Meeting Minutes
Health Information Technology Council Meeting
March 2, 2015
3:30 – 5:00 P.M.

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

Meeting Attendees

Name	Organization	Attended
Marylou Sudders	*(Chair) Secretary of the Executive Office of Health and Human Services*	*
Darrel S. Harmer	*(Chair) Acting Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
Bill Oates	*Chief Information Officer, Commonwealth of Massachusetts*	**
David Seltz	*Executive Director of Health Policy Commission*	Yes
Áron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	Yes
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	
Patricia Hopkins MD	*Representative from a small Physician group Practice Rheumatology & Internal Medicine Doctor (Private Practice)*	Yes
Meg Aranow	*Senior Research Director, The Advisory Board Company*	Yes
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	Phone
Normand Deschene	President and Chief Executive Officer , Lowell General Hospital	No
Jay Breines	Community Health Center	No
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Yes
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	Phone
Margie Sipe, RN	*Performance Improvement Consultant; Massachusetts Hospital Association (MHA)*	Yes
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	Phone
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	Phone
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	No
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Yes
Daniel Tsai	*Acting Director of Medicaid*	***

*Alda Rego in for Secretary Sudders
** Claudia Boldman in for Bill Oates
*** Kris Williams in for Daniel Tsai

Guest

Name	Organization
Jessica Costantine	AARP
Manu Tandon*	BIMDC
Marilyn Kramer	CHIA
Lisa Fenichel	Consumer
Cathleen Wheeler	DMH
Aditya Mahalingam-Dhingra	EHS
Naveen Chandrasekaran	EHS,
Daniel Cohen	EOHHS
David Bowditch	EOHHS
Kathleen Snyder	EOHHS
Kris Williams	EOHHS
Laxmi Tierney	EOHHS
Marc Silverman	EOHHS
Nick Hieter	EOHHS
Ratna Dhavala	EOHHS
Robert McDevitt	EOHHS
Stacy Piszcz*	EOHHS
Claudia Boldman	ITD
David Smith*	MA Hospital Association
Jennifer Monahan	MAeHC
Mark Belanger	MAeHC
Micky Tripathi	MAeHC
Murali Athuluri	MAeHC
David Bachand	NEQCA / Tufts
Karen Latta	Orion Health
Kary Nulisch	Orion Health
Divya Kumaraiah	Patient Ping
Julie Sanders	Patient Ping

*phone attendee

Meeting called to order – minutes approved

The meeting was called to order by Adla Rego at 3:33 P.M.

The Council reviewed minutes of the December 8, 2014 HIT Council meeting. The minutes were approved as written.

Discussion Item 2: Participant Update – I-EATS OTP Node Slides (5-23)

See slides 5-23 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.

Cathy Wheeler from the EIM-ESM Management Office of the Massachusetts Department of Public Health presented on the electronic submission of the Opioid Treatment data

(Slide 6) I-EATS - What is it? - The Inbound Enrollment and Assessment Transfer Service is a secure, encrypted, electronic submission of intake, enrollment and health assessments from the Electronic Medical Record (EMR) of a provider to the virtual gateway.

(Slide 7) Why I-EATS? - At this point in time the Department had moved all of its human service contract client data entry to Enterprise Invoice Management/Enterprise Service Management (EIM-ESM). This was an enormous step forward for the Department. There were many improvements as a web based service but it still meant all of the data entry was a manual process. At the same time opioid use was increasing, more quality data was needed, and the old legacy system was inadequate. The large opioid treatment providers were the only ones not coming in through EIM because they were already using EMRs and had found a way to mimic the needed excel files. An easier electronic submission was the critical option.

(Slides 8-9) Background – The Substance Abuse Management Information System (SAMIS) was the old Structured Query Language (SQL) database which was no longer being supported by Microsoft. It was no longer getting necessary updates, including security updates, and was no longer compliant with the federal Center for Substance Abuse Prevention (CSAP) data requirements. By 2010 the Department had succeeded in moving everyone off of the database with the exception of Opioid Treatment Program, and the idea of asking providers to enter redundant information into the EIM system was not appropriate.

