one.

Objectives

- Improve efficiencies in the system by streamlining administrative tasks through the adoption of HIT
- Decrease duplicative administrative functions for providers
- Use HIT to support evidence based medicine

Ms Aranow stated that there is an opportunity to use stronger language to engage the vendor community. It is implied, but we should be stronger to engage self-developed systems.

Other comments were made regarding the EHRs to produce acceptable bills for payment. Reduce redundant clinical payments as well. Engage self-development community (EHRs) to align and integrate the applications.

At this point there was an extensive conversation regarding wordsmithing.

Goal 4: Improve population health: The healthcare system must deliver care to a broad array of patients with unique conditions. However the health needs of different communities are determined by factors other than the health care system. In order to improve the health of communities and entire populations, the Commonwealth must have the ability to monitor the incidence and prevalence of certain health conditions and health status, identify interventions that improve health outcomes and complement medical care with public health approaches to addressing health status. HIT should provide the Commonwealth with the necessary tools to monitor conditions related to the public's health for ongoing public health programs, to support emergency preparedness, and inform the impact of health care reform.

Objectives

- Support patient-centric care coordination within and among communities across the state and surrounding state
- Support the Commonwealth's public health surveillance and improvement initiatives
- Improve healthcare system efficiency, resulting in better value for Commonwealth residents

Ms. Fenichel addressed the Secretary, "is this where there would be a wellness piece?" Secretary Bigby responded in the affirmative and Dr. Shoup added as an objective.

Dr. Bell stated she would like to go on record that this approach to goals is great and then added that something about safety seems to be missing. There are a number of things we could add to make it a bit more robust, but then she added that she endorses this goal approach.

Ms Aranow seconded that thought and stated that this lays out the four goals we are trying to achieve in Massachusetts. Could we use the objectives to direct our efforts in certain parts of the populations, help align members in the private hospitals? It is done a little in the chronic disease section. Maybe we could state, one or two practitioners or low income. I don't know if that is too much to ask at this time.

Dr Bell asked if we should consider how we then measure the objectives. "I am not saying put a line in the sand, but there would be a process that could be measured."

Dr. Shoup then read the slide regarding achieving HIT Goals and Objectives as follows:

Strategies to Achieve the Commonwealth's HIT-Related Goals and Objectives
The Commonwealth of Massachusetts understands that achieving these goals and objectives will require a core set of strategies to ensure that all healthcare stakeholders move forward together in support of our Vision. These core strategies include the following:

1. **Establish Governance:** Individual organizations have found that clearly defining the decision-making process around HIT-related projects is key to the success of the project. Past

community-wide HIT pilot projects in the Commonwealth have demonstrated a greater need for governance in projects involving more than one organization.

2. **Ensure Privacy and Security:** A patient's confidence in the way those involved in handling or accessing their health-related information is at the core of their trust in the healthcare system.
3. **Implement HIT in the Clinical Setting:** As mentioned previously, only 40% of providers in the Commonwealth use an EMR in their office, and few patients have timely electronic access to their health-related information.
4. **Implement HIT in support of Population Health:** The Commonwealth has found that electronic reporting of information required for public health or quality reporting can dramatically improve accuracy while decreasing resources required to support older manual processes. However, very little information is reported electronically today.
5. **Ensure Workforce Development:** HIMSS has found that there is a 40% gap in the number of experienced professionals required to implement all HIT-related projects in the country when compared to those available to perform the work today.
6. **Monitor Success**: In order to keep the Commonwealth 'on track' to achieving its HIT goals and objectives, it will implement a program to monitor progress.

Ms. Fenichel pointed to core strategy #2. She added the provider has to trust the system as well.

Dr. Bell stated that we need a good governance model. The real question is 'what is our strategy for governance?' There is a public / private partnership. It is 40% physicians? We have a lot of providers that aren't even close, so do we start with physicians, and then go forward with other providers?

Dr. Shoup explained that it is the physician then we move to physician assistants, and other providers.

Ms. Fenichel stated that needs to be spelled out. To which Dr. Shoup responded that it will be in other chapters.

He then concluded his presentation explaining that we have made note of your comments, and we will incorporate. Secretary Bigby added that it would be sent electronically and the council could edit.

