Meeting Minutes
Health Information Technology Council Meeting
August 7, 2017

3:30 – 5:00 P.M.

One Ashburton Place, Boston, MA 02108

HIT Council Members

Name	Organization	Attended
Alice Moore	*Undersecretary of Health and Human Services (Chair- Designee for Secretary Sudders)*	Y
Daniel Tsai [1]	*Assistant Secretary, Mass Health*	N
David Seltz [2]	*Executive Director of Health Policy Commission*	N
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Y
John Addonizio	*Chief Executive Officer, Addonizio & Company*	Y
John Halamka, MD	*Chief Information Officer, Beth Israel Deaconess Medical Center*	Y
Juan Lopera	*Vice President of Business Diversity, Tufts Health Plan*	N
Justine Carr, MD	*Former Chief Medical Officer, Steward Health Care System*	Y
David Whitham	*Assistant Chief Information Officer for Health and Eligibility*	Y
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Y
Manuel Lopes	*Chief Executive Officer, East Boston Neighborhood Health Center*	Y
Michael Lee, MD	*Medical Director, Children's Hospital Integrated Care Organization*	Y
Patricia Hopkins, MD	*Rheumatology & Internal Medicine Doctor (Private Practice)*	Y
Sean Kay	*Global Accounts District Manager, EMC Corporation*	N
Ray Campbell	*Executive Director of Massachusetts Center for Health Information and Analysis*	Y
Diane Gould	*President & CEO, Advocates, Inc.*	Y
Katie Stebbins	*Assistant Secretary of Innovation, Technology, and Entrepreneurship, Executive Office of Housing and Economic Development*	N
John Budd	*Mirick, O'Connell, DeMallie & Lougee, LLP*	N
Lauren Peters	*Associate General Counsel & Director of Healthcare Policy, Executive Office for Administration & Finance*	Y
Margie Sipe, RN	*Assistant Professor, MGHIHP and Nursing Program Director at Brigham and Women's*	Y
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	N
Naomi Prendergast	*President & CEO, D'Youville Life and Wellness Community*	Y

[1] Monica Sawhney attended the August HIT Council meeting as Dan Tsai's designee

[2] Katherine Shea-Barrett attended the August HIT Council meeting as David Seltz's designee

Guests

Brian Pettit	EHS
Dave Bowditch	EHS
John Gilbert	EHS
Julie Creamer	EHS
Kathleen Snyder	EHS
Nick Hieter	EHS
Ratna Dhavala	EHS
Jennifer Monahan	MAeHC
Mark Belanger	MAeHC
Michael Chin	Mass Health
Joe Heyman	Wellport HIE
Steven Byrne	Beacon Strategies Group
Murali Athluri	MAeHC
Jerry Kilcrease	Orion
Micki Tripathi	MAeHC
Ryan Thomas	Orion
Mark Stone	ICA

Discussion Item 1: Welcome

The meeting was called to order by Undersecretary Alice Moore at 3:32 P.M. Undersecretary Moore welcomed the Health Information Technology Council to the August 7, 2017 meeting. The May meeting minutes were approved as written.

Discussion Item 2: HIway Infrastructure Update

See slides 3-7 of the presentation. The following are explanations from the presenters, with additional comments, questions, and discussion among the Council members.

An update on Mass HIway infrastructure was presented by David Bowditch

(Slide 4) *Implementing the new Mass HIway Direct Messaging System: "HIway 2.0"- Mr*. Bowditch provided an update on one of our core systems, Direct Messaging, which is in the process of being upgraded. At our last session we went through a review of why we are doing this and some of the key improvements to look at. One of the key improvements is to look for a system that is EHNAC accredited so that the HIway can join Direct Trust and work with other HISPs and other health information exchanges more readily, more securely and in a more standard fashion. The team is also looking to implement a system with the current standards in mind; a commercial solution that is upgraded and maintained on a regular basis and will bring us new features. Additional detail is provided in the two slides in the Appendix.

From a progress standpoint, the HIway put together a procurement team, and has selected a vendor. They are currently in negotiations with that vendor and the goal is to have that contract in place before the end of October.