(Slide 10) Rise in Opioid Addiction/SAMIS Failing – In spring 2014 the Department started moving quickly to the IEATS solution because the legacy system started to fail miserably and there was a risk of losing a ton of data if providers were not moved immediately to EIM. The team moved as many providers that were not ready to be electronic into the EIM manually. The legacy system was retired in June 2014 with IEATS transmissions starting this year. IEATS is now incredibly important source of data for the bureau.

(Slide 11) DPH Benefits – Staff are now able to better manage the program, they can generate all sorts of reports and the data is readily available for analysis. Now the Department is not just looking at opioid

events, but also where the patients were before, during and after these events. The Program is also now able to meet the CSAP reporting requirements.

(Slides 12&13) Provider Benefits – The IEATS system eliminates redundant data entry and provides the tools needed for patient status and billing related reporting. Custom health assessments are available by level and providers can electronically submit their 837 claims. Providers can use the EIM-ESM to track and understand their billing status within days of submission. Whereas the old system took months to reconcile, providers now receive payments in 5-7 days, rather than 15-30 days.

(Slides 14- 17) Conceptual View of the IEATS Project- Ms. Wheeler explained the steps in message delivery from end to end.

(Slide 18) I-EATS Development – The OTP-HL7 was initiated as a virtual gateway project. The Department was given money to enhance the EIM-ESM. There were always concerns over fail spots and providers found the security requirements very burdensome- for example constantly needing to change passwords. Once the decision was made to join the Mass HIway the architecture changed and it solved the security problems - the HIway saved the project!!

(Slide 19) I-EATS Development – The I-EATS went live in April of 2014- the first provider submissions were in October. Starting in February over 3,000 enrollments were transmitted with the expectation that come the end of April 2015 there will be over 15,000 enrollments in the system.

(Slide 20) On-Going Challenges- The HIway team was great to work with. The biggest challenge was the EMR vendors. We are asking them to customize systems for Massachusetts and some vendors actually said no, AMS/NetSmart for example. For some of the smaller providers the cost of the systems and complexity was too much. The biggest problem has been the middleware needed to connect, which has nothing to do with the HIway, but has required use of the LAND. Enhancements are in the works but it can be a challenge to coordinate changes among all parties.

(Slide 21- 23) Current Provider Status – Currently Habit OpCo, Stanley Street Treatment and Resources (SSTAR) and Community Substance Abuse Centers (CSAC) are submitting. NetSmart providers are currently waiting to transmit HL7. The Boston Public Health Commission is currently submitting data manually in EIM-ESM, but is planning to transmit in 2016. Lahey Clinic and Mercy Hospital are slated for 2017 and smaller sites like North Charles, Bay Cove Human Services, and The Addition Treatment Service of New England will remain manual submitters.

- Question (Laurance Stuntz): Is the data in here useful to other providers and are there plans to expose it to the wider provider community? If not, what would the issues with that be?
    - Answer (Cathy Wheeler): Yes, the information does go into a CSAP provider data mart and they do re-release it with other datasets, but it is de-identified. That is all done through CSAP. Confidentiality laws that govern substance abuse data (CFR42) limit what can be released.
- Question (Karen Bell): In terms of the level of clinical data being shared and claims, diagnosis, and encounter information are you able to extract additional information out of the EHR*?*

