Meeting Minutes
Health Information Technology Council Meeting
April 4, 2016

3:30 – 5:00 P.M.

One Ashburton Place, 21st floor Conference Room
Boston, MA

HIT Council Members

Name	Organization	Attended
Alice Moore	*Undersecretary of Health and Human Services (Chair- Designee for Secretary Sudders)*	Y
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	N
Charlie Desourdy	*Acting Commonwealth Chief Information Officer*	Y
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Y
Daniel Tsai	*Assistant Secretary – Mass Health*	Y
David Seltz	*Executive Director of Health Policy Commission*	Y
David Whitham	*Assistant CIO for Health & Eligibility, EOHHS*	Y
Jay Ash	*Secretary of Housing and Development, Commonwealth of Massachusetts,*	Y
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Y
Jay Breines	*Executive Director, Holyoke Health Care Center*	N
John Addonizio	*Chief Executive Officer, Addonizio & Company*	Y
Juan Lopera	*Vice President of Bussiness Development, Tufts Health Plan*	Y
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	N
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve College of Health Sciences*	Y
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Y
Margie Sipe, RN	*Assistant Professor, MGHIHP and Nursing Program Director at Brigham and Women's*	Y
Meg Aranow	*Senior Research Director, The Advisory Board Company*	N
Michael Lee, MD	*Director of Clinical Informatics, Atrius Health*	Y
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	Y
Patricia Hopkins MD	*Rheumatology & Internal Medicine Doctor (Private Practice)*	Y
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Y

Guests

David Bowditch	EHS
Julie Creamer	EHS
Kathleen Snyder	EHS
Michael Chin	EHS
Nick Hieter	EHS
Ratna Dhavala	EHS
Ryan Thomas	Orion Health
Jennifer Monahan	MAeHC
Mark Belanger	MAeHC
Micky Tripathi	MAeHC
Erica Morin	Berkshire Health Systems
Lisa Fenichel	Consumer Advocate
Erika Scibelli	Health Policy Commission
Darby Buroker	Steward Health Care
Kris Williams	EHS
Joe Heyman, MD	Wellport HIE (Whittier IPA)
Kate Barrett	Health Policy Commission

Discussion Item 1: Welcome

The meeting was called to order by Alice Moore at 3:34 P.M.

Undersecretary Moore welcomed the Health Information Technology Council to the April 2016 meeting and noted that the agenda and slides were sent out in advance for review prior to the meeting. New members of the HIT Council were introduced: Jay Ash, the Secretary of Housing and Economic

Development for the Commonwealth, Juan Loperas, Vice President of Business Diversity at Tufts Health Plan and John Addonizio, Chief Executive Officer at Addonizio and Company.

Ms. Moore thanked and honored two previous members of the Council, Steven Fox and Dr. Lawrence Garber for their great participation and assistance in the transformative stages of the HIway. The Council praised their contributions.

Undersecretary Moore announced that expiring membership terms are under review at the Governor's Board. If there is an interest in a re-appointment please let Undersecretary Moore know. For people that are interested, it is generally suggested that applicants provide a resume. There is a process that the Boards and Commissions Office can let us know about. If anyone has questions they are encouraged to contact the Undersecretary's office after the meeting.

Undersecretary Moore stated that today's meeting looks at how the HIway will move ahead here, focusing on somewhat of a more accelerated, more advanced approach to the HIway. We have in the past focused so much on getting folks signed up for the HIway and some of the logistics operations of being on the HIway and we have been adept at providing access for public health reporting information via the HIway. Now, through MassHealth, through the Massachusetts eHealth Institute (MeHI) and through the Department of Health and Human Services IT department, we are looking at the next generation of the HIway - of course we will look for HIT Council input and work through some of the Advisory Committees that will be ongoing. We will very much have an agenda moving forward and we will absolutely need everyone's valuable advice in a continuing way.

The December 7th meeting minutes were approved as written.

Undersecretary Moore introduced Sharon Boyle and Kathleen Snyder to give an update on opt-in/opt-out consent requirements. Undersecretary Moore stated that the last time we had this discussion this Council had unanimously urged leadership to seek ways to provide for more flexibility for Direct Secure Messaging (DSM) – the team is happy to walk though some of the legal and policy considerations that will happen.