(Slide 5) *Implementing HIway 2.0 Cont.* – The general timeframe, once the contract is signed is to get to the point where we can go live on the new system, or 'HIway 2.0,' within the first three months. Once live, the team will start onboarding new participants onto the new system and migrate those on the old system onto the new 2.0 platform. We will continue to operate both the current HIway 1.0 and HIway 2.0 during that migration and it will not impact communications between systems during that time.

(Slide 6) *Implementing HIway 2.0 Cont.* – Prior to go-live, in those first 3 months, the main activity will be working with the vendor to connect EOHHS up to the 2.0 system – including all of the internal connections to Mass Health, the Department of Public Health, making sure all of the internal systems are setup, as well as the HISP to HISP connection between the new HIway 2.0 and all of the other HISPs that are used by other vendors and HIEs around the state. That should be fairly straightforward given that we are looking at an EHNAC accredited environment. We expect that all to happen in the first 2 months and the last month will be pilot work. The team will identify some pilot sites and make sure that everything is running smoothly. At the same time, we will be planning for the initial move, figuring out what our prioritization is for migrating existing customers from HIway 1.0 to 2.0. Some organizations have an urgent need for capabilities that are not available in 1.0 so we would offer them an early adopter capability- for instance those using OCHIN are unable to work on HIway 1.0 and we want to work with them as quickly as possible. Also, some of the MEDITECH sites are using functionality relating

to multi-recipient messages which is not available in HIway 1.0. The organizations that are ready will be prioritized in the roll-out. Webmail users will be migrated fairly easy and early on in the process.

(Slides 7) *Implementing HIway 2.0 Cont.* -As a plan is developed, the team will look to the vendor plans, and will begin laying out the timelines. In March, during the procurement process, the team did an analysis or breakdown of current connections for current participants. The team then asked vendors to provide a plan for each of those connections. More detail on each connection and key task ahead is provided in slide 7.

- Comment (John Halamka, MD): Over the last couple of weeks we have seen the Quality Payment Program and the inpatient prospective payment rules come out which defer Meaningful Use Stage 3 a year, and certification of the edition of your EHR software which was 2018 will be now 2019. As we try to migrate the HIway to new standards and new capabilities a lot of it is driven by regulatory deadlines - all of the regulatory guidelines, inpatient and outpatient, are now are pushed forward a year. It's good - it gives us more breathing room, opportunities to optimize and make changes thoughtfully.

Discussion Item 3: HIway Connection Requirement: Year 1 Update

See slides 9-12 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 year one connection requirement was presented by Michael Chin, MD, Senior Policy Analyst at MassHealth

(Slide 9) *Year 1 Attestation Form: Who, When, How*- Several of the slides are ones that the Council has already seen, with the exception of the red boxes which provide updates and/or highlights.

February of this year is when the regulations, known as the Mass HIway Regulations, went into effect - thanks to over a year of effort and a lot of input from the HIT Council. One key part of that regulation was to implement the statutory Massachusetts General Law Chapter 118i requirement that all providers in the Commonwealth have to connect to the statewide HIE, the Mass HIway. The regulations implemented a phased-in approach and there are two aspects to that approach. The first aspect is the date by which a provider type organization needs to connect to the HIway, in other words, the year one connection requirement. It changes based on the type of provider an organization may be. For example, the first organizations that must comply with the year one requirement are the acute care hospitals. Next year is when large and medium medical ambulatory practices and large Community Health Centers must connect. In 2019 small Community Health Centers, will be required to meet the year one requirements.

The second part of the HIway connection (skip to slide 11) explains how to meet the requirement in years one through year three. The only organizations required to connect right now are the Acute Care Hospitals (circled in red on slide 11).

Looking back to slide 9- the bottom of the slide speaks to how the state is going to know that an organization is compliant with that connection requirement. The answer is that they will report to the state using an attestation form.

(Slide 10) *Year 1 Attestation Form: What*- For this first year, the due date was last month (July 1st) so the state has already started receiving those attestation forms. The attestation form is purposefully designed not to be a huge lift. The form is two pages long and essentially asks for two pieces of information: how does the organization meet the requirement, and if the organization has an EHR, how does that EHR connect to the HIway.

