

Meeting Minutes
Health Information Technology Council Meeting
November 7, 2016
3:30 – 5:00 P.M.

One Ashburton Place, Boston, MA 02108

Name

Organization

Attended

| | | |
|-----------------------------|--|---|
| Alice Moore | <i>Undersecretary of Health and Human Services (Chair- Designee for Secretary Sudders)</i> | Y |
| Daniel Tsai | <i>Assistant Secretary, Mass Health</i> | Y |
| David Seltz | <i>Executive Director of Health Policy Commission</i> | Y |
| Deborah Adair | <i>Director of Health Information Services/Privacy Officer, Massachusetts General Hospital</i> | Y |
| John Addonizio | <i>Chief Executive Officer, Addonizio & Company</i> | Y |
| John Halamka, MD | <i>Chief Information Officer, Beth Israel Deaconess Medical Center</i> | N |
| Juan Lopera | <i>Vice President of Business Diversity, Tufts Health Plan</i> | Y |
| Karen Bell, MD | <i>Chair of the Certification Commission for Health Information Technology (CCHIT) EOHEd</i> | Y |
| David Whitham | <i>Assistant Chief Information Officer for Health and Eligibility</i> | Y |
| Laurance Stuntz | <i>Director, Massachusetts eHealth Institute</i> | Y |
| Manuel Lopes | <i>Chief Executive Officer, East Boston Neighborhood Health Center</i> | Y |
| Michael Lee, MD | <i>Director of Clinical Informatics, Atrius Health</i> | Y |
| Patricia Hopkins, MD | <i>Rheumatology & Internal Medicine Doctor (Private Practice)</i> | Y |
| Sean Kay | <i>Global Accounts District Manager, EMC Corporation</i> | Y |
| Ray Campbell | <i>Executive Director of Massachusetts Center for Health Information and Analysis</i> | Y |
| Daniel Mumbauer | <i>President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA</i> | Y |
| Katie Stebbins | <i>Assistant Secretary of Innovation, Technology, and Entrepreneurship, Executive Office of Housing and Economic Development</i> | Y |
| John Budd | <i>Mirick, O'Connell, DeMallie & Lougee, LLP</i> | Y |
| Lauren Peters | <i>Associate General Counsel & Director of Healthcare Policy, Executive Office for Administration & Finance</i> | N |
| Margie Sipe, RN | <i>Assistant Professor, MGH IHP and Nursing Program Director at Brigham and Women's</i> | Y |
| Normand Deschene | <i>President and Chief Executive Officer, Lowell General Hospital</i> | Y |
| Robert Driscoll | <i>Chief Operations Officer, Salter Healthcare</i> | Y |

HIT Council Members

Guests

| | |
|------------------|-------------------|
| Brian Pettit | EHS |
| Kris Williams | EHS |
| Lisa Fenichel | EHS |
| Ratna Dhavala | EHS |
| Dave Bowditch | EHS/Mass HIway |
| Julie Creamer | EHS/Mass HIway |
| Karishma Patel | EHS/Mass HIway |
| Nick Hieter | EHS/Mass HIway |
| Ryan Ingram | MA Dental Society |
| Murali Athuluri | MAeHC/ Mass HIway |
| Len Levine | MAeHC/Mass HIway |
| Jennifer Monahan | MAeHC/Mass HIway |
| Mark Belanger | MAeHC/Mass HIway |
| Terri Wade | Maples Rehab |
| Dave Bachand | NEQCA |
| Sarah Moore | NEQCA |
| Joe Heyman | Whittier IPA |

Discussion Item 1: Welcome

The meeting was called to order by Undersecretary Alice Moore at 3:30 P.M.

Undersecretary Moore welcomed the Health Information Technology Council to the November 2016 meeting. The August meeting minutes were approved as written.

Discussion Item 2: eHealth Plan

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.

Laurance Stuntz, Director of Massachusetts eHealth Institute, provided an overview of the eHealth Plan. The plan was distributed to the Council prior to the meeting.

The Executive Office of Health and Human Services (EOHHS) and MeHI have a statutory responsibility to create and periodically update a statewide eHealth Plan. In 2015 the two organizations pulled together workgroups and identified ways that they would update the 2010 plan and begin crafting the 2015 plan. Laurance presented to the Council in December of 2015 about the general principles of the plan. Four tactical goals related to Electronic Health Record (EHR) implementations, engagement in health information exchange and two others have been added to the plan since then. Each is laid out in more detail in the plan itself.