Dr. Shoup explained that he would make these changes and send it out to the council tomorrow.

V. Ad hoc work groups

Dr. Shoup went next on the agenda to discuss the Ad hoc workgroups. He explained that part of the governance structure we developed includes that anyone making recommendations cannot (financially) benefit from their suggestion. It will be up to the Council to name these groups, and instruct and inform, what is expected of them.

There are a number of activities underway, REC, HIE, WFD, Beacon, where we are going to see the same people. One of the recommendations that came through the Beacon discussion is that we could bring in all these activities and inform these workgroups.

He then referenced a document that was distributed to the council at the beginning of the meeting. What you have in your hand out are groups we have named, and folks we thought should be in each group. Then you have a blank page. He requested that the Council members look it over again through the lens of a public / private partnership. We need the best and brightest.

Dr. Bell noticed that some groups are larger than others and asked if there may be subsets. Dr. Shoup stated yes. We thought we would err on the side of more than less. Then depending on the project or concern, we may choose a subset. This could be vendors or any number of individuals. It has been structured in a way not to exclude.

Ms Aranow asked if we know how to get long term care involved? Should they be active participants? Dr. Shoup stated that absolutely they should be involved and then added if the council notices any other key stakeholder missing, to please point it out.

Ms. Fenichel stated that consumer education is something that should include the consumer voice and elicit input from and give information back to the consumer. Consumers have ideas of what they want in a personal health record. This (the description of the Consumer Education and Outreach Workgroup) seems more like marketing to the consumer.

Dr. Shoup stated that the goal is to get consumer input. Dr. Bell added that we need good consumer input on the HIE technology side as well.

The Council held a brief discussion concerning the lists they were reviewing. Including how we would reach out to the various groups, if people knew they were on the lists? It was commented that Ms. Gilboard of MeHI has been reaching out to hospital associations. Ms. Fenichel added that we need to cast a wide net. And then asked what kind of time commitment is going to be expected.

Dr. Shoup stated that we need to be sensitive to schedules, and be flexible which may mean to meet in the evenings. There may be times of intensive meetings; there may be other times when matters are a bit more routine. He further stated that there needs to be Council members and MeHI staff members involved in all of the groups.

VI. Other

As there was no other business to discuss the meeting concluded at 4:45 p.m.

FOR DISCUSSION
DRAFT
PURPOSES ONLY

massachusetts eHEALTH institute

MeHI Update:
Grant Status and HIT Plan Updates

December 22, 2009

A Division of MTC

Agenda

Update on Grant Applications

- Regional Extension Center – Cycle 1
- Health Information Exchange - Planning Grant
- Workforce Development Grant - submitted
- Community College Consortium - new
- Beacon Communities - new

MeHI Strategic HIT Plan Update

- HIT Council Review process
- Ad Hoc Workgroups

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

REC Application Status

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute
A Division of MTC

MeHI Received Positive Input on Cycle 1 Application

Regional Extension Center Program Funding

Initial Cycle	Approx Funding	Preliminary Application	Preliminary Approval	Full Applications		Decisions to Award
1	$350,000,000	8-Sep-09	29-Sep-09	3-Nov-09		21-Jan-10
2	$290,000,000	22-Dec-09	5-Jan-10	29-Jan010		31-Mar-10
3	Cancelled					
Total Amount of Funding Available:				$640,000,000		
Award Floor/Ceiling:				$1,000,000 to $30,000,000		
Approximate Number of Awards:				70		
Program Period Length:				Four-year project period with two budget periods		

Funding will be used to support:

Core Support Funds outreach and educational activities, grants and program management, local workforce support, and participation peer-learning and knowledge transfer activities facilitated by the HITRC. ($500,000 to $750,000 per Regional Center per year for the first two years)

Direct Assistance Support Funds direct onsite technical assistance to providers. This will be tied to the number of providers supported through the Regional Center. Approximately $640 million will be allocated among the successful applicants in proportion to the numbers of priority primary-care providers to receive direct technical assistance.

