Meeting Minutes
Health Information Technology Council Meeting
August 1, 2016
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	*Assistant Secretary, Mass Health*	Y
David Seltz	*Executive Director of Health Policy Commission*	Y
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Y
John Addonizio	*Chief Executive Officer, Addonizio & Company*	N
John Halamka, MD	*Chief Information Officer, Beth Israel Deaconess Medical Center*	Y*
Juan Lopera	*Vice President of Business Diversity, Tufts Health Plan*	Y
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	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*	N
Michael Lee, MD	*Director of Clinical Informatics, Atrius Health*	Y
Patricia Hopkins, MD	*Rheumatology & Internal Medicine Doctor (Private Practice)*	Y
Sean Kay	*Global Accounts District Manager, EMC Corporation*	Y
Ray Campbell	*Executive Director of Massachusetts Center for Health Information and Analysis*	Y
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	N
Katie Stebbins	*Assistant Secretary of Innovation, Technology, and Entrepreneurship, Executive Office of Housing and Economic Development*	Y
John Budd	*Mirick, O'Connell, DeMallie & Lougee, LLP*	Y
Lauren Peters	*Associate General Counsel & Director of Healthcare Policy, Executive Office for Administration & Finance*	N
Margie Sipe, RN	*Assistant Professor, MGHIHP and Nursing Program Director at Brigham and Women's*	N
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	Y
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Y

**Attended via phone*

Guests

Name	Organization
Deb Schiel	CHIA
Lisa Fenichel	Consumer Advocate
Gary Sing	EHS
Julie Creamer	EHS
Kathleen Snyder	EHS
Michael Chin, MD	EHS
Nick Hieter	EHS
Ratna Dhavala	EHS
Erika Scibelli	Health Policy Commission
Jennifer Monahan	MAeHC
Len Levine	MAeHC
Mark Belanger	MAeHC
Micky Tripathi	MAeHC
David Bachand	NEQCA
Ryan Thomas	Orion Health
Ryan Ingram	Mass Dental Society
Sarah Moore	Tufts Medical Center
Joe Heyman, MD	Wellport HIE (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 August 2016 meeting. A new member of the HIT Council was introduced: Mr. John H. Budd, Esq. was appointed to

the Expert in Law Health Policy seat. It was noted that membership will change as the Governor appoints people to the Council.

Prior to the HIT Council meeting some of the newer members were provided with a HIway orientation session. Ms. Moore is happy to share the deck and review the orientation slides with others.

The June meeting minutes were approved as written.

Discussion Item 2: HIway Regulations Update

See slides 3-5 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 4) *June 2016 HIT Council Meeting Follow-up* – EOHHS has been developing statutory requirements related to the HIway- the language [MA Chapter 118I) says that all providers must adopt fully interoperable electronic health records by January 1 2017. This Council has had several meetings related to those topics and several discussions about opt-in and opt-out mechanisms. At the last Council meeting several members provided feedback about some of the issues and the MassHealth team raised those issues to their Advisory Groups: Defining provider organizations; Provider organizations with multiple entities; Requirements for direct messaging and quality reporting versus public health reporting; Provider to provider (P2P) communications outside of HIway; and, Centralized opt-out for HIway-sponsored services.

The approach proposed for the first item, defining provider organizations, was to define the organizations that are specified to connect in the first wave. The Council was reminded that the approach will be a phased-in connection requirement. In general, the Advisory Groups were in support of this idea, that we would initially define provider organizations that have specific connection dates in the regulations and remain silent on those that are not yet specified.

The second issue raised was related to provider organizations with multiple entities and how to apply the regulations to each of those separate entities. For example, Health System A may have two acute care hospitals and three physician groups. The proposal presented to the Advisory Groups was to have the regulations clarify that acute care hospitals, for example, would each need to satisfy the connection requirement, but EHS would remain flexible as to how those hospitals might connect. The health system may connect as one entity or individual direct connections to the HIway for each of the acute care hospitals. EOHHS is purposefully not taking a strong stance either way- they just want to get people exchanging and decrease any barriers to care coordination. In general, the Advisory Groups agreed with this approach and there was support to move forward.