- Comment (Alice Moore): The other two goals were related to care coordination and patient engagement.

This plan was jointly developed with input from roughly 105 community meetings on the MeHI side with a whole bunch of other stakeholders. It also combined input from EHS and takes into account some of the activity that has gone on over the past year.

- Comment (Alice Moore): I know this was a long process that started long before I started at EOHHS, and it has gone through a number of revisions, I think in many ways the eHealth Plan for the Commonwealth will remain a work in progress; I am not sure that our work is ever done in this area, but I do think this is a good start. There was one question submitted by John Halamka, MD – a member of the Council that could not be here today. His question was ‘given that the private sector is now offering RLS services do we build or buy them?’
 - Response (Gary Sing): I think in general, at the HIway we want to promote adoption of commercial products because we want to try to standardize across different options or solutions that are out there. You can imagine that each individual agency or organization builds their own RLS for example you are going to run into some problems with interoperability. The more that we can promote usage of a solution or solutions that can communicate with each other, that follow industry standards, I think the better. With that said, I think there are some other questions that we want to consider when we think about whether to build or buy. For example, what is the use case and what is the integration pattern or plan for how to actually implement these RLS services- who will be using them, what will it take to get RLS data from the system that you are trying to extract information from and deliver it to the provider that is requesting the information? Among the RLS private sector offerings, what is the coverage that each of those services provides to the state– is it 100% or are they just focused in particular regions, and what sort of national coverage do these options or services have, what do they cost and I think one thing that we would have to think about is what would the HIway charge for them to be connected to the HIway so that different providers could use them as a vendor; what is the value of the RLS service to the providers and then thinking through which providers would adopt the services out there and what would they spend for them. So, not just what the HIway would charge the vendors to participate on the HIway, but what the providers themselves would pay to the vendors. These are just some proposed questions that a provider might want to consider if they

are thinking about this decision of should we buy an existing RLS solution or should we build something ourselves.

- Question (Deborah Adair): Related to that, we have providers that have brought up the number of applications that are out there, available now, and I know from recent discussions that the HIway functionality is not there yet. So, we'd like to use the HIway, but is there any timeframe for when that might be available? It is hard when we have people knocking down our doors to offer us other solutions.
 - Response (Alice Moore): Part of what is also happening at the same time as the eHealth Plan is out there being reviewed is a general upgrade, or plan, to staff the HIway in a different way, in a much more strategic way; policy and implementation focused. Since the inception of the HIway we have spent a lot of time on the technical details and operations of the HIway, and continuing to improve, as we see from meeting to meeting, the efforts of the IT staff to increase access and simplify access, so I think in answer to your question, it is going to be a work in progress to beef-up the functionality of it an increase access.
 - Comment (Gary Sing): One thing to add to that- we've had a lot of discussion around the event notification service (ENS) and it is something that we are very interested in. We are actually in the process of staffing-up and hiring folks to actually be able to dedicate to the ENS and to the extent that there may be some synergies with an RLS as well, we will be considering that as an option. As we mentioned, we see ENS as a very high priority and we are bringing people on to help with that process.
 - Comment (Michael Lee): The RLS is so much more difficult to really do and also make valuable to the end users; there are a number of components that are tricky. You are seeing that pop-up so well in the private community now with CareQuality, Epic's CareEverywhere and a number of other vendors that already connect with each other. Surescripts as the main pharmacy notification service adds a whole additional component. It would seem to me that the likelihood that we are going to be, at a reasonable speed, and functionality to make that work in excess of what the private market is offering, I think is unlikely. Whereas I think event notification would work out a lot of that locally, and it works really well and people like it, it would be great to dump that into the HIway- a single path for everybody and everyone can take advantage of the stuff we have already worked out- that would add tremendous value. As long as you focus on getting the direct provider to provider messaging going and the event notification service going, I think you have a value package that everyone can really appreciate – you may not need to go further than that right now.
 - Comment (Deborah Adair): My comment was also more about the competition in the market right now. The Hospital Association is working on something- people are asking why we are not working together.
 - Response (David Whitham): I think that is a good point and to echo what Gary said, we've heard that and really are aligning our resources moving forward. There is a level of due-diligence there so that we understand all of the requirements. We are hoping to have a timeline out sometime next year.

A motion to approve the eHealth Plan was made - the eHealth Plan was approved as written.