(Slide 12) *Year 1 Attestation Form: Status update*- As of a few weeks ago, EHS has received attestation forms from over 50 acute care hospitals in the Commonwealth. In the next few months the team will be doing a few things. They will be reviewing those attestation forms and following-up for clarifications as needed, and they will be aggregating some of the information that has been received on those forms. The team is also scanning the incoming information with the lens of 'how do we better design the year 2 attestation form?' Some preliminary findings are provided at the bottom of slide 12 – not all forms have been processed yet. The HIway and EOHHS welcomes any feedback from the Council today and moving forward.

- Questions (Laurence Stuntz): What is the universe that you are expecting forms from?
    - Response (Michal Chin, MD): Great question, and as part of that clean-up this month we are finding out exactly what is the universe. The regulations point to the Department of Public Health's facilities list for the definition of an Acute Care Hospital. The regulations say that anyone that meets those definitions of an Acute Care Hospital needs to submit an attestation form. There are over 70 organizations on that list but there has been some back and forth regarding things like organizations with multiple facility types – or a hospital with several satellites.

- Question (John Halamka, MD): I am curious Michael, since the changes in the regulations around consent were passed in February, have you seen an uptake in Provider to Provider use cases?
    - Response (Michal Chin, MD): I think you are alluding to the slides in the appendix?
    - Response (David Whitham): We have our eyes on that and have not seen anything yet, but are very hopeful.
    - Response (John Halamka, MD): As we move to Value Based Purchasing, more and more folks want to share data for different purposes and given that the consent is very simple and clear – we, for example, changed our software to now send many more messages than previously.
    - Comment (David Whitham): And that is a statistic I was happy to see – a third of the market using provider to provider communication use case to attest. It was higher than anticipated.
    - Comment (Michael Chin, MD): Looking at slide 31, since the regulations clarified the opt-in and opt-out mechanism, did we see a spike in the HIway provider to provider

transaction? I think it is too early to tell. The 32% maybe hints that we are moving in the right direction but we do not have a definitive answer to that right now.

Discussion Item 4: Mass HIway Event Notification Service (ENS) Update

See slides 13- 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 Mass HIway Event Notification Service (ENS) was presented by David Whitham

(Slide 14) *Mass HIway ENS: Overview- As* the Council knows, we are looking to roll out real-time notifications, a HIway Event Notification Service. To that end, we have done a lot of preparatory work with the Council and stakeholder communities. In December we did an environmental scan of the landscape around the nation as it relates to Event Notification and the state of ENS business. In the period between March and June, the state held stakeholder engagement sessions throughout the Commonwealth. During June and July, an RFI was released to collect information from ENS vendors.

(Slide 15) *RFI Preliminary Findings*- There were seven vendors that responded to the RFI. Several have a strong presence in Massachusetts already. The volume that is handled from the different vendors obviously ranges from thousands to millions. They have connections not only from EHRs, but also from existing HIEs. They demonstrate their abilities to connect to different types of services. They all support ADTs. They all have the capacity and capabilities to manage opt-in/opt-out. Two of the vendors have standalone opt-in and opt-out mechanisms which would be helpful to the HIway because we look at leveraging that mechanism for future centralized services on the HIway. All vendors have provider to patient relationship mechanisms. Most of the vendors are at 99.9% accuracy rates in identifying patients. A key issue identified in the stakeholder sessions has been allowing the provider to manage the granularity of the info received. This has been mentioned before related to alert fatigue.

(Slide 16) *Mass HIway ENS: Anticipated Timeline*- The deployment by vendors ranged from three months to eight months. Most of the vendors can send ADT's and ENS notifications through the Direct Messaging protocol, which is core to the Mass HIway. The team is currently developing the RFR which will be released later this year. In early 2018, we will prepare to launch the service with a soft launch of the ENS by summer 2018.

- Question (John Halamka, MD): This may be a question for Alice. To what extent can this group review some of the RFR responses? We obviously would like to follow the procurement rules.
    - Response (Alice Moore): I do not know the answer to that off the top of my head -we will get back to John on that.
    - Comment (David Whitham): Personally, I would love to utilize the expertise of this Council.
    - Comment (Alice Moore): There is a Selection Committee and I believe that nothing can be shared until the decision is made public.
    - Comment (Kathleen Snyder): We have in the past had subject matter experts (SME) from the Council, such as John served as the SME on our first procurements.

  - Response (John Halamka, MD): Even having input on RFR responses that are de-identified may be helpful. For example, if a vendor says they have 99.9% patient matching, this may not be true.

