Draft Minutes

Massachusetts Health Information Technology Council Meeting

January 24, 2011
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)*
Marcie Desmond – *Chief Information Officer, Administration and Finance, Commonwealth of Massachusetts*
Lisa Fenichel, M.P.H. – *E-Health Consumer Advocate*

MTC:

Mitch Adams
Rick Shoup
Carole Rodenstein
Judy Silva
Bethany Gilboard
Donna Nehme

Other:

Norma Lopez, MD
Katie McNamara – *Regis College NP Program*
David Smith - *MHA*
Bert Ng – *Commonwealth Healthcare Financing*
Claudia Boldman, *A&F*
Mark Jacobs, MD – *Caritas Christi Health Care*
Lorillyn Allan - *Lahey Clinic*
Renee Lin – *Healthplangeek.com*
Karen Walsh – *CMS*
John Halamka, MD, *BIDMC, Harvard University and NEHEN*
Manu Tandon, *Executive Office, Health and Human Services*
Deb Schiel – *EOHHS/Office of Medicaid*

The thirtieth meeting of the Massachusetts Health Information Technology Council was held on January 24, 2011 at One Ashburton Place, Matta Conference Room Boston, Massachusetts.

Secretary Bigby called the meeting to order at 3:33 pm.

I. Approval of the December 8, 2010 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 December 8th meeting.

II. Physician Health IT Advisory Ad Hoc Group Presentation: Mark Jacobs

Purpose:

- MeHI organized this group as a unique assembly of physician HIT champions who can provide advice and recommendations.
- It will assist the MeHI REC and the healthcare community to help promote the adoption of HIT to improve quality and safety.
- Physicians can best encourage the adoption and utilization of EHR, e-prescribing, and the HIE by leadership and sharing best practices.
- Chaired by Mark Jacobs, MD and Vice Chairs Norma Lopez, DO and Judith Melin, MD.

Goal:

- Ensure that MeHI REC initiatives support physician goals throughout Massachusetts
- Advise and recommend strategies to the REC that maximize and optimize physician HIT Awareness and adoption.
- Review and help develop educational and training materials that are interesting and relevant to physicians
- Engage colleagues, associations, and trade groups to help promote health IT initiatives that improve quality, safety, and the value of healthcare. For example MA Medical Society, NE College of Healthcare and physicians.

Mark commented on the Physician HIT Advisory Group members:

- All involved believe in the implementation of EHRs across the Commonwealth

- Are positive about creating and making this happen
- Seek to establish one software platform for all the initiatives
- The assembly of this group was done with Bethany Gilboard's help

Question: Secretary Bigby asked about the mix of physicians in the group. Do you have representation from Community Health Centers, Internal Medicine, pediatricians and so on?

Bethany replied that there is a good mix of physicians from across the Commonwealth.

Initial Topics the Group will address through three subcommittees will be formed

1. First subcommittee – Guide for Organizing Optimal Data Entry and Extraction (Good-e)
    - develop a guide to help physicians achieve Meaningful Use
    - emphasis on key points of structured data input and extraction (reporting)
    - REC may be able to use these guidelines to standardize some functions among IOOs (implementation and optimization organizations)
    - could potentially influence standards for quality reporting for PQRI and HEDIS measures
2. Second subcommittee – Paperless Office workflow experienced redesign (POWER)
    - focus on helping physicians and office staff move from paper-based systems to paperless technology
    - requires redesign of office workflow to achieve efficiency and safety
    - design a doctor-to-doctor training approach and use best practices to help in implementation
3. Third subcommittee – Vendor Evaluation Tips (VET)
    - focus on developing a list of questions and criteria for physicians to consider when evaluating HER systems
    - help to demystify the process and focus on the ten most important components in making a selection
    - vendor agnostic and avoid direct comparisons between products
    - be available for one-on-one discussions

Additional Feature – the group discussed working on enhancements to the REC homepage to include:

- Section on FAQ's to be answered by physician members
- "Ask a doctor" – blogs that would be linked to the member-only portal

The Secretary thanked Dr. Jacobs for this exciting and practical engagement

Question: What can the Council do to make sure they are supporting the efforts of this group?

Answer: Not sure, the physicians are very excited about this project. They may ask for resources as they become more involved in the tasks.

Question: Have you thought about how to achieve Meaningful Use?

Answer: This is a challenge, but first we would create a blue print/white paper that includes:

a. Shared wisdom
b. A list of local meetings and forums to spread the word
c. Newsletters or some type of publications
d. Email and mailings

Question: How will physicians react to a structured EHR?

Answer: Interoperability standards and a direct communications plan will be helpful. The HIE clearly define standards for operability.