Discussion Item 3: HIway Regulations Update

See slides 4-15 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 regulations was presented by Kathleen Snyder, Chief MassHealth Counsel and Gary Sing, Director of Delivery System Investment at MassHealth.

(Slide 5) Background – On Friday EHS released the HIway regulations for public comment. The regulations were released to really address two main statutory requirements and we’ve gone over this information quite a bit over the past few HIT Council meetings. One of the statutory requirements was to establish an opt-in/opt-out mechanism for the HIway and also the requirement for all providers to adopt fully interoperable EHR’s that connect to the state HIE by January 2017. Once the comment period is completed EHS will take the comments back and discuss them as appropriate. The goal is to get everything approved by January of 2017.

(Slide 6) Public Comment Period – The slide provided additional details on the public comment period for the regulations, including a hyperlink to the public posting. A public hearing will be held Monday November 28th.

(Slide 7) HIway: Current & Future - A schematic of where we are and where we are moving to was provided. As of right now we have direct messaging; this is the only service fully implemented at scale on the HIway. In the future we will have an event notification service so the regulations are being developed with that in mind. These future services are considered HIway sponsored services which could also include the RLS we just referred to. The regulations discuss the ENS despite not having the service available yet.

(Slide 8) HIway Direct Messaging – In the regulations section 101 CMR 20.07 we have our opt-in/opt-out mechanism. It has been broken out by the HIway sponsored services- direct messaging and ENS. It states very clearly that HIway users “may transmit information via HIway Direct Messaging in compliance with applicable federal and state privacy laws... Mass HIway users may implement a local opt-in and/or opt-out process that applies to the use of HIway Direct Messaging by their organization, but are not required to do so.”

(Slide 9) Opt-in/Opt-out Mechanism - For the HIway sponsored services we are providing an opt-in/opt-out requirement- you must provide notice to your patients. The regulation states “HIway Participants must provide written notice of how the organization uses HIway-sponsored Services.” For the specific opt-out the regulations state “The HIway or its designee will administer a centralized opt-out system; a HIway Participant that has an established relationship with a patient shall: Notify the HIway if the patient decides to opt-out; and/or provide written instructions to a patient how to notify the Mass HIway if they want to opt-out.”

There have been a number of questions about the direct messaging piece. EHS wants to be very clear to everyone that disclosure requirements still apply. There are federal and state privacy requirements that are in place to protect information before it is disclosed- those all still apply. What EHS has done in the

regulations is align the use of direct messaging with other similar electronic messaging. This also aligns with those using another HIE, or solutions such as CareEverywhere.

For the HIway sponsored services we have taken the position that the mechanism is opt-in with notice and the notice requirement will include specific requirements on how an individual can opt-out. The opt-out will be controlled centrally by EHS, it will allow patients to opt-in or opt-out, there is still discussion about whether that will be a global opt-out/out-in. EHS is also allowing participants to choose to implement an additional local opt-in and/or opt-out process that applies to the use of HIway-sponsored Services by their organization, but they are not required to do so. If a participant exercises this choice, then the local process must supplement, and must not replace, the HIway opt-in opt-out mechanism.

- Question (Michael Lee): We (Atrius) have about 10,000 patients that have opted-out of the Mass HIway, over a year ago, before EHS stopped collecting the opt-in/out-out from pilots. How are they going to be handled?
 - Response (Kathleen Snyder): There are a few providers in this situation, where they have affirmatively sought an opt-in- I think from our perspective the requirement is the same as any other means of electronic communication. I would expect that you would need to update your HIway notice because the information that was put out 2 or 3 years ago, is outdated. Especially as we look towards rolling out HIway sponsored services you would need to update that. Atrius is in a unique situation where you do have this population – we are taking the position that you do not need to do anything affirmative one way or another. Now it may be that Jessica decides you do need a local opt-out, I am not sure what the internal discussions have been.
 - Comment (Alice Moore): I really do think it depends on the entity- it is up to you to communicate back to folks who may have already indicated a preference.
 - Comment (Kathleen Snyder): I do think that the notice that most participants were using did discuss the RLS so it is a different set of services. As Alice said, it is up to each individual participant to decide.

(Slide 10) The HIway Connection Requirement – The phased in approach was introduced. Initially EHS will only be requiring that certain provider organizations connect- different organizations will need to connect at different times. The way they need to connect will also be phased in. The providers that are part of the initial wave are acute care hospitals, medical ambulatory practices with 10 or more licensed providers, and large community health centers (CHCs). The acute care hospitals would need to connect by the effective date of the HIway regulations; the ambulatory practices and large CHCs would need to connect by January 2018.