Discussion Item 2: Opt-In/Opt-Out and Regulations Update

See slides 3-15 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An update on the opt-in/opt-out regulations was presented by Kathleen Snyder, Deputy General Counsel at the Executive Office of Health and Human Services, and Sharon Boyle, Chief MassHealth Counsel.

(Slide 4) *Executive Summary* – Today the focus is on the mechanisms that the statute requires, which is for the state to have a mechanism for individuals to opt-in and a mechanism for them to opt-out at any time – this is where we framed the discussion. What we proposed to do for opting-in is to provide notice - require participants to provide notice to individuals who come into the offices either by posting it on the wall, or distributing it at the same time they distribute their Notice of Privacy Practices (NPP) documents. EOHHS does not want to be overly prescriptive but also wants to make sure individuals are aware of how the participant uses the HIway. That is the proposal to promulgate the opt-in process.

The opt-out is something where we will spend most of the time today. We have a mechanism for managing a centralized opt-out process- similar to a 'do not call' list. Like telemarketing, we can do that for the HIway hosted services [Relationship Listing Service, Event Notification Service] – we are pretty confident we can do that. We are still working on how they would handle a centralized process for the opt-out of direct messaging- we know that is something there is a lot of interest in. We think providing public notice will reduce the opt-out - people are generally going to accept the notice and accept that it is the way it is. We are hoping that it will do a lot to manage the provider burden that people are experiencing. Today we did want to talk a little bit about the-opt out process, and wanted to give people information on potential solutions for how to do that.

(Slide 12) *Draft: Proposed Mechanism for Opt-Out* – [note; presenters skipped over several of the background slides since most of the Council members have been previously briefed on the Mass HIway services offered.

- Comment (Alice Moore): Can I stop you for a second and see if anyone would like us to walk through those slides.
- Question (Deborah Adair): I had a question unless you would like us to hold those?
    - Response (Alice Moore): I think we can do that afterwards, but is there anybody who wants to get a sense of those two different types of functionality? I will look to Daniel Tsai to do that.
    - Response (Daniel Tsai): This came from the process last summer and fall where several sub-groups took a look at both what providers and stakeholders needed in terms of HIway functionality to make it much more useful, where the effort of adopting and joining the HIway would be more worthwhile. EOHHS is looking to promote Accountable Care and Population Health efforts. Direct messaging is a function of the HIway that is happening right now. The HIway hosted services are the Relationship Locating Service (RLS) and an Event Notification Service (ENS). Daniel asked if David Whitham to describe what the RLS does.
    - Response (David Whitham): The RLS keeps a record of interactions and transactions between HIway participants. If an Emergency Room transmits a message to a primary care clinician that registers as a relationship with the HIway that would be available for the primary care physician and the ED can determine what relationship that patient has. The relationship is only available to the participants that have a direct HIPAA connection to the patient – not generalized information that is available to everyone.
    - Comment (Daniel Tsai): That is an existing service today, and the Event Notification Service was the area highlighted as the most helpful for facilitating the ADT messages, this would be

new functionality that would be built into the HIway. Topics of consent were not an abstract topic.