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

Regional HIT Extension Centers

- Summary of Funding – Total $640 Million (Average Award is estimated to be $8.5 Million)
- Awards are anticipated to range from $1 Million to $30 Million
- There will be approximately 70 awards
- Award length = 4 year project – two separate two-year budgets.
- Estimated start date is January 15, 2010
- Award of 4 year cooperative agreements. Initial preliminary application due on September 8th with matching requirements as follows:

  FY2010 = 90/10
  FY2011 = 90/10
  FY2012 = 10/90
  FY2013 = 10/90

- It is expected that each Regional Center will provide federally supported individualized technical assistance to a minimum of 1,000 priority primary-care providers in the first two years of the four-year cooperative agreement project period – which must represent at least 20% of primary care providers in "region"

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

Overview of HITECH Application Opportunities:
State-wide Health Information Exchange Application

Awards to states and qualified State Designated Entities (SDEs) to develop and advance mechanisms for information sharing across the health care system

Total funding is $564M with grants in the $4M - $40M range over 4 years – est. start date: 1/15/2010

Grants to establish and implement appropriate governance, policies and network services within the broader national framework to rapidly build capacity for connectivity between and among health care providers

Areas of focus include the following:

- Governance
- Finance
- Technical Infrastructure
- Business and Technical Operations
- Legal/Policy

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

ARRA/HITECH Opportunities for MeHI

Key opportunities pursued by the Massachusetts eHealth Institute:

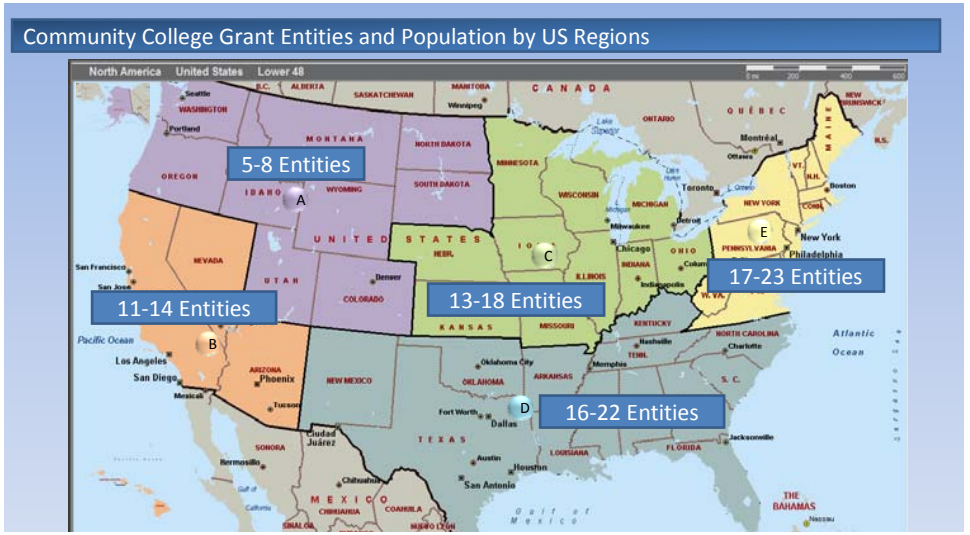
- HITECH Regional Extension Center to support implementation of electronic health record systems in 2500 physician offices: applied for approximately **$15 M** for Massachusetts (MeHI)
- HITECH Statewide HIE with collaborative governance and sustainable funding model: applied for $ 945K in planning funds out of total of **$10.6 M** for Massachusetts (MeHI)
- ARRA Workforce development grant through Department of Labor for health information technology training: EOHHS applied for **$4.9** on 10/5/09 and MeHI may need to provide some support.

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

Community College Consortia for HIT Training

- 5 regions created by pairing contiguous HHS regions
- NE and Mid-Atlantic with potential for $ 17.25M in funding for 2 years
- Community College educational programs to begin by 9/30/2010 and be completed within 6 months



- Focus on 6 skills supporting EHR implementations
- MeHI coordinating 13 states:
  - NE status plus VA, MD, PA, NJ, NY, W.VA and DEL
- LOI due 1/6/10 and full application 1/22/10

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

HIT Plan Review

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute
A Division of MTC

MeHI Strategic Plan Goals and Objectives Review

Goal 1: Improve access to person-focused healthcare: Each individual has a unique combination of health-related risks and/or conditions. Therefore, the Commonwealth will continually strive to support access to the best care for every person seeking care. In addition, consumers and patients will have increased opportunity for well-informed and personal choices through use of technology.