- Question (Laurance Stuntz): Did you ask about cost and business models? And what are you seeing in terms of range of cost, plans, etc. for the deployment of this?
  - Response (Alice Moore): As we said, we cannot provide too many details right now. We can only speak in general terms.
  - Response (John Gilbert): In the RFI we asked for examples of cost models but nothing was too specific. We saw examples where charges were based on size of patient panel for certain providers. Having said that, we did not get too specific as to what those sizes would be. It was a very open question.
  - Response (Laurance Stuntz): As we develop the RFR we should think about what business model we want so we can say to the vendor you need to align the cost with the value. We wouldn't want vendors that charge for small value items.

- Question (Manny Lopes): I am not sure if this applies to the ENS, but we are learning about this new thing called blockchain. There was a big article about it recently in the Boston Business Journal (BBJ). I am not sure if this is that a solution worth contemplating. Other than the BBJ story I do not know a whole lot about it but it seems like that does a lot of what we are looking for.
  - Response (Alice Moore): Can you describe what blockchain is, if you know?
  - Response (David Whitham): Blockchain is essentially an accounting for transaction system. It allows you to do distributed dissemination of information. I do think it is very exciting, we actually had a number of folks from Massachusetts provide white papers to CMS or one of the other federal entities, investigating how blockchain can be used in healthcare. I believe that is still a number of years away. The banking industry is really still conceptualizing how to utilize it. But it is exciting. It allows you to distribute the ownership of information and retract the ownership of information. What we rely on right now for the HIway is really Direct messaging.

- Question (Deborah Adair): Last time we had a lot of good discussion around different kinds of data and transactions, and John talked about the BAA maze. When will we be able to merge some of that discussion as we move ahead with selection? Will we have an opportunity to have input on that?
  - (Alice Moore): We need to figure that out, and definitely make sure that there is HIT Council participation. If anyone is interested in participating, please let me know. The feedback we received last time was terrific, so I think participation from those that have expertise will be immeasurably useful.

Discussion Item 5: BMC's PreManage ED Implementation

See slides 17-25 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.

Arthur Harvey, Chief Information Officer at Boston Medical Center (BMC), provided an overview of the organization's PreManage ED implementation.

Alice Moore provided background/context for the presentation: PreManage ED is a product that will link into the HIway. It is not a state sponsored product or tool just to be very clear. This presentation provides an interesting example of what the future can hold in terms of the ways in which providers can work and track information in their own shops, and for their patients potentially across systems.

(Slide 19) *Pre-Manage ED*- The PreManage ED system is really a care management system for the ED. It specifically came out of some work done with the Massachusetts Hospital Association (MHA) in conjunction with the Governor around opioid management. Part of the challenge is that we get frequent flyers going from ED to ED with drug seeking behavior and there is really no good way to share that information across institutions. There was nothing systematic in place prior, so some initial funding was provided to get a vendor to help BMC with this project. MHA also provided project management. At a technical level, PreManage ED is an Event Notification Service combined with a certain amount of User Interface (UI) to allow for notes to be taken. As of July, BMC has had 10 systems live in the state, 7 more should be coming up this month with 11 more by the end of the year. As a cynical CIO I am here to tell you there is no way they are all going to get it done but that doesn't mean we will not continue to keep driving to a solution.

(Slide 20) *BMC Emergency Department*- The BMC ED sees patients from all around the Commonwealth so there is a high volume of organizations seeking information from BMC. BMC is an early adopter of this, recognizing the increase in opioid related ED visits. Quick stats on the ED were provided on the slide.

(Slide 21) *PreManage ED at BMC*- The principal use case here was to provide opioid management by bi-directional sending of ED information between institutions. The theory being that if someone showed up at the Cambridge Health Alliance (CHA) ED, we would be able to get a note. We could follow people around the state. BMC is really more of an information provider than an information consumer. BMC leadership looked at this and thought there were other things we could be doing with this. We felt that of the 130k visits, we generate a lot of admissions, and felt that by flagging certain patients we could intervene earlier in the process of care and keep them out of admissions. This all goes back to our work with MassHealth to try and more appropriately treat patients at lower acuity settings. The other thing BMC felt strongly about was duplicate data entry and/or logging into multiple systems. They refer to it as a "PDF" or Project Dup Fail). ED providers do not have time to mess around with logging into multiple systems. The thought originally was that this would be the external, one stop shop.