- Comment (Kathleen Snyder): From the legal construct, the disclosure of information is the same. For the last few years we have referred to this as just consent, and what we want to do is reframe the statutory requirements as the mechanism for opt-in and opt-out. Just to reframe it, there is always going to be a HIPAA element for any information that will go with the HIway, the same way there is a disclosure sent via fax.
- Comment (Sharon Boyle): It should be pretty straightforward- for all of the functions that the HIway has – our proposal to promulgate regulations so we have an opt-in through notice. The providers are required to provide their patients with notice, just like a Notice of HIPAA Privacy Practices, that is the opt-in. For opt-out we do look for some feedback for all of the activities, we have a technical way, and we would like to do a centralized opt out to reduce the burden on providers, we view that as being ideal. We may not be able to technologically, or easily, manage a centralized system for opting-out of the direct secure messaging function. Comment (Daniel Tsai): Let me provide a little more context for the folks that are new to the HIT Council. This began when we all looked at participation and usage of the HIway. One topic that was clear last summer and fall was that despite the number of entities connected, which tend to be larger, the primary use of the HIway was around reporting to DPH and use by certain systems that had the sophistication to use the HIway. It was this catch-22 of not getting members onto the HIway, so other providers are not getting on, so why would I want to get on. The other piece is that when we talked about the notion of every provider managing their own opt-out there was a concern- for many it was a source of truth issue- if I walked into one provider's office and not the other, how they are adjudicated. The state is thinking through what a centralized opt out process would be-in terms of 42 CFR Part 2, HIPAA and so forth, all while also trying to get to a more integrated system for improved population health.
- Comment (Deborah Adair): In the last couple of meetings we have had we talked about the opt-in and opt-out. I support the, I'll call it opt-out method, at the last meeting we had the proposed two opt-out models and I think that what we want is something different than what we had, and in my mind I'm thinking it's really opt-out. The law still says opt-in, by doing this I do not really think we are doing opt-in anymore. My suggestion was that the law needs to change to opt-out, that is what we were looking for. We have had a very difficult time to try to figure out how to get the HIV and 42 CFR Part 2 patients to participate in the HIway.
- Comment (Alice Moore): By "you," you mean Partners?
    - Response (Deborah Adair): Yes- we have this method where they have to consent to have their stuff go in, and once it is shared it expires, we had them consent again, we are willing to do this a new way but we are going to have to undo what we have done. In the law Section 13 also talks about opt-in: <u>*Section 13.*</u> *The ability of any provider to transfer or access all or any part of a patient's electronic health record under this chapter shall be subject to the patient's election to participate in the electronic health information exchange as provided in section 11.* I am concerned about calling it opt-in when it is not really not.

- Response (Alice Moore): That is why we have the lawyers here, we may have a difference of opinion. I know there was a path that had been well traveled which has led us to a place where we need to evaluate what it can do, and what it cannot.
- Response (Sharon Boyle): The one thing I wanted to say is the HIPAA, 42 CFR and others- all of those laws apply, not just to the HIway but also to the fax machine and the phone- every other use and disclosure that there are. I agree with you- you would need for Part 2 for example, a way to gather required consent regardless of whether it is going via the HIway or via fax. I do not think that is an issue - that is one of the things I wanted to help untangle. Those HIPAA and 42CFR Part 2 laws got conflated with the state statuary requirement to provide for a mechanism for opting-in and opting-out. What we are planning to do, with support from HIT, is to promulgate proposed regulations to show the world what our mechanism is, and again the opt-in mechanism is to provide notice to explain to patients 'this is a process that we use- just like the fax I will appropriately use and disclose your health information.' I take issue a little bit with the fact that we are just doing opt-out because providing a clear notice to is a very effective means of providing an opt-in mechanism.
- Response (Alice Moore): This is just the discussion phase, where we get to bat it around and discuss which might work and which may not- this is just the start of a lengthy process
- Comment (Mike Lee): I think this is overall an elegant solution to a tough issue and I appreciate the effort put into it. If you allow organizations to also decide then there is nothing that prevents an organization from increasing their level of comfort. From the patients perspective RLS and ENS are a little more complicated and the state has not set up a mechanism for managing those. Our public notice could say that we are sending your information across the HIway, we could change it later, and in the meantime we could continue to allow opt-out at a provider level. I think what you have done provides us with a little more flexibility to differentiate the two without you having to redo this...
- Question (Patricia Hopkins): Is there standardization of language on the notice form?
    - Response (Sharon Boyle): When we promulgate regulations we want to give as much flexibility as possible – general guidance that they must provide notice to the patient. Similar to the HIPAA NPP- no prescribed text, but that is something we can consider.
- Comment (Lawrence Stunt): Coming back to Debbie's point, I think about the interest in opt-in model, was to give patients information about what we are going to do, but it was also for the HIway to provide a secure mechanism for patients to decline to participate. I think that this is a good model that does all of that. I think it provides information for providers and patients, but it will be important to give participants that standardized language especially as some providers do not have the means to come up with a standard form. MeHI is interested in helping provide that support. The public notice I think provides adequate information to patients if they care to use it. I also think this to me is opt-in with a default option that you are opting in. When we did research, north of 80% of patients felt direct messaging was a good idea, it is something that patients really want. If we can test this out I think it is a good option.
- Comment (Kristen Madison): One of the reasons for opt-in is to engage the patients. With this process we are eliminating that active engagement. The idea behind it is that it would be maintained through a very broad definition of notice. I would encourage in the regulations that we

really push on how that process occurs. For example, if it is going to be broad rule, like posting on a web portal notice or a poster, that is very different than each patient receiving a piece of paper. The only difference here is that we are not asking for a signature at the clinic. I am thinking about this from the perspective of how we want people to buy in to this process. I think it is important for the direct secure messaging, but certainly more important for the ENS and RLS services.