Objectives:

- Improve adoption of HIT by all caregivers in the Commonwealth, supporting efforts to improve clinical outcomes.
- Improve provider use of technology that will support patient centered medical homes and the use of technology to transform practice as appropriate
- Improve provider use of technology to manage chronic disease and improve health outcomes.
- Provide access to personal health information for all individuals who desire access.

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

MeHI Strategic Plan Goals and Objectives Review

Goal 2: **Improve the quality of health care across all providers:** The quality of care should be predictable. Data from EHRs, claims, and other sources will be available as more providers adopt HIT. These data should be used to identify areas that need improvement at the individual provider level and across systems of care.

Objectives

- The Commonwealth will adopt a common set of quality measures across all payers and providers
- The Commonwealth will adopt meaningful use measures as defined by the federal government for reporting purposes
- Support patient-centered care coordination that results in fewer preventable hospitalizations, readmissions and other indicators of poorly coordinated care.
- The state will collect and report quality measures for all providers and track progress on reaching quality improvement goals.

MeHI Strategic Plan Goals and Objectives Review

Goal 3: Improve efficiencies in the health care system and slow the growth of health care spending:

The Commonwealth has several opportunities for improving efficiencies in the delivery of health care. As the state explores payment reform as a mechanism for slowing costs HIT must support the transformation of the payment system to a more transparent and efficient one.

Objectives

- Improve efficiencies in the system by streamlining administrative tasks through the adoption of HIT
- Decrease duplicative administrative functions for providers
- Use HIT to support evidence based medicine

MeHI Strategic Plan Goals and Objectives Review

Goal 4: Improve population health:

The healthcare system must deliver care to a broad array of patients with unique conditions. However the health needs of different communities are determined by factors other than the health care system. In order to improve the health of communities and entire populations, the Commonwealth must have the ability to monitor the incidence and prevalence of certain health conditions and health status, identify interventions that improve health outcomes and complement medical care with public health approaches to addressing health status. HIT should provide the Commonwealth with the necessary tools to monitor conditions related to the public's health for ongoing public health programs, to support emergency preparedness, and inform the impact of health care reform.

Objectives

- Support patient-centric care coordination within and among communities across the state and surrounding state
- Support the Commonwealth's public health surveillance and improvement initiatives
- Improve healthcare system efficiency, resulting in better value for Commonwealth residents

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

Achieving HIT- Related Goals and Objectives

Strategies to Achieve the Commonwealth's HIT-Related Goals and Objectives

The Commonwealth of Massachusetts understands that achieving these goals and objectives will require a core set of strategies to ensure that all healthcare stakeholders move forward together in support of our Vision. These core strategies include the following:

1. **Establish Governance:** Individual organizations have found that clearly defining the decision-making process around HIT-related projects is key to the success of the project. Past community-wide HIT pilot projects in the Commonwealth have demonstrated a greater need for governance in projects involving more than one organization.
2. **Ensure Privacy and Security:** A patient's confidence in the way those involved in handling or accessing their health-related information is at the core of their trust in the healthcare system.
3. **Implement HIT in the Clinical Setting:** As mentioned previously, only 40% of providers in the Commonwealth use an EMR in their office, and few patients have timely electronic access to their health-related information.
4. **Implement HIT in support of Population Health:** The Commonwealth has found that electronic reporting of information required for public health or quality reporting can dramatically improve accuracy while decreasing resources required to support older manual processes. However, very little information is reported electronically today.
5. **Ensure Workforce Development:** HIMSS has found that there is a 40% gap in the number of experienced professionals required to implement all HIT-related projects in the country when compared to those available to perform the work today.
6. **Monitor Success**: In order to keep the Commonwealth 'on track' to achieving its HIT goals and objectives, it will implement a program to monitor progress.