  - Answer (Cathy Wheeler): Yes, the health assessments are looking at the overall status of the client and they collect information on a quarterly basis to check progress. CSAP is looking at the substance abuse, mental health, and environmental factors. It is a very rich database. The provider that submits the information can ask for a de-identified extract.
- Question (Patricia Hopkins): Do you see standardization that would allow everyone to be on the system? Is it the federal government setting the standards?
  - Answer (Cathy Wheeler): That would be great. Our original goal was to design this for anyone that needs to be reporting and a lot of the data we collect is defined by regulations.
- Question (Claudia Boldman): Now that the data is in XML, will it affect the types of reports you are able to generate? In other words, not just PDF reports?
  - Answer (Cathy Wheeler): Yes, CSAP can do that. The Department gets the information to them, and then CSAP can clean up and de-identify the data before sharing.
- Question (Laurance Stuntz): Is this the universe of providers that are submitting?
  - Answer (Cathy Wheeler): No, this is really the tip of the iceberg. We envision others joining. Only those that have contracts are in right now.
- Question (Laurance Stuntz): In terms of new connections, will that be a custom interface with each EHR vendor?
  - Answer (Cathy Wheeler): Yes, we have a standard, but we need to work with each individually. There are no national standards.
- Comment (Daniel Mumbauer): In terms of NetSmart, we found out today that most of the work we have done has now been tossed out. Now they are building it a second time using different technology. We came to the table early on, so now there are a lot of changes, and a new approach. The original cost was in the $50-$60k range. The only positive was that they did not come back and say they would charge more to fix things. At the same time this is a multi-year project and we have 12 full time staff doing manual data entry with the OTP group, costing hundreds of thousands in staff salaries.
- Question (Karen Bell): There are a number of large healthcare systems in the state using systems like Epic and some of them have substance abuse centers. How do they link on?
  - Answer (Cathy Wheeler): So far we have no one on in terms of major vendor connections but if the provider is a customer we will work with them.
- Comment (Daniel Mumbauer): Unless you are owned by a hospital system and that hospital allows you in, it becomes very expensive for providers to get the right user licenses.
- Question (Patricia Hopkins): What is the guesstimate for people that need treatment in the state? Patients change providers all the time, is the 15,000 enrollments just 8 people shopping around?
  - Answer (Cathy Wheeler): I am unsure what the total figure would look like, but these are unique enrollments.
- Question (Lisa Fenichel): Have you explored the benefit to patients?

    - Answer (Cathy Wheeler): This is really an administrative solution. Very directly, the better run the clinic, the better the data, the better treatment a patient will receive.
- Comment (Daniel Mumbauer): Have you thought of this being a report card for providers that can be shared publically - I see this as the beginning of that initiative. More aggregated reports.
- Question (Deborah Adair): Just to clarify this is a requirement correct?
    - Answer (Cathy Wheeler): Yes, those that are not on are working to catch up fast. Spectrum is desperately waiting for NetSmart.

Discussion Item 3: HIway Operations Update (Slides 24–47)

See slides 24-47 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 HIway operations the Query and Retrieve pilots was provided by Darrel Harmer.

(Slides 25 – 27) HIway Stability – December, January and February incident calendars were displayed. There are three different severity levels, red indicates a Severity 1 or Severity 2 which means all or most Mass HIway components impacted as a result of outage. Yellow indicates a Severity level 3 – one Mass HIway component was impacted as a result of the outage. EOHHS has been working closely with Orion and LogicWorks to resolve issues and be as transparent as possible. February is the first sign that things are improving.

(Slide 28) 2015 Incident Summary Dashboard- A new incident summary dashboard was provided. The goal is to be at 99.9% availability by the end of the month, or no more than 44 min of downtime a month, which includes emergency maintenance.

(Slide 29) HIway Availability Trends- An additional incident metric was introduced. The red line on the graph is the measure of monthly availability and the blue line on the bottom shows the days with an outage. Both are going in the right direction, but not where we need to be yet.

- Comment (John Halamka): Want to say thank you to Darrel and the team for building transparency here. We all agree there was downtime in the past, and that could create reputational issues, but now we have dashboards, graphs and facts showing improvement – we can hold ourselves accountable. I am glad we are using the two measures, outage time and days a month, because being down for 10 minutes every day of the month is equally bad. I am looking forward to the month of March and hitting that 99.9% by April 1st!
- Question (Áron Boros): These are all outcome measures, can you share with us what happened, and what some of the solutions were? Is it optimistic in March that we have solutions, or did February look good because no one was at work?
    - Answer (Darrel Harmer): The transactions are steady so people were working, but it really was a combination of things. In some cases it was software and hardware capacity issues, others have been tuning issues, our infrastructure is a bit more brittle than it should be. One of the biggest problems was upgrading the trust gateway, which is the

middleware platform. Our immediate goal was to stabilize what we had in production, now the key is for us to fully understand the infrastructure, do more capacity planning and hopefully simplify the environment.