  - Response (Sharon Boyle): I think that is useful feedback, and worth further discussion - how prescribed we should be with the notice, that is something that is important and still open to discussion. The regulatory process will include a comment period as the Undersecretary noted.
  - Response (Kristen Madison): As far as I know HIPPA is just a notice, not a mechanism for opt-in.
  - Response (Sharon Boyle): I agree, under HIPAA you can make uses and disclosures, there is no requirement to talk about it with the patient, you do not discuss how their information is being shared over fax. There is a requirement to provide the patient with a an NPP but they do not always discuss it.
  - Response (Deborah Adair): I just want to come back to an earlier point, HIPAA does not have an opt-in phrase, so I am just worried about the patients. They get very concerned on where their data goes. We have had the patients opt in, we tried to talk them into it, we explained it, and patients did not want it. Now if patients go look at the law they could say we were never given the option to opt-in.
  - Response (Alice Moore): It is not as though there is not a mechanism to opt-in
  - Response (Sharon Boyle): There is a way for them to express their desire not to opt in when they receive the notice and they will be given appropriate opportunities to opt out.

- Comment (Alice Moore): This is not unlike other systems.
- Comment (David Seltz): First I wanted to note that this is a great conversation thank you for putting this work together; this is exactly the type of conversation this Council should be having. From a policy perspective we are supportive, the policy has always been around how to remove unnecessary barriers to participation, how to better facilitate healthcare and to underpin our transformation in Massachusetts. The charge of the lawyers from the last meeting was to have them look and see what we can do in the regulatory framework, I think this is a great process Madam Secretary. Interestingly, the Health Policy Commission is in the process of developing guidance that requires risk bearing organizations and Accountable Care Organizations to provide notice to patients around the right to file an appeal- an internal appeals process. The first approach was to give patients the notice that they can make an appeal - we had a discussion around what a notice should do, and what it should look like to say even with broad flexibility about what form that notice might take- this is what it could look like. We also took it a step further and said this is what it might look like. That may be something worth looking into-what form providers are using to provide that notice. A feedback loop on how the providers are doing this, either via email, poster or a more active way, may provide us with some insight into how providers are approaching this. Last point, is probably on an wish list, when we talk about an opt-out process it is interesting to think about how we may have a customized opt-out, not for the entire HIway, just the individual participant, but I know that technology is many years away.

- Comment (Deborah Adair): I want to make note of pages 11-14 in the minutes, and remind the Council that there was a vote regarding the direct messaging piece - we said that with 'appropriate changes to language as necessary'- on this proposed opt-out, we only have the RLS and the ENS.
    - Question (Alice Moore): Considering what language?
    - Response (Deborah Adair): There was discussion about whether direct secure messaging required consent. The Council approved that we did not need to get consent. We said there would be some consideration of the language in the law.
    - Comment (Alice Moore): I think what we did really was to say that we would engage in a regulatory statuary option - the team approached it to understand what at this point we can do at regulation level - look at the statue and what it does and does not provide. What it does here is based on those three options, and what is possible in the regulatory realm.
    - Comment (Sharon Boyle): The statue does not currently distinguish between different functions. All functions could provide for the ability to opt-out - to the extent that we can. We are still working on that for Direct Secure Messaging.
- Comment (Daniel Tsai): One of the areas that would be helpful is, say we wanted opt-out for Direct Messaging, a centralized opt-out would not work for Direct Messaging by virtue of there being no 'box' to check - the HIway has no knowledge at any time, just like we do not know that two providers fax to one another right now. Unless we start to collect the information, the alternative is to have every single provider do their own opt-out, which does present more of a challenge, as Sharon mentioned the opt-out from Direct Messaging will be much lower with this model. There are other options we have seen in other places, the opt-out linked to the practice - opting out has a higher bar in some cases. It would be helpful to hear from this group how folks relay those messages.
- Comment (Mike Lee): I think since we already have the opt-in and opt-out built, we may allow the opt-out at the local level until you figure out where the centralized opt-out will be. It will be easier to communicate to patients that this notice (as an organization) is going to be about Direct Messaging so that everyone understands that piece, then they can tell people the value- it is hard to explain the ENS and RLS to anyone, even us on the Council. I do answer a lot of questions – we have patients that have made multiple selections over time around (1400 of them) we deactivate over time- even at a large organization it does become a burden. I think you have it right here, but I do not think there is a way to manage consent for Direct Secure Messaging. The consent forms I have seen lay out all of the ways that information is used- that is more clear to patients- 'we have many ways of sending your information, not just the over the HIway'- a notice that lays it all out is better.
- Comment (Deborah Adair): There is no law that says you need opt-in or opt-out for faxing.
- Comment (Audience- Joe Heyman): Speaking on behalf of Whittier IPA, which represents 50 practices, roughly 200 doctors. First would like to say I support this proposal, it is fantastic, but I am a little nervous that the conversation is going back to maybe we can decentralize the opt-out. I do not know if anyone on this panel represents small practices, but the burden of opting-