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

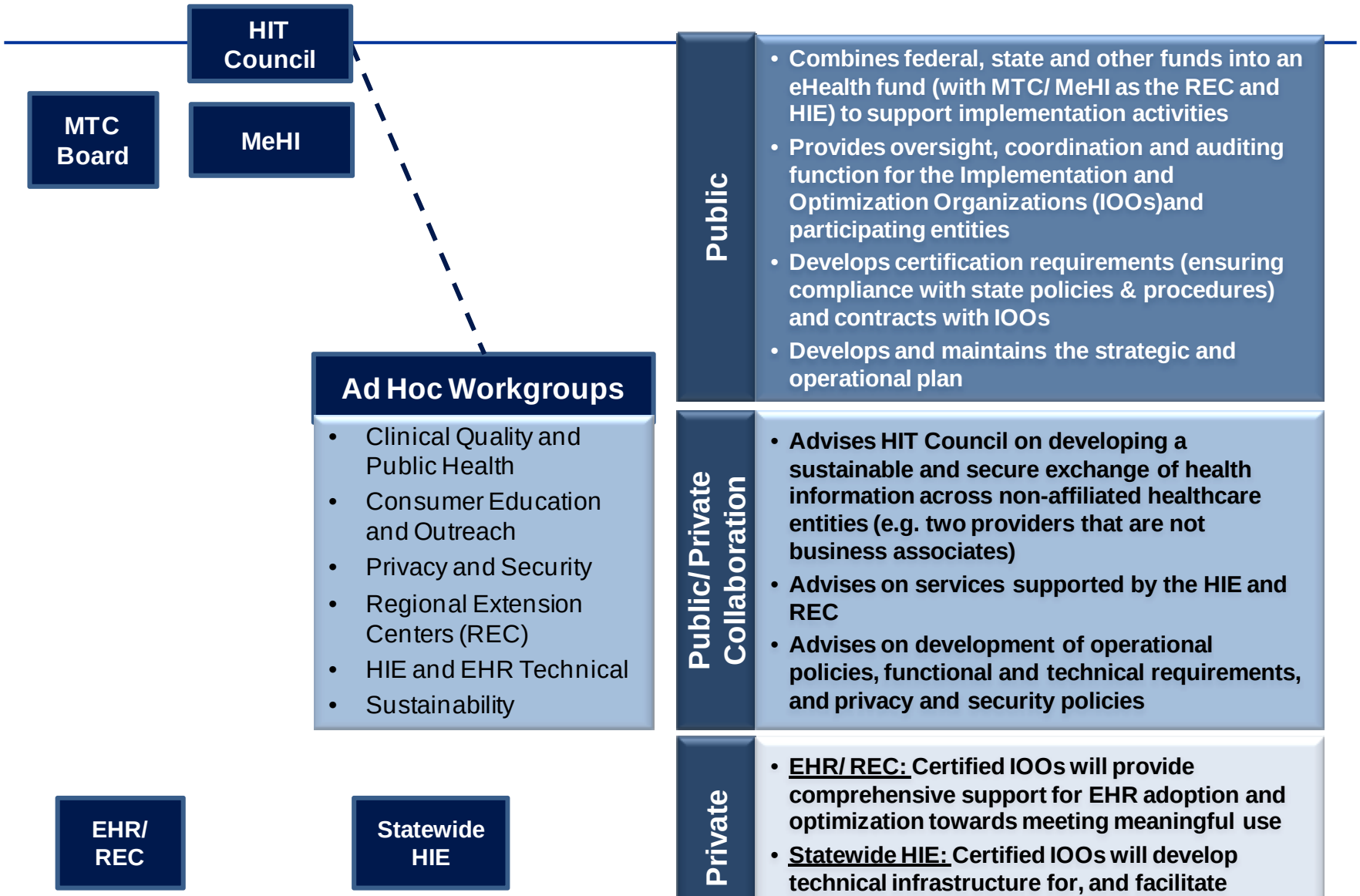
massachusetts eHEALTH institute

AdHoc Workgroups

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

massachusetts eHEALTH institute

MeHI Stakeholder Engagement



DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

Ad Hoc Advisory Groups

Advisory group	Tasks
Clinical Quality and Public Health Workgroup	• Make recommendations for prioritizing the services supported by the HIE • Advise on quality and public health reporting priorities • Advise on activities of the IOO related to the secondary use of data flowing through the HIE • Make recommendations on the types and sequence of services (e.g., single sign on) to support adoption of the HIE by all stakeholders, including providers
Consumer Education and Outreach Workgroup	• Make recommendations on consumer and other public education • Make recommendations on stakeholder education and outreach services • Advise on public and media relations with targeted messages to consumers, providers, policymakers, and other stakeholders as appropriate • Advise on marketing and business development • Advise on workforce development efforts
Privacy and Security Workgroup	• Advise on privacy and security policies for the HIE (and participating systems) • Make recommendations on common consent and authorization policies for the State-wide HIE • Make recommendations on minimum requirements that participating entities must meet in order to participate in the HIE
Regional Extension Center (REC) Workgroup	• Advise on the activities and performance of the Regional Extension Center • Provide guidance to MeHI on the content of the RFQ for certification of IOOs, to the extent appropriate • Receive and review periodic reports from MeHI (acting as the REC) • Provide guidance on common tools or approaches to meet the goals of the REC
HIE and EHR Technical Workgroup	• Advise on how to develop and maintain functional and technical requirements for the HIE • Receive and respond to periodic Project Management Office reports • Provide recommendations on a common security framework or certification program • Advise on maintaining the IOOs approach to implementing nationally recognized interoperability and terminology requirements and standards • Advise on the technical architecture • Evaluate vendor capabilities as needed and provide recommendations
Sustainability Workgroup	• Advise on options for long-term sustainability • Provide recommendations on how to address long-term financial sustainability of HIE and REC services. • Interpret national and Commonwealth legislation as it relates to operation of the HIE and provide recommendations

DRAFT – CONFIDENTIAL
FOR DISCUSSION PURPOSES ONLY

eHEALTH institute