- Question (Daniel Mumbauer): Can providers call someone when there are issues, is there a help line?
    - Answer (Nick Hieter): Yes, there is a path for providers to send their problems in – a support email and phone number. Currently the issues coming in are specific to a provider, or a specific LAND box, not an overall HIway issue. Since we fixed the trust gateway it has helped a lot. We have also implemented LAND monitoring processes so we can provide notifications to participants.
    - Comment (Daniel Mumbauer): Would be interesting to see what the metrics are in this forum as well, that's also a good indicator of provider experience.
    - Comment (Darrel Harmer): We want to be as proactive as possible. We should know before providers. The other thing we have done is tried to be much more communicative about problems. We are sending out emails when the HIway is down with when it will be back up, and let participants know when there is maintenance.

(Slide 30) HIway Stabilization Plan – As part of closing out deliverables from Orion, EOHHS had negotiated a contract amendment in December with Orion to focus on deliverables, outstanding and otherwise. A lot of those fell into the stabilization area, including things like monitoring the LAND boxes, server monitoring and documentation. The HIway would also like to conduct a performance test which is a key part of the capacity planning. These are on a 30, 60, 90 day release plan, the final batch will be delivered in March.

(Slide 31) Stabilization Sprint- A 6 week sprint to get to that 99.9% by April 1st. Orion has brought in a lot of resources from all over the country. The team is working on identifying, testing, tuning and making enhancements to stabilize the HIway. Once stable, the team will look at the overall structure and how start to simplify things, make us more agile. One of the biggest problems is that it is difficult for providers to connect. Another goal is to reduce costs.

- Comment (Kary Nulisch): The key is the first 60 day sprint, we have 12-15 extra resources nationwide. After things are stable the next step is to simplify and look at why things are so complicated, why things are so brittle, and how to make things better long term.
- Question (Karen Bell): What makes Massachusetts unique, or more brittle than other states?
    - Answer (Kary Nulisch): A lot of it has to do with the LANDs – every implementation is unique.
- Question (David Seltz): Can you give the Council an idea of the value, how much the 90 day sprint is costing, and were there accountability provisions put in for Orion's performance? Are they carrying some of the risk?
    - Answer (Darrel Harmer): The biggest thing is that they do not get paid. A bulk of the resources working on the sprint are on Orion's dime, we are not paying for them. We have a good shared risk approach right now.

(Slide 32-35) HIway Participation- A list of new participants and new connections was provided for December, January, and February.

(Slide 39) Progress Relative to SFY'15 Targets- We are doing very well in terms of new Participation Agreements and now have 372 with 297 connected to the HIway HISP and another 64 are coming in through other HISPs. Overall we are doing well getting participants signed on and connected, but are still struggling with the actively using numbers. Right now it looks like we will fall short of hitting 421 active users by the end of June.