in and opting-out means having to keep separate records. Unlike large hospitals or networks that have the wherewithal, this creates a barrier for the small practices who are reluctant to use the HIway. Anything that this Council can do to remove the barrier and burden on a small practice would be great.

- Comment (Daniel Mumbauer): I love the idea of you handling the opt out- most of my clients fall into the 42 CFR bucket - 42 CFR and HIPAA apply to the fax machine, phone, screaming down the street, those laws continue to be covered by separate laws. You have to have the right kind of consent. I look at the RLS that does not seem like a practical thing to use, Direct Secure Messaging does not have a huge issue- it is the next step down, the RLS, I see that as a bigger issue because we have a release, and our releases expire. We manage this at a small local level.
    - Response (Sharon Boyle): This may be worth a separate conversation, those rules do apply. No one here should be under the impression that those rules do not apply.
- Question (Daniel Tsai): Question for Joe- let's say David built the perfect centralized opt-out, from a Direct Secure Messaging standpoint, it will be a difference in the workflow. Even if we could identify who was on the do not call list- what would it take for the clinician to do this?
- Comment (Audience- Joe Heyman): I am not sure I can answer that. If there is a centralized system, that means that someone is holding the information that the person opted-out. A lot easier for someone to look at a list and see that the patient is not on it than it would be for a provider to keep their own list. Having to compile a list is just much more difficult than others providing that record.
- Comment (Dan Tsai): The simplest starting point when standing up is you are either in the HIway or you are out. If you go to one practice, what is the source of truth- you are either on the do not call list or not. It is much easier to adjudicate. These are some of the details that we are operationally going to have to figure out. If we do not have the 'do not call list'- if someone is pinging for ENS and David is on the do not call list and I am interacting, how do we catch it at the HIway. We are not storing the information, it does not go back to the provider, but those are the details we need to hear about- the operational workflow to work through.
- Comment (David Seltz): When we did our research into the opt-out space- there is a vendor space where vendors can come in and work though some of those records, how does the ping come back, and some of this is part of the private sector needing to work with those providers.

Undersecretary Moore stated that this discussion will continue beyond today.

Discussion Item 3: State Medicaid Director Letter 16-003

See slides 16-20 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An overview of the State Medicaid was presented by David Whitham, Assistant CIO for Health & Eligibility at EOHHS

On April 29th this year CMS issued a letter announcing the expansion of funding and scope for HIE. Previously matching funds were only available for Meaningful Use eligible providers (EPs) and eligible hospitals (EHs). Given Stage 2 and 3 of Meaningful Use focus on care coordination, support is becoming available for non-Meaningful Use providers and to help the EPs meet stage 2 and stage 3. For example funding can support onboarding to the HIway. It does not include the ongoing operations or maintenance and funds cannot be used to support EHR use or functionality of EHR systems.

- Comment (Daniel Mumbauer): I understood our nurse practitioners with psychiatric training are not eligible providers from a state perspective, but clarification is needed at the federal level.
    - Response (Daniel Tsai): We had the discussion with the feds and we have logged a formal request with CMS to look at the psychiatric nurse specialists and get permission to give them incentive payments. One of the technicalities is the definitions of each type of provider. That being said, they are moving that request through the process and the legal team is developing a response to that. As soon as we receive feedback we will then disseminate it – it is something that is actively in process.
- Comment (Daniel Mumbauer): Most of the younger grads come out as NPs with a specialization- that group is even less grey- I can understand the confusion- it sounds like both sides need to agree. We had that exact distinction in the letter.
- Comment (David Whitham): My understanding is that the authority comes from the state, not just the Medicaid providers.