massachusetts eHEALTH institute
A Division of MTC

ARRA: Beacon Community Cooperative Agreement

December 22, 2009

Agenda

- Overview: Beacon Community Cooperative Agreement Funding Opportunity

- Discussion
  - Stakeholder Consortium
  - Letters of Support
  - Funding Categories
  - Proposed Participants

- Next Steps

Summary of Beacon Community Comparative Agreement

ARRA Funding Opportunity Announcement released on December 2, 2009 from Office of the National Coordinator for Health Information Technology at the Department of Health and Human Services

Objectives:

- **To develop "beacon" communities to demonstrate vision for HIT future**
- **To provide funding to communities to build and strengthen their HIT infrastructure and exchange capabilities to model meaningful health IT**
- **To promote the development of a nationwide health information infrastructure built on sustainable efforts of local providers and communities**

Target:

- **Communities with relatively high level of health IT adoption**
  - **If urban, at least 30% of health care providers must have EHRs**
  - **If rural, at least 25% must have EHRs**
- **Ability to demonstrate feasibility of cost and quality improvements**
- **Demonstrate attraction of public and private-sector funding**
- **Consortium of stakeholders with lead applicant**

Use of Funds

- **HIT and Exchange Infrastructure** funds to advance meaningful use of health IT across the community to build the foundation for health IT enabled health system improvements

- **Integration of HIT Into Care Delivery fun**ds to be used to promote utilization of providers of advanced functionalities of health IT system information exchange and enable progress on the specific and measurable outcome improvement goals
  - Instituting clinically relevant decision supports for providers and patients (alerts, reminders, order sets) to inform clinical and shared decision making at the point of care;
  - Improving medication management (enabling medication reconciliation, monitoring and improving medication-taking);
  - Instituting use of registry functions (e.g., maintaining an electronic list of patients with the same chronic disease and utilizing that list to facilitate patient recall, reminders, scheduling of planned visits, and adherence to evidence-based guidelines);
  - Improving care coordination;
  - Engaging patients and families and;
  - Promoting technologies and best practices that enhance the protection of information of all holders of identifiable health information.

- **Evaluation, Performance Monitoring and Feedback** funds to be used to monitor and evaluate the progress towards the health care and population health goals of the Beacon Communities strengthened by HIT infrastructure and exchange.