- Comment (Micky Tripathi): The ability to hit 421 depends on the scale being brought in from the vendors. eClinicalWorks (eCW) for example has a large number of providers, but they are not necessarily all going to connect on this schedule. It is a three part process, getting the providers signed up, connected and then actively using. eCW decided to change their policy in respect to for how to connect providers to the HIway which made a huge gap between the number that signed up and are actually connected and using. To meet that target we would need to push the schedules out. There are a number of other smaller things, but eCW was really the biggest one. We are confident we will get there, just on a longer timeline.
- Question (Áron Boros): Do the barriers described apply to all 5 tiers? We are missing the target on large hospitals pretty significantly. Is it the same problems you are describing? Strategically if we could get all large tier one entities that would be a huge step in the right direction.
    - Answer (Micky Tripathi): It is a lot of the same issues, but more pronounced as you go down. The hospitals have more control of the technology, so for them it is more an issue of priority. As you go down the tiers providers are more subject to vendors. The large providers, on the one hand, have more control of the technology so they can get to the connection point faster, but on the other hand, they have complex workflows to align. When a small provider is on they can use it almost right away with a less complex workflow.
- Question (Karen Bell): This doesn't sound like a problem that can be solved by throwing money at it, however there is $28 million on table for successful HIEs – are we going after some of that money?
    - Answer (Darrel Harmer): Yes, we are working with The Massachusetts eHealth Institute (MeHI) on that right now.
- Comment (Deb Adair): I am surprised more people are not using it for Meaningful Use. At Partner's we have tried to reach out to different organizations, especially for Meaningful Use numbers, but we end up using paper. I do not think it's an education issue anymore, I think everyone knows.
- Comment (Micky Tripathi): The other thing with Meaningful Use is people will do what's easier. If you have a HISP you can figure out that 10% within that network, even if it's not that meaningful- just checking the box.
- Comment (Darrel Harmer): Next month we will have a recalibration of the 421 and some new goals set against that June date. We are confident we will get there, just not as quickly as hoped.

(Slide 40) HIway Transaction Activity- The good news, the transactions have been steady at roughly one million a month. In December there was a bookkeeping change in order to get the slides completed in time for this meeting. We are now ending on the 20th, so the December count lost 10 days of transactions. The volume includes both production and test transactions. A deeper dig into the February numbers showed a vast majority are production. The big bump has been the Syndromic Surveillance and Immunization reporting.

- Question (Áron Boros): In the past we saw a breakout of the transactions; how many provider to provider transactions versus public health reporting, etc. Is that analysis something we can see next month?
    - Answer (Darrel Harmer): Yes, we will bring those to the April meeting.
- Question (Karen Bell): How much of our use is related to Meaningful Use, and if Meaningful Use goes away what is our future?
    - Comment (Lawrence Stuntz): Is your question what portion of this is being done because someone is paying for it?
    - Comment (Patricia Hopkins): Yes, it would be helpful to see what portion is provider to provider versus inpatient organization transactions.
    - Comment (Darrel Harmer): In February about 84% of transactions were to a Public Health Registry. The other piece that is only showing up here minimally is the Relationship Listing Service (RLS), which we see as is a key value proposition.
- Comment (John Halamka): Meaningful use Stage 3 will have a significant focus on interoperability, whether it appears in a Meaningful Use penalty or other pay for performance activity. I would not worry about HIway volume related to changes in government programs.

(Slide 41) Comparison of Key Metrics- This slide looks back to the provider activity reported in March 2014. It is easy to focus on where we have fallen short and lose sight of what we have accomplished, almost doubling the signed on, and almost tripling the signed on organizations. The total transactions to date have almost quadrupled. There is evidence we are making real progress, but still have a lot of work to do.

(Slide 42) Development Release Schedule – The Children's Behavioral Health initiative (CBHI) is deep into system testing and on target for a March release.

(Slide 43) HISP to HISP Connectivity – An update on the HISP connections was provided – McKesson/RelayHealth and MedAllies have been added since the December meeting.

(Slide 44) RLS Unique Patients – Currently in a holding pattern as the pilots continue working through the consent issues.

(Slides 45&46) Phase 2 Pilot Update –

Beth Israel Deaconess (John Halamka): We know the RLS is essential for two kinds of activities – one will be care coordination, especially when patients show up in an unexpected location. Records can be

located and retrieved from a location where the patient has previously given consent. We have collected consent using a paper based process and have had about 60% of patients opt in. We think we can really accelerate this process by putting a check box in the personal health record (PHR) and are just about done coding that process. This model is very patient-centric and does not necessitate a provider visit which may only happen once a year. Once they are enrolled in the HIway care coordination is improved. For example if a patient is admitted to the Emergency Room, other institutions involved in their care could be notified and the Accountable Care Organization (ACO) could be notified that the patient was admitted to the Skilled Nursing Facility (SNF). Care management is a high value use case for the HIway. Give us another month or two and the PHR connection will be up.