(Slide 19) *Supported Activities*- The expansion of scope included behavioral health, home health provider, labs, public health providers. These providers can access these activities but funding supports the cost of HIway onboarding only- it does not support funding of EHR. The State Medicaid Director letter supports design of interoperable systems that support EPs in coordinating with other interoperable systems if it helps the EP demonstrate Meaningful Use. Examples can be provider directories, care plan exchange, public health systems, and HISP services. CMS is clear they are willing to investigate other services.

(Slide 20) *Final Thoughts*- The scope of the HIE letter was very prescriptive – the State has to match the 10% funding. Funding must connect EPs to the providers needed- participants need to document and benchmark the things that are currently not defined. EOHHS is reviewing and continuing to work to propose something to this Council in the future.

- Question (David Seltz): This is an offline question maybe, but when we talk about Medicaid is it all providers that bill Medicaid- is it based on revenue?
    - Response (David Whitham): Yes, you just need to be providing Medicaid services.
- Question (David Seltz): It says they need to be coordinating with EPs and EHs- did they define coordination? Or is it by virtue of working with them?
- Response (David Whitham): The letter speaks to use cases that support Meaningful Use metrics, things like care coordination and medication reconciliation.
- Question (Daniel Mumbauer): In the past MeHI has funded many projects, including moving data from our system to public health, is that the type of project that would be funded for this kind of initiative? And what is the option here for behavioral health?

  - Response (David Whitham): When you have the infrastructure and capability but perhaps cannot connect to the HIway.
- Question (Daniel Mumbauer): If I needed to buy another piece of software that is not fundable?
  - Response (David Whitham): Correct, it cannot be used for software.
- Comment (Mike Lee): At Atrius we have no recipients to send transactions to. Part of this funding is to say that behavioral health providers can use funding to enable our providers to send to them- enhances the EP's ability to meet Meaningful Use but also enhance communication.

Discussion Item 4: Outreach Deep Dive Approach

See slides 21-24 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

David Whitham provided an overview of the deep dive approach for increasing active use of the HIway.

(Slide 22) *Focus on Active Use*- The HIway Account Management Team has shifted its focus from helping participants connect to the HIway, to helping participants use the HIway. We have discovered that active public health reporting does not translate to active use. We are now in a 'deep dive' project to look closely at how to transition the providers from technically connected to active use cases- especially sending and consuming information from other participants.

(Slide 23) *eHealth Progression* - The Account Management Team is going from step 5, back to step 3 to ensure participants on the HIway are taking full use of the services that are available to them. Across all parts of the IT- one of the key gaps that was identified when this started up. The HIway team is now engaged at the clinical level, administrative level, and technical level which is what allows these services to be successful. We have 10 active participants in this effort and we have a lot of use cases; the team is in the process of documenting this. Mr. Whitham encouraged others to join the effort- help us help you and contact the team for a deep dive.

Discussion Item 5: FAST Initiative Update

See slides 25-27 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An update on the FAST Initiative was provided by the Director of HIway Operations, Dave Bowditch provided

(Slide 26) *FAST Initiative Update – Provider Onboarding*- One of the things we are doing on the HIway is to take on some short term quick hit projects that will help us to improve the onboarding and connectivity including new documentation, and simplified the ways to connect. We wanted to bring one to your attention today. The provider directory (PD) collects all of the information at the provider organization so others can look up and send a message to them. It is a very cumbersome process with a spreadsheet so for the PD we are working on a web process that will allow participants to come in and add someone for a webmail. We will make a web service available for easier communication. We are prioritizing what we hear from providers and this one is just gearing up.

Discussion Item 6: Operations Update

See slides 28-39 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Dave Bowditch provided an update on HIway operations.

Note: The regular operations slides were provided for review offline due to meeting time constraints. Overall HIway participation is continuing to grow, and there is an increase in provider to provider transactions despite the short month in February.

Discussion Item 7: Conclusion

See slides 40 and 41 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Alice Moore provided closing remarks before adjourning the meeting

The next meeting of the HIT Council is June 6th 3:30-5PM.

The Advisory Groups will meet the week of April 11th

The HIT Council was adjourned at 4:54.