III. HIE Update

- Governance

1. At the December 8 HIT Council meeting the HIE and Legal Policy workgroup presented recommendations for a governance structure which was approved.
2. One of the key recommendations was to create an HIE-HIT Advisory Committee which would consist of a broad range of health care stakeholders to include:
   - Academic medical centers
   - Community hospitals and health centers
   - Long term care facilities
   - Large and small MD group practices
   - Pharmacies, laboratories
   - Health benefit plans
   - Patients
   - Financial/other expertise

Question: Will there be a vetting process?

Answer: Meg Aranow and Lisa Fenichel agreed to look at the list of recommendations and report back to the Council. It was also stated that the Council members can make recommendations.

The Secretary thanked Meg and Lisa for volunteering to take this important task on.

- HIE Challenge Grants
  MeHI submitted two applications for two HIE Challenge Program grants, Themes 2 and 5.

  Theme 2: improving Massachusetts post-acute care transfers (IMPACT)

  Project Partners
  MeHI/MTC, MDPH, UMass Memorial Medical Center, St. Vincent Hospital, Fallon Clinic, Overlook VNA and VNA Care Network of Worcester, Beaumont Westborough, Blaire House, Christopher House, Jewish Health Care, Knollwood Nursing Home, Life Care of Auburn, Masonic Home, and University Commons Beaumont.

  IMPACT Project has Four Objections
  1. Complete development and testing of a paper and an electronic version of the state's Universal Transfer Form (UTF), based on t he Clinical Document Architecture (CDA)/Continuity of Care Document (CCD);
  2. Develop a tool that translates clinical information into consumer-friendly language that is meaningful and easy to understand for patients and families for use in a personal health record (PHR) or printer on paper;
  3. Establish learning collaborative that will engage post-acute care providers, and build on existing cross-continuum teams to implement and disseminate forms and processes that assure safe care transitions; and
  4. Deploy objectives 1-3 within existing HIEs in Massachusetts and align them with future HIE initiatives.

  Theme 5: Massachusetts Department of Public Health Network (MDPHnet)

  Project Partners
  MeHI/MTC, MDPH, Harvard Pilgrim Health Care, Harvard Medical School's Department of Population Medicine, MA League of Community Health Centers, (additional delivery network to be confirmed).

  Summary
  The MDPHnet project seeks to create, a scalable, transportable, open source, distributed system that allows public health agencies to use patient and encounter level data residing in practice-based EHRs, without requiring transfer of protected health information (PHI). This automated distributed analytic tool will use

normalized data across multiple EHRs to allow authorized users to generate routine counts and standard reports, as well as to build customized complex queries.

Proposal covers the following 4 aims

Aim 1: create technical infrastructure to perform distributed public health analysis of EHR data.

Aim 2: create EHR based data repositories.

Aim 3: develop governance mechanisms.

Aim 4: Use distributed analysis to address major public health topics.

Theme 5 – real time analytic application

- Leverage some capabilities that exist
- Mass league and Harvard med school
- Meeting next week for potential next steps if funded
- Approx 2 million dollars
- 1.9 million in grants
- Pull data from DHR via health information exchange (Karen B)
- Centralized data base with PHI– staying away from
- Expecting to hear award results sometime in February

HIE Procurement Activities

- Advisory Group subject matter expert (SME) Facilitation
    - Hire firm to provide facilitative services with HIE SME to facilitate HIE-HIT Advisory group meetings and staff to work on discrete white papers and other knowledge building and analysis deliverables.
- Solution Integrator (SI) RFP
    - Monitor and manage day-to-day HIE operations, develop implementation guides, gather and refine stakeholder input and manage the assembly of key data, e.g., provider directory input.
- HIE Services RFP
    - Examples of initial HIE services are provider directory services and certificate management services.
- Public – Health Information Service Provider (P-HISP) Services RFQ/RFP
    - Vendor(s) to provide at least a base set of HIE services to enable clinical data exchange at a subsidized rate for providers and provider organizations that meet economic hardship criteria.

Comments:

- We need to research and distill all the information about best practices and bring in firms that have deep expertise for doing this.

- There are a number of firms that does this type of work
- A lot of the firms have already done this work. Pay them for the practices they have already created.
- Interesting service model without a business plan behind it.
- A doctor will pay $25 a month to be connected to a health service provider. The concern is that there are probably few firms that would be willing to connect that small provider. To help the small firms we may need to offer a subsidy.
- Because of the state Medicaid health plan, this might be needed in the future.
- This seems like a slice of the sustainability model, need a full sustainability model.
- Need to determine what is the best approach to get the smaller firms connected.