Atrius (Mike Lee): We have a similar story. Roughly 250,000 patients were given consent forms, we are currently shy of 60,000 signed, consented and logged into Epic. We are still scanning and there is still a lot of work to do there. The online version of the consent form is in the test portal now. About 300,000 patients enrolled in the portal. We are hoping to release that on a similar timeline to BID and we are still a month or two away. We have done test transactions with the RLS, but still more work to do.

Partners (Deborah Adair): I still worry about the HIV and 42 CFR regulations that require consent each time, also individually whoever accesses the information must have consent. I hope that we can talk about this at an upcoming Council meeting. I am not sure there is a best practice, and I don't know what the answer is, but and I think it is unfortunate that we are not sending out any CCDAs over the HIway for patients that have HIV. They are often the most vulnerable population. We do not have the right consent setup to do that can be facilitated easily.

- Comment (Mike Lee): The two steps we have done for that was that we explicitly called out HIV on our signup form. We wanted to make sure people were aware there could be potential information in the HIE and those with concern can opt out. The second is that we are declining to send transactions if HIV is in the problem list. We are completely blocking those. Even if the patient had consented we actually are not sending it. The plan is to try that for a few months and see how it goes. Unfortunately there is not a pure to filter certain information that way if it's been cataloged differently – HIV medication on the medication list but not HIV in the problem list for example.
- Question (Laurance Stuntz): Are you also tracking how many of those you block? Just so we would have some statistics to allow us to make the case that if the patient does consent than it should be shared?
- Answer (Mike Lee): We have not done that but that is certainly something we can look at to inform the legislature and the public. The amount of transactions going electronically right now is quite low. We just started routinely sending the summaries of care on a scheduled referral. If there is an outside referral it looks to see if the patient is consented and if the provider is on the HIway. If those two things match we will send it out over the HIway. That is pretty low right now, and it will limit it further with who can act on it when it's received electronically. If providers are not transacting over the HIway, or there is no HIway address, then we are auto faxing.

- Question (Patricia Hopkins): Do you have a similar line item in place for Hepatitis C? I am confused as to why this is an issue since it is going from healthcare provider to healthcare provider. I think the risk of not knowing is greater than the risk of knowing. Why should I be at risk if I don't know these patients are HIV or Hepatitis C positive? The whole point of this is that we need information about the patient so the carve outs are not quite understandable.
- Comment (John Halamka): It would be the wisdom of the state legislature that passed Chapter 224 and every provider in the Commonwealth wants repealed.
- Comment (Patricia Hopkins): Is that something we can go to The Massachusetts Medical Society with to help repeal? Instead of looking at the past, we need to look at the changes in technology that allow us to do this more effectively.
- Comment (Mike Lee): I totally agree with you and would be all for repealing. I think the best thing is to let it go forward and show that the HIway works, show that it has value, and then I think we will be able to report on the impact and have greater ability to attack legislation effectively. We have such little demonstrated right now and we need more transactions to occur to argue the provision.
- Comment (John Halamka): The Fenway Community Health Center CIO would actually argue that Chapter 224 prevents the safe care of HIV patients. There are plenty of people that would be happy to argue on our behalf.
- Comment (Darrel Harmer): There has been strong interest from the Council to be less presentation-like and more interactive to deal with things like this. For the April meeting we will do that.

(Slide 47) Communications & Outreach – A list of past and upcoming webinars and presentations are on the HIway website. There is also a link to sign up for the Newsletter. The Provider Directory Extract is now available online as well.

Discussion Item 4: Wrap-Up (Slide 48-49)

See slides 48&49 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.

Wrap-up presented by Darrel Harmer.

The schedule for the 2015 HIT Council Meetings was provided.

2015 Meeting Schedule*

- ~~*No meeting scheduled in January 2015*~~
- ~~February 2 – *Cancelled*~~
- ~~March 2~~
- **April 6**
- May 4
- June 1
- July 6
- August 3

- September 14 *(1st Monday of September is Labor Day)*
- October 5
- November 2
- December 7

** All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21st floor*

The HIT Council meeting was adjourned at 5:00 P.M.