Related to the third issue, currently the HIway use is segmented into provider to provider communication, public health reporting, quality reporting and payer case management. The initial

thought was that in order for a provider to satisfy the direct messaging connection requirement they could send a direct message in any of those categories.

Theoretically, a provider could use public health reporting via the HIway to satisfy that direct messaging connection requirement. This Council brought up an important point which is that the key purpose of the regulation is to promote care coordination amongst providers – particularly as we are in this restructuring phase at MassHealth there will be increased expectations on providers to have improved care coordination and improve care integration between physical health, behavioral health and long-term support services. Being able to satisfy the direct messaging connection requirement via public health reporting does not seem to align very well with the overarching care coordination goal. The Advisory Groups felt there were pros and cons to each of these different options, understanding that the most benefit is really from provider to provider communication.

- Comment (John Halamka, MD): Shouldn't the Meaningful Use Stage 2, and as we head into MACRA which has a lot of the Stage 3 proposals, really require provider organizations, both eligible professionals and hospitals, to be doing at least 10% of transitions of care through direct messaging anyway. So in some ways we inherit at the state level what is happening at the federal level.
    - Response (Gary Sing): That is a great point, that 10% is a threshold that is defined by Meaningful Use. This is one of the items that we are still taking into consideration- what exactly does that connection requirement look like? Would we use that 10% or set a higher bar? This is something we are still in discussion about.
    - Response (John Halamka, MD): My advice would be to be careful getting into a situation where the state and federal government misalign in their thresholds because I think we are going to see a massive amount of change as MACRA is revised.
- Question (David Seltz): Just to clarify, it was the advice of the Advisory Group to allow the regulatory requirement to be satisfied even if a provider organization is solely doing public health reporting?
    - Response (Gary Sing): In the long run the goal would be to have provider to provider communication be the only way to satisfy the requirement. There is some discussion around whether there is some phased in approach where you could do some public health reporting in year one for example, but that is still under discussion.
- Comment (Daniel Tsai): That is consistent with what MassHealth is thinking. John what is your point of view in terms of the Meaningful Use requirements? Part of the discussion underlying this is in regard to what can we, as a state, track in terms of a requirement– John do you have any idea how easy it is to track that 10% piece and how easy is it to make it consistent with federal and state requirements?
    - Response (John Halamka, MD): That is an excellent point– I asked Kate Goodrich, the author of MACRA, how should we define the denominator for a transition of care? Is it a referral? Is it an order? She said, 'well, you as a provider can define however you think it is most appropriate.' I could say 'well it's 7'. We have to make sure it is something that

is measurable because at the moment MACRA is not telling us how they are going to measure the denominator for transitions of care.

- Comment (Mike Lee, MD): To echo what John is saying, it has to be measurable and useful at the same time. Meaningful Use says any transition of care can be in the denominator, but if it's a referral, it is not clear when you need to send the referral- do you send that now, or send that in three months? What happens if the patient reschedules and goes to another physician? No one is getting the information they are supposed to get at the right time. Without having clinical utility, it is not worth measuring something for the sake of measuring. I know I have raised this before, but organizations need to be able to receive, not just push out documents to meet Meaningful Use thresholds. If you are only going to do acute care hospitals and large organizations for now, places like Atrius Health would be first- and there is no incentive in the community to receive those messages so nobody signs up – then I cannot meet the threshold because no one is there to receive messages. We have to pay attention- if we are going to do this in some kind of a phased way we need to think about making it useful so that people care about it. I agree provider to provider communication has to be a requirement for the HIway, but it needs to include sending and receiving messages in a reasonable time. If it is phased in it is never going to work.
- Question (Juan