Award Amounts and Time-line

• Funding Available:	$220,000,000
• Average Award Amount:	$15,000,000
• Award Floor:	$10,000,000
• Award Ceiling:	$20,000,000
• Approximate Number of Awards	15
• Projected Period Length:	36 months
• Applicants Selected:	February 2010
• Cooperative Agreement Awards:	March 2010
• Anticipated Start Date:	April 2010

Letter of Intent due on January 8, 2010
Full Application Deadline: February 1, 2010

Grant Requirements

Letter of Intent:

- Specific and measurable health systems improvement goals
- Geographic area
- Organizational mission, capability and experience
- Ability to leverage existing programs and resources

Full Application:

- Project abstract
- Project narrative
  - EHR/meaningful use gap analysis
  - Goals/objectives
  - Proposed strategy
  - Populations with specific needs
  - Project management
  - Core performance measures
  - Evaluation
  - Coordination and continual improvement
  - Organizational Capability Statement
- Sustainability Plan
- Collaborations and Letters of Commitment from Key Participating Organizations
- Budget Narrative

Approach

- Develop consortium focused on Eastern Massachusetts and possibly one of three MAeHC pilot communities

- MHQP/Boston to be the lead applicant for funding opportunity
  - Convene necessary stakeholders
  - Leverage other roles including Regional Extension Center and Health Information Exchange

- Gather support from key state entities
  - State Health IT Coordinator (Rick Shoup)
  - Medicaid Director
  - Public Health Officials

Proposed Participants

Eastern MA Health Initiative (EMHI)
- Atrius
- BIDMC
- Children's
- Dana Farber
- MA Eye & Ear
- Lahey
- Partners
- Tufts Medical Center
- Blue Cross
- Harvard Pilgrim
- Neighborhood Health Plan
- Tufts Health Plan
- Brandeis
- Harvard University
- Tufts University
- Winchester Hospital

MAeHC Communities
- North Adams
- Brockton
- Newburyport

Greater Boston Aligning Forces for Quality (AF4Q)
- AIM
- Atrius
- BCBSMA
- BIDMC
- BMC
- BMC – HealthNet
- Boston Public Health Com.
- Brandeis University
- MA Coalition for Prevention of Med Errors
- Dimock
- EACH
- EMHI
- EOHSS
- Harvard Med School
- Health Care for All
- HPHC
- MACIPA
- Caritas St. Elizabeth's Medical Center
- Lahey
- MA Business Roundtable
- Cambridge Health Alliance
- MGH
- MHQP
- NEHI
- Children's Hospital Integrated Care Org
- NHP
- Partners
- Winchester Healthcare Mgmt.
- Roxbury Comp. HealthCenter
- Tufts Health Plan
- Tufts Medical Center
- Umass Boston
- Partnership for Healthcare Excellence

AARP
Behavioral Health
Boston Health Commission
Boston HealthNet (HCCN)
Boston Interfaith
Consumers/patients
DHCF
DPH
Employers
Evaluation
Foundations
FQHC's
HCQCC
Health Care for All
Hebrew Senior Life
Home Health
Labs
Long-term care
Lowell CHC
MACIPA
MAeHC
Masspro (QIO)
Massachusetts Senior Care
Medicaid
MHDC
MMS/MHA
NEHEN
Northeastern University
Partnership for Healthcare
PHOs, IPAs, POs
Public Hospitals
Radiology
Surescripts/Rx
Surgicenters
Unions
University of Massachusetts
Veteran's Administration

Potential Stakeholder Groups

- Regional Extension Center program
- State Health Information Exchange program
- VA Hospitals or Department of Defense sites
- Indian Health Service or State or Local Tribal Health site
- Health Research and Services Administration grant programs
- Centers for Medicaid and Medicare Services Demonstration projects
- State Medicaid payment program
- Medicare Quality Improvement Organization
- Department of Agriculture and Department of Commerce broadband funding
- Department of Agriculture telehealth funding
- State Primary Care Association(s)
- Health Professional Societies
- Health Center Controlled Networks (HCCNs)
- Health Plans
- Hospital Systems
- Community Colleges
- Universities and academic health centers
- Employers and employer groups
- Consumer groups

Additional Considerations

- Discuss in context of enabling healthcare reform
- Support for ACOs
- Support for Administrative Simplification
- Unifying quality outcomes
- Meaningful Use for 2011 and 2013
- MA-specific goals (HCQCC)
- MA will support multiple applications as long as they meet grant criteria and coordinate with state.

Next Steps

- Project Kickoff – December 15, 2009
- Letter of Intent due January 8, 2010
- Letters of support required for full application
- Full application due February 1, 2010
- Agreements awarded in March 2010 with April 1, 2010 start date