- Question (Raymond Campbell): The principal use case sounds similar to the Prescription Monitoring Program (PMP) that the state has. Are they overlapping, or are they complementary?

- Response (Arthur Harvey): I will actually get to that exact question in a minute.

(Slide 22) How it Works at BMC – The patient workflow starts with the PreManage ED system sending patient demographic and visit information via an ADT interface. PreManage does the match in their database and sees if there is any history on that patient in Massachusetts. If it meets the criteria, both the state/MHA criteria and the BMC criteria, it sends back a message to us right to our ED application which is Epic's ASAP via an Hl7 message. These are the same kinds of transactions we have been doing in healthcare for a long time. The reason BMC set it up this way was so that clinicians do not have to enter it directly. Some clinicians do not even know it's there; it is just a button in Epic. BMC felt that was critical for adoption.

(Slides 23&24) *ED Trackboard*- A screenshot of the BMC ED Trackboard was provided in slides 23 & 24. Icons tell a provider various things about a particular patient. If a patient is being followed for a Boston ACO there are notifications that will come up for a number of interesting things. If there was an issue reported (e.g. if the patient is part of a pain management contract with another physician), this information is available. This is all information from outside of the BMC system so it is very useful.

(Slide 25) *Benefits and Challenges* – Timely access to information has greatly impacted utilization-knowing when a patient is high risk, when to intervene etc. Overall BMC likes it. The staff like it, and it is good for organizations they do business with. It is good for patients. The ED staff has been very pleased with how it is working. It has had very minimal impact on their daily affairs. BMC built full Epic interfaces, not just the ADT messages. BMC built full messaging. If BMC puts in a note to Epic, we can send to this system, as appropriate, so the system users do not have to do anything specific and only certain notes will go.

The vendor, Collective Medical Technologies (CMT), has been very accommodating. The BMC team cares greatly about this initiative, and is concerned about the rate of adoption across the state. BMC has dispatched staff from their ASAP team to other Epic shops to help write the code and to do the direct integration. If you do not have the direct integration, it becomes cumbersome. Right now, we are consuming and allocating most of our own internal data, because we are so large and because other larger systems are still in the process of implementing a solution.

Lastly, this was driven by a mandate to manage opioid patients. Mr. Harvey sits on the Steering Committee for this, and was explicitly told when asked, that yes, the information would flow into PreManage ED so that doctors only need to go to one place. That has turned out not to work. There is a lot of backstory here about the challenges but the fundamental problem is that we are not getting the right opioid data about prescriptions which in turn makes it far less useful for managing patients. This is partially why some are taking a wait and see attitude. Overall we are happy we did it. We are content but if we do not get the prescription information up and running I question the long term viability. If we had an ENS you could certainly do some of that there. The good news is that it was a pain free implementation thanks to CMT.

- (Alice Moore): Just to undress the issue of access to the PMP, that is a statutory challenge. There are certainly some legal barriers. This is certainly an issue to continue to talk about and see what

might work. I think PreManage ED has been discussed for a variety of other potential purposes such as another initiative I am involved in related to reducing ED boarding with Behavioral Health conditions. There are HIPAA privacy concerns, but one of the ways to address ED boarding is getting the high utilizers access to care management earlier rather than continuing to cycle through EDs. I hear that you are communicating with the ACO via insurance I assume. I guess my question is about really making it accessible to others that may not have access to resources that you have access to along the way. What is being offered to those folks to join?

- Response (Arthur Harvey): I think that is a fair question. Originally this was all driven by the opioid use case in the ED. I have no particular relationship with CMT other than I am part of the Steering Committee of this project. They clearly think they can do more stuff with this. The Swiss army knife approach is a little concerning. Boarding is a good use case for this, but now you are getting into the question of the users beyond the ED. The UI (user interface) turns out to, luckily, be my EHR (Epic). I am a little less concerned that the web based UIs are not there. Everyone has very different thinking around how they want to use it and that is the challenge.
- Response (Alice Moore): The challenge is of making these applications available via the HIway and, as stewards of the system, not dictating that people use it in a certain way but ensuring that it is accessible by all those in the system.
- Comment (Arthur Harvey): I should point out, just to be even more rigorous, that you do not actually need to use HIway to access PreManage ED. You can certainly ship ADT messages directly to them.

