

HIE Network Users Roundtable Discussion
January 19, 2011
Draft Meeting Summary

Participants

Claritza Abreu, Executive Office of Health and Human Services
Michele Alexanian, MA Health Data Consortium
Meg Aranow, Boston Medical Center
Leon Barzin, Massachusetts Medical Society
Mark Belanger, Massachusetts eHealth Collaborative
Karen Bell, MD., CCHIT (via phone)
Ken Bernard, Health New England
Colin Brenan, CIMIT
Michael Brown, MD., Harvard University Health Services
Ray Campbell, Mass. Health Data Consortium
Steve Carter, Cambridge Health Alliance
Ed Charbonneau, Joslin Diabetes Center
Alec Cheloff, Massachusetts Eye and Ear Infirmary
Brian Churchill, Sturdy Memorial Hospital
Marilyn A. Daly RN, MPH, Neighborhood Health Plan
E. Delroy Dixon II, South Shore Hospital
Bill Fandrich, Blue Cross and Blue Shield of Massachusetts
Renee Fosberg, Emerson Hospital
Larry Garber, MD., Reliant Medical Group
Bethany Gilboard, Massachusetts e-Health Institute
Nael Hafez, Pediatric Physicians' Organization at Children's Hospital
John Halamka, MD., CareGroup Healthcare System
Arthur Harvey, Boston Medical Center
R. Scott Hawkins, Boston Healthcare for the Homeless Program
Joseph Imbimbo, Tufts Health Plan
William Kassler, MD., MPH, CMS, US Dept. of HHS (via phone)
Judith Klickstein, Cambridge Health Alliance
Arvind Kumar, CRICO/RMF
Michael Lee, MD, Atrius Health
Daniel MacNeil, Dotwell
Marie Maloney, Senior Whole Health (via phone)
Keith Maxwell, Mass. League of Community Health Centers
Christina Moran, MA eHealth Collaborative
Matthew Moss, South Shore Hospital
Thomas Murphy, South Shore Hospital
Dan Nigrin, MD, Children's Hospital
Ike Nnah, Radius Hospital
James Noga, Partners HealthCare
Dennis Puls, Winchester Highland Management
David Querusio, Harvard Pilgrim Health care

Pat Rubalcaba, Partners HealthCare
Paul Sawyer, MACIPA
Craig Schneider, Mass. Health Data Consortium
Bill Shickolovich, Tufts Medical Center
Jenna Sirkin, MA Health Data Consortium
David Smith, Massachusetts Hospital Association
Brian Stahl, Heywood Hospital
Anand Sundaram, CRICO/RMF
Manu Tandon, Executive Office of Health and Human Services
Micky Tripathi, Massachusetts eHealth Collaborative
Gordon Vineyard, MD, MA Health Data Consortium
David Wessman, Division of Healthcare Finance and Policy
David Whitman, Dimock Community Health Center

Massachusetts HIE/HIT Advisory Committee Network Users Roundtable Discussion

Manu Tandon, Secretariat CIO, EOHHS

John Halamka MD., CIO, CareGroup

The Massachusetts statewide HIE program focuses on infrastructure and adoption and has a multi-stakeholder governance model. Phase 1 of the HIE plan will be an information highway, including the creation of infrastructure to enable secure transmission and exchange among clinicians, public health, and stand-alone registries. The Virtual Gateway will feed into the direct gateway, which leverages existing and new MassHealth infrastructures. The last mile adoption program includes statewide outreach, recruitment, and training programs so that under-resourced practices are not left out of the HIE project. Users will be able to access the Virtual Gateway through all levels of EHR connectivity. Phase 1 of the project goes live in October 2012.

(please see handout)

Q: How will we manage patient message deliveries?

A: The state HIE will have the capability to delivering messages to various addressees, but it still won't determine the addresses. We haven't determined if we are building a "white pages" or a "yellow pages" model.

Q: Will we have the ability to do advanced directives?

A: If we develop the address depository, this should be available for phase 2 or 3.

Q: Should this type of program exist in other states in New England as well?

A: It is possible, MA runs the New Hampshire HIE (similar standards), Rhode Island has also selected identical standards, and Vermont is on the same track.

Q: In a web portal approach, where is data meant to reside and who will manage it?

A: The government has to persist some of the data. Secure data starts at an endpoint and is sent to a repository where it can be viewed.

Micky Tripathi: Workgroups are dealing with important policy imperatives

John Halamka, MD: The state is holding an encrypted message in transport; this is a temporary solution.

Questions:

- What do you think of the overall approach?
 - Service offerings
 - Infrastructure phasing and priorities
 - Last Mile Adoption Program
- Will this meet some of your expected interoperability needs? How can it be modified to better meet your needs?
- What do you think are the key success factors for the statewide HIE service? What do you think are the key failure factors?
- What are your biggest concerns with the statewide HIE approach?

Discussion:

Comment: The state will hold clinical data on all patients, there is some discomfort there. This needs to be transparent.

Q: How will MeHI engage with providers?

A: MeHI will do analysis of users and then come up with a vendor strategy. There will be a 2-4 month process for the analysis.

Q: How will services be manifest?

A: John Kelly is writing the software guidelines. It will be compatible with LDAP, DNS, SOAP, REST, and others. We want to deploy enough options to make it accessible, but not have to support 100.

Q: The Provider directory will include multiple states, retirements, etc. How will doctors be identified?

A: We will need to know the provider affiliation/location and develop routing logic to ensure documents are being sent to the correct organization.

Manu Tandon: The insurance companies know who the PCPs are and can provide use cases.

John Halamka: The RFR is a learning process; no one has solved this yet. Manu needs help with both administrative and clinical transactions.

Q: Which vendors have expressed interest?

A: Manu Tandon: This will be posted after February 6.

John Halamka: KLAS Report shows all HIE vendors in US have very few customers.

Q: How will the provider directory be defined to vendors?

A: The provider directory will locate entities rather than individuals. In Massachusetts, we will keep it simple by only thinking about the entities, and leaving it up to them to route the information to the correct individual in the organization. Anything other than the IP address of

the entity will be completely optional for individuals to provide and will be defined by convention.

Micky Tripathi: Health Bridge, for example, has a provider directory but most information is no longer accurate.

Manu Tandon: What input into the governance should the CIO community have? How will we handle funding cuts? We want a business service people can rely on.

Comment: We need to know exactly who is going to be held accountable. We need penalties in the contract.

Ray Campbell: Are we comfortable having the state be mission critical, and relying on their services?

Comment: Money implies a relationship and dependence on the state. How long will this be self-sustaining?

Manu Tandon: The intent of this project is that it succeeds, we have no other motive. We will be looking for reality checks all along the way when making decisions.

Comment: This is a question of government control vs. free market. I am troubled by the government sustainability factor, what happens when administrations change?

John Halamka: This shouldn't be affected by changes in administration because Medicaid funding is longitudinal and less politically dependent.

Comment: I think that it's good the government is involved. That means there will be open forums like this one, and more transparency.

Micky Tripathi: The government can take risks the private institutions cannot. Once the model is proven, we can transition to private services.

Comment: If nothing else, we need at least a separate committee overlooking the project, such as an advisory committee to help with participation.

Manu Tandon: Establishing an advisory committee would be the least we would do to oversee the implementation. When using federal money, there are always restrictions. In this process the feds have been flexible and supportive. This will solve the problem of sending clinical data across disparate systems. If the community believes this has business value, then it will be sustainable.

Q: Change in leadership could cause a change in direction. This needs to be communicated.

A: We are committed to a certain effort; risks of directional change are low. Use cases could change by priority, but it would take years to change the strategy.