IV. REC Program Update

- 4 years to achieve milestone targets for CAHs/RHs and for PPCPs
- February 2014 new deadline
- 90/20 Federal funding for all 4 years
- Biennial program evaluation – March-May 2012
- Must pass biennial evaluation to receive funding in years 3 and 4 – may be eligible for additional funding for the final two years if positive evaluation
- Will receive the original per-provider amount requested in direct assistance for additional 13 providers
- Budgets will be revised to reflect program changes and additional guidance from ONC.
- Implications of REC program changes
  - Better opportunity to focus on specialists with additional time
  - Potential to receive more funding
  - Biennial review increases in importance
  - Review all agreements and contacts for implications (IOO, EHR vendor, provider)
  - Review and revise REC business model to reflect program changes
- REC Critical Access Hospital and Rural Hospital Funding
  - Current Funding
    - April 2010 supplement intended to ensure provision of services to critical access hospitals (CAHs) and rural hospitals (50 beds or less) in REC's service area
    - $12,000 available per CAH and Rural Hospital
    - Services and payments tied to same milestones as original REC funding
  - New Supplement
    - RECS are eligible for an addition $6,000 per CAH/RH (for a total of $18,000 per CAH/RH0

- Application was due and completed by January 12, 2011 in order to be considered
- The definition of CAH and RH as not changed based on the original list associated with the FOA to identify eligible hospitals in their area
- Can request modification to the list after additional award is granted.

- REC Enrollment and Operations
  - Target enrollment is 2487
  - Current enrollment is 1956
  - February with whole outreach
  - Working with MBI so we can be right behind them
  - Personal care medical homes and those without EHR access
  - We have the time now to go to the small practices
  - Patient centers, medical homes, and the small medical practices
  - 75% with EHR – gives more available to support more PCPs
  - We are going to model this – install another 5 or 6 hundred which would get us closer to meeting the state objectives

Question: Will your efforts be different with this new phase?

Answer: Yes. In some ways as follows:

- Need to accelerate physicians meeting with the IOO's
- Establish partnership with Mass Medical Society
- Use marketing firm – help us get the word out
- Email blast, social media, the whole gamut
- We have broken the state up in regions and have CRMS addressing certain areas

Will keep the Council posted on our progress.

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- IOO and EHR Vendor Update
  - Process for reviewing all of the contracts
  - Requires a couple iterations to make sure they have incorporated all of the requirements.
  - Continuing to meet with folks on a weekly basis
  - IOO Provider Contracting Compliance Process
    - Provide contract template process (basically the same) – they return back to us showing they meet the requirements
      - We provide them terms and provisions

    Comment: The contract provides clearly what they need to have in place.

- Provide contracting process

- IOO Contracting Milestones
  - Contract/template submitted
  - Contract/template reviewed
  - Contract/template approved
  - Contracting with practice (#PPCP)
  - Milestone 1 payment requested
  - Milestone 1 check paid

Questions: Regarding the review and revision of funding, and looking at numbers:

1. How much money available for direct support? $12 million
2. Could this support a few hundred more? Possibly 100

Question: With regards to the biennial review, how are we doing?

Answer:

1. Need to have all 2500 signed up by June
2. We need 50% of PCP at stage 2 of payment by the biennial review
3. Want to make sure we do a quarterly report
4. Drawing down appropriately
5. Operation plan for 4 years submitted
6. We have a formal documentation process to go through in order to declare that we have made the numbers.

Dr Bell announced that Beth Israel Deaconess Medical Center is the first hospital with a self developed system to be certified. They are well on their way to meaningful use and John Halamka played a key role in this accomplishment.

V. Medicaid Update presentation by Deb Schiel

- Activities currently underway
  - Section A: The State's "As-Is" HIT landscape – developed based on work generated in Core Component 1 – Current Environment Scan
  - Section B: The State's "To-Be" landscape – developed based on work generated in Core Component 2 – State Medicaid Health IT Plan (SMHP)Vision Development
  - Section C: Activities necessary to administer and oversee the EHR Incentive Payment Program – developed based on work generated in Core Component 4 – Provider Incentive Payment Program Plan
  - Section D: The State's Audit Strategy – developed based on work generated in Core Component 4 – Provider Incentive Payment Program Plan
  - Section E: The State's HIT Roadmap – developed based on work generated in Core Components 1,2,3, and 4.

- Components of SMHP
  - Results of EHR Provider Survey and meetings with external stakeholders and professional organizations
  - Current state of HIT governance and MassHealth IT systems (work with MeHI)
  - Provider EHR outreach and communication strategies including websites, fact sheets, email blasts, leveraging existing communication channels within EOHHS/MassHealth, MeHI and external partners such as professional organizations
  - Operational processes, flows and preliminary staffing models for administration and oversight of the incentive payment program
    - Acceptance process of provider applications from NLR
    - Provider registration, eligibility and attestation verification
    - Provider appeals
    - Provider notifications
    - Payment and reporting of incentives
    - Fraud/abuse and auditing processes
    - Federal claiming as well as program reporting
- Plans for EOHHS/MassHealth HIT initiatives to support EHR adoption and state-wide HIE (i.e. HL7 Gateway, Immunization Registry, Electronic Laboratory Reporting, etc.)
- Medical Assistance Provider Incentive Repository System (MAPIR) requirements
    - Multi-state initiative-Massachusetts is one of 13 states developing the core MAPIR product
    - Interfaces with the CMS National Level Repository (NLR) both receiving the provider incentive payment applications through daily batches as well as sending information related to provider eligibility, payments and appeals back to the NLR
    - Interfaces with MassHealth Medicaid Management Information System (MMIS) for disbursing incentive payments to providers
    - Allows providers to enter incentive payment eligibility and meaningful use attestations through existing MassHealth provider web portal
    - Allows Incentive Payment Program staff to process provider incentive payment applications, verify eligibility/attestations as well as approve applications for payment of incentives
- Stakeholder involvement
  - EOHHS/MassHealth
  - MeHI Team
  - External stakeholders
- Next Steps

- Submit SMHP to CMS in early February shortly followed by the HIT Advanced Planning Document and receive approval from CMS to begin steps to implement and administer provider incentive payment program
- MassHealth implements all systems and components of the SMHP that are approved by CMS (March 2011 through July 2011)
    - Continue MAPIR core product development, testing and release activities
    - Massachusetts specific MAPIR customization, testing and certification by CMS
    - Implement MMIS change orders
    - Implement and launch provider outreach, communication and marketing strategies
    - Address all regulatory requirements
    - Continue refining administration and operational components of the Incentive Payment Program
    - Hire and train Incentive Payment Program staff
    - MassHealth is planning to launch Incentive Payment Program in July/August 2011 pending CMS approval

VI. Marketing Update

- Review of Selection History
    - Initial decision to engage a marketing firm was to meet the ONC requirement of signing up 2,500 providers by January 31, 2011.
    - Nine firms submitted their best and final offers to MTC, which where reviewed by internal MTC staff. The top four firms were identified.
    - With the top four identified, all proposals were given to MeHI management and two Health IT Council advisors for feedback.
    - After their review and feedback, two firms were invited to present their proposals in person to MeHI and the two Council advisors: KSV Boston and Solomon McCown & Company.
    - Following the interviews there was no clear consensus on which firm to engage.
    - On November 15, 2010, Health IT Council approved expenditure of funds for marketing services to be provided by either of these firms.
    - Since that approval, it was discovered that the two council members did not receive the full proposals from all nine firms, and what they did receive lacked detail. As soon as this was discovered, it was rectified immediately.
    - Timeline for selecting a marketing firm was pushed back to give Council members time to review the full proposals.
    - During this time, the RECs enrollment numbers were exceeding our initial expectation without the help of a marketing firm, demonstrating that our outreach strategy was

working. Additionally, the deadline date for enrollment was pushed out until Spring of 2011.
  - Because of these two factors, it was suggested we rethink our marketing objectives and approach.

- Reassessment of Marketing Needs
  - With the extension of the REC member sign up timeline and our success of signing up members without the help of a marketing firm, MeHI needs to reassess marketing and communication requirements.
  - MeHI will update the marketing/communication strategy, identifying where we have and lack the necessary personnel and skills to meet the requirements.
  - MeHI will develop the website in-house, with limited outside help with technical requirements, such as the development of a vendor selection tool and vendor status reporting tool.
  - MeHI recommends that we engage an outside vendor to help develop collateral material that will 1) compliment our website; 2) be directed to specific audiences; 3) be able to be updated in-house (this will keep our development costs down).
  - MeHI will also begin a highly focused outreach campaign to target key stakeholder groups.

Summary: We will update the strategy and present back to the Council in February outlining a process for moving forward and we will go back and look at the firms that we have in the stable.

Comment: Regarding changing the audience – REC outreach, HIE outreach, etc., we cannot have a system where the real focus is the patient opting in. Some on the Consent Policy workgroup believe the State law needs to be changed.

Comment: One would prefer to get everyone on board and the focus needs to be on why everyone wants to be on board. What is the value proposition?

Question: Opting in for clinical care purposes vs. opting in for third party access to your information vs. mandated health reporting. How does this impact the patient's privacy or ability to change? Did the Privacy and Security Group address these issues?

Answer: The Privacy & Security workgroup are working on these issues and a meeting is scheduled for Wednesday, January 26 to finalize their thinking. They could not come to agreement on legislative matters. Once finalized, their recommendations will be brought before the Council for their consideration.

VII. Other

With no further questions.

Meeting adjourned 5:05 p.m.