- Question (Manny Lopes): Great presentation Arthur. This is a message for the Council and also a question to Arthur in terms of provider confusion. I think it folds up to what Ray was saying in terms of what solution do I use at the point of care as there are many solutions. This is a little bit of the concern I have, not only around this solution, but now you have the Massachusetts Prescription Awareness Tool (MassPAT), CareEverywhere and others. There are a number of ways to access information and I worry about the "blow by effect". A provider may say I am going to use something else or not use it at all because there are just too many options. So that is something for us to consider as we continue to evolve. As a state, what are we going to truly recommend as the solution for everyone to get the most accurate information in the most timely way?
  - Response (Alice Moore): The Council is well suited to discuss this as we think through the HIway applications. The good news is that people are using this to communicate and coordinate care.
  - Comment (Arthur Harvey): I completely agree with Manny on that point. We do have a lot of solutions out there and there is a lot of confusion in the market. Patient Ping is another example. It really is a toolbox with 52 wrenches in it when you just need a hammer.
  - Comment (David Whitham): We, as the HIway, position ourselves as the enablers, but we can help you get it done. If it comes to being a centralized source of data, that is a perfect role for what the HIway can do. I think that this is a great discussion to continue with the Council.

- Comment (John Halamka, MD): Every day we see another vendor that says they can work magic with ADTs, whether that is Patient Ping, Right Place or CMT. Our view at BIDMC has been that we want to be a good citizen, and so long as BAA's are in place we will send records of our ADT information so the community can benefit from that. I think our role as a Committee should be how can we open the plumbing. At the moment we have chosen to contribute to the PreManage ED, but to not actually consume the results. In the future we might. The way BIDMC has chosen to both comply with the Mass PAT rule but also provide integration and utility is when a clinician first clicks, we say: "Oh, Clinician, have you registered and are you in good standing with this service or database?" If so, in our EHR we will cache your credentials so the next time you log in, you are simply replaying your legitimate credentials. We do not have a special backend access process. The doctors have the benefit of the Mass PAT integration without having to login each time.
    - Comment (Arthur Harvey): I completely agree with John's assessment that we as stewards of health information, need to be good citizens. I completely agree that if there are certain legal agreements in place, I have no issue contributing this kind of information to a service. It makes sense. But then the question is, what do you do with the information? I do not want to send ADT messages to somewhere that charges me to contribute information.
    - Comment (John Halamka, MD): That is an important point. Everywhere we go the data submission is free.
- Comment (Laurance Stuntz): This gets back to the Event Notification Service and where the value comes from. I think the state infrastructure of collecting ADT data and making it available makes a ton of sense as a public benefit. Allowing folks to build on top of that solution is what people will want. I do think that we can arrive at some interesting models to make this sustainable.
- Comment (Deborah Adair): We are starting a pilot for PreManage ED but we have had so much discussion about this topic, and about the various vendors, and what do we want to do. It is not just the ED that we want to share information with. We look to the Mass HIway. We do not want to duplicate our efforts. We are involved in the pilot but want to make sure we have the right timing to do this right and not over-do it.
    - Response (Alice Moore): Yes, I agree there is also benefit from the experimentation.
    - Comment (David Whitham): We are agnostic. You can bring the PreManage ED solution and have it participate for you on the HIway.

- Question (Diane Gould): There are a number of community based Behavioral Health providers excited about this. This is information that will help us do a better job with care coordination. A lot of questions about consent still come up. Many people are not interested in having their events shared. I wondered if you could comment on your experience around consent.
    - Response (Arthur Harvey): We have the ability to opt patients out of it. We have been very specific with what information we are putting out there and making sure we have consent to ship the information. The same issue we have with Care Everywhere or any other data

sharing between institutions. It is nothing different. We have narrowed the use case to ED admissions so you are not getting Behavioral Health notes in a more generic long term sense- just getting the acute information.

Conclusion

See slide 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.

Alice Moore provided closing remarks before adjourning the meeting

The next meeting of the HIT Council is **November 6, 2017 3:30-5:00 PM**.

The state continues to look for a Mass HIway Executive Director- the Council was encouraged to think about/pass along the job description to any potential candidates.

The HIT Council was adjourned at 5:00 PM.