(Slide 11) Phased-in Connection Requirement – There is a four-year lead-in period for the connection requirement. Initially in year one for example, an acute care hospital could meet the requirement if they send or receive a HIway Direct message for at least one use case within any of the categories. There are categories of direct messaging usage – submitting public health information to the Department of Public

Health (DPH), for reporting quality metrics or for provider to provider communication. In year one EHS has not made a distinction, as long as you are using the HIway direct messaging. In year two it will be restricted to just provider to provider communication – this is in line with the policy goal of providing better patient care between different providers. As many know, Massachusetts recently received approval for its 1115 Waiver and one of the key goals of the waiver is to improve integration between physical health, behavioral health, long term care and other social services. This is a large mandate we see as a potential lever to help move us in that direction. In year two the use case must be within that provider to provider category- and that can be sending or receiving.

In year three the requirement will be to both send and receive – this addition was actually developed as a response to some of the recommendations of the HIT Council where previously for Meaningful Use providers were sometimes just sending messages to meet the threshold. In fact, some were sending a fax in parallel because that is the piece that was making it into the continued care workflow. Year 4 is where the penalties start to kick in. EHS feels this gives providers sufficient time to ramp up infrastructure which they are able to use to help meet these connection requirements.

The last bullet on the slide describes ADT submissions by acute care hospitals – related to a process to populate the ENS. In order for the HIway to provide a robust database to really populate that ENS to determine which members will be part of the system, who is going to be notified when an ADT event occurs, we will be requiring acute care hospitals to submit ADT messages within one year after the service is launched. This is really to help increase the value proposition- the more hospitals that we can get to participate in the state, the more valuable it will be for the community.

- Question (Ray Campbell): With the ADT submission requirement, what kinds of data are you going to be capturing beyond the basics? The reason I ask is because a piece of legislation was just passed encouraging Massachusetts Center for Health Information and Analysis (CHIA) and the Department of Public Health to do a better job of sharing information with trauma centers in the Commonwealth. The problem is that our data is highly retrospective- I think what they are looking at is more ADT-type of information but you need to know that for instance that a patient was admitted and it was considered a trauma case. It gets around what data would you be collecting, along with the fact that this person with this name and address was admitted to the hospital – would you be collecting anything about why they were admitted? Or if you think about ED boarding issues, it becomes important to know when they arrived at the ED and when they left the ED. I think collecting just the ADT data raises a host of questions around what data elements will be collected or what data elements you want a year or two from now.
 - Response (Gary Sing): That is a great question – as we start thinking through how we want the ENS to be developed those are the types of questions we need to be prepared to answer. I think as a general principle we want to collect the minimum amount of information necessary to perform the services that we want to provide. For example, if we want the ENS to address the ED boarding issue then we would ask for whatever fields are included in the submission. This is still an open question being discussed.

- Comment (David Seltz): As someone who reflected at the last meeting that I was concerned about just having public health reporting fulfilling this – I like the way you thought of this progressive encouragement of provider to provider communication. One reflection related to year four – in some cases we are talking about 2022, it is hard for me to predict if these are going to be really hard to do in that period of time, or really easy. To whatever extent there might be some flexibility, some sub-regulatory ability, to make sure that we are not doing these regulations one time and there is stuff on the books for another 10 years, we want to keep these evolving and continue pushing providers in these areas. It is less a criticism and more just a reflection that the world could look a little different during that period of time. How we keep on the cutting edge of the progressiveness here is something to think about.
- Response (Kathleen Snyder): I think that we do have a fairly robust sub-regulatory mechanism which is in our policies and procedures which is in the process of being updated to reflect the new regulations. As the market, and this industry is constantly evolving quickly, we share your sentiment that we do not want people to sit back and wait for year four. We are hoping that the business proposition will drive folks to the HIway.
- Response (Gary Sing): We do have additional levers, for example we released the procurement for the full-scale ACO program and included in there are HIway connection requirements. For those you have to get connected to the HIway- we are not waiting until year four. If you are not complying with the HIway connection, then that is a contract management issue where we would need to work with the providers on a mitigation plan. Also, we do anticipate needing to update these regulations as the first wave of providers is only acute care hospitals, large ambulatory sites and CHC's – there are a lot of different types of provider organizations in the state so we do anticipate needing to update these to include those additional providers.
- Question (Laurance Stuntz): Quick technical question- is year one the beginning of year one or the end? In other words when do you need to meet these requirements? Is it as of the date or is it as of the end of that year?
 - Response (Gary Sing): That is an interesting question – we have had some internal discussions about it. Right now I would say it is likely the end of year one, but I think that is an area where we could be more clear in the regulations to make it less ambiguous.
- Comment (Robert Driscoll): As a behavioral health organization I have mixed feelings that we are not on slide 10 and the waiver just came out which makes it clear that behavioral health providers need to be part of the ACO. Unless we push behavioral health providers to participate in this initiative early on, I am concerned that they will be behind. I know there are some initiatives like Connected Communities but the reality feels like we have certain pocketed projects going on. In light of the waiver it feels like we need to try to pay more attention to where we are at with behavioral health providers and what we can do to push this further along as a group. At the same time no one likes to be pushed, but I do think quite frankly it is in everyone's best interest. Maybe we consider trying to set some target dates that we can work together towards.

- Response (Alice Moore): That is really great feedback. As many of you know behavioral health is the Secretary's passion. Any efforts to bring everyone along together; communicating and sharing information within the boundaries of the state and federal privacy laws, is a priority for her.
- Comment (Gary Sing): In addition to the RFRs that were released for the ACO we are releasing a procurement in February for the Community Partners. In addition to investing in the medical provider world, Mass Health is going to be procuring community based organizations that have expertise in providing behavioral health and long term support services. As part of that procurement we will be requiring HIway connectivity as well. As I mentioned, there are other levers we can use so I think that would synergize well with the approach you are mentioning which is including a timeline for the community.
 - Response (Robert Driscoll): As part of that you may want to look at the DSRIP funding – I know there is a portion of money that is supposed to come to the Community Partners side. Honestly if each one of us has to go out and figure out how to do it's not going to work. Certainly one of the reasons we lag as an industry is because we are trying to piecemeal funding and I do see DSRIP as a way to help move us along collectively.
 - Response (Gary Sing): That is a good point – we want to make sure that the DSRIP funding is used in a way that is responsible and helps drive adoption in those communities and organizations.
 - Comment (Ray Campbell): I am hearing a recurring theme – it feels like it would be useful for the community to have a roadmap to the HIway in terms of which functionality you are contemplating rolling out and roughly what timeframe. If people want to start making plans or behavioral health providers want to know where the fit in the scheme of things I think that would help. Even if the state is not going to stick to the deadlines, understanding there is a lot going on right now, at least having a general sense of the phasing would be helpful – knowing where you are in the que will drive some of the feedback during the public comment period. It may be useful for stakeholders to have some sense of the long term plan.

(Slide 12) Implementing a Fully Interoperable EHR – As mentioned, the statutory requirement to connect includes using fully interoperable EHR. For the regulations we are going to be saying that if you have implemented HIway direct messaging that gives the core functionality for provider communications you satisfy the 'interoperable' requirement. The provider organization would need to submit information regarding their EHRs to the Mass HIway at the time of their initial HIway connection date. This will help the state to develop a comprehensive view of the landscape and help to inform us in future decisions if we decide to do something else with this particular clause. EHS has been developing what that attestation form might look like – example questions are included at the bottom of the slide.

- Question (Mike Lee): Sometimes the specifics around this are tricky in terms of who works for who. If a provider is moonlighting at Atrius Health are they counted as part of our organization, or the other organization they work at? How do we figure that part out?

- Response (Kathleen Snyder): The participation requirements are at the provider organization level; it wouldn't be as an individual doctor. We have taken it from the licensed professional to the organization level.

(Slide 13) HIway Policies & Procedures – Currently EHS is enhancing the policies and procedures to provide a sub regulatory baseline to be able to provide updated information and use cases. Everyone will be pleased to hear that EHS is working to streamline the participation agreements as well as aligning the language to reflect the current offerings and pending regulations.

(Slide 14) Conclusion – The public comment period is ongoing. There is information on the website about how to submit comments as well as details on the public hearing.

Discussion Item 4: Deep Dive Program Update

See slides 15-22 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.

Efforts to Increase Provider-to-Provider Coordination over the HIway (Deep Dive Program) was presented by David Whitham

(Slide 16) Focus on Workflow Modernization- The overall goal of the Deep Dive program is to improve provider to provider communication and patient transitions of care through increased use of direct messaging. Our approach is to engage clinical and business leaders for these use cases- this is not an IT project; it really takes the full buy-in from the entire organization. The first step of the project is to establish technical readiness between two trading partners and identify a specific use case. The team works with the organizations to report metrics and share lessons learned to create a use case library.

(Slide 17) Deep Dive Milestones and Deliverables – An example milestone timeline for a Deep Dive engagement was provided. The target is for a three-month engagement between the two organizations; of course that can be variable given the factors at each organization.

(Slides 18-20) Deep Dive Dashboard and Examples – Building upon the energy and excitement of the regulations changes we anticipate bringing on additional organizations.

- Question (David Seltz): Remind me, are we providing any financial support to these organizations or are we just providing consulting, technical assistance through this process?
 - Response (David Whitham): Correct, there is no additional funding going to these organizations. We are unable to provide any stipend for the cost of any EHR manipulation, but the project management support, workflow support and so forth is part of this.
 - Comment (Laurance Stuntz): Several of these organizations are grantees under the eEquip grant MeHI runs so they are getting some financial assistance for the purchase of their EHR and a requirement of that grant is that they use the HIway in a meaningful

way with use cases. That has been a mechanism we have used to help funnel those guys into this program.

- Question (Juan Lopera): With the waiver and the DSRIP dollars that will be allocated, does that in any way provide opportunity for the organizations to tap into the intersection of those dollars?
 - Response (David Whitham): We will be working with entities that have access to the DSRIP funding- I cannot speak directly to the DSRIP but they are two separate streams. We feel that when we are able to engage in DSRIP activities we will be ready to actually fill in and provide those supports.
 - Comment (Gary Sing): In general, the DSRIP is being split into three primary streams: funding for ACOs, funding for Community Partners and funding for statewide investments. Under statewide investments are the things we think are critical to ensuring the DSRIP program and the waiver in general. One of those investments is called technical assistance – so the state would be looking for a vendor to provide technical assistance in 8 different domains which includes HIT.
 - Comment (Manny Lopes): Adding to what Juan said, I think there is an opportunity with the ACOs that are being created- the connections between them and their trading partners within their ACOs. Even within some of the pilots there are many organizations that have never traded information electronically with each other. It is another lever for the HIE that would be in everyone’s best interest.

(Slide 21) Lessons Learned – The 5 biggest take-aways from the Deep Dive engagements included Motivation and trading partner commitment is key, the project only moves forward when two or more information trading partners are highly motivated and committed to exchanging information with one another. Direct technology is still challenging to work with, most project time is spent establishing, testing, and validating connections. The team also found that many clinical and operational conventions still need to be established, including emphasis on both people and processes as part of change management. Changes are needed at multiple points throughout a patient visit- from front desk to clinical teams, medical records and IT.

Discussion Item 5: Relationship Listing Service (RLS) Update

See slides 22-25 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.

An update on the RLS pilot project was provided by David Bowditch

(Slides 23- 25) RLS Pilot Lessons Learned – Over the past several years we have reported on how the RLS pilots are doing and everyone is aware of the challenges we faced in pilot. There were four strong organizations working with the team. There has only been small growth over the past few years, often the reasons for not joining the RLS related to consent. The timing right now with the regulations made it important for us to make a decision about the RLS. We knew we could no longer continue with the pilot due to that change in opt-in/out so now we are bringing things to a close and gathering the lessons learned. The team has met with representatives from the four pilot sites to form a plan. The technical

aspect is fairly minor- essentially turning off the feed coming in; this will happen over the next few months. Goal is to either secure the data that was delivered or destroy it – from a contractual standpoint the team is making sure that everything is tied-up appropriately. The team does not anticipate a big impact on those going forward plans for those organizations, although they did put a great deal of effort into building up. A lot of lessons were learned and the team will be putting them together in a more comprehensive document, but the main take away was that when patients were educated and the staff was educated on exactly what the RLS was for, and the way that their records could be electronically shared with their other care providers so they wouldn't be carrying manila folders of health information from doctor to doctor, everyone was really supportive. It was a big leap to get to that level of education, but those are the kinds of things the team is learning and sharing. The teams will continue to gather lessons learned and leverage that information as we explore additional HIway services. We hope the providers that worked with us on the pilot will continue to work with us moving forward.

Conclusion

See slides 26&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 **February 6, 2017 3:30-5:00 PM.**

The HIT Council was adjourned at 5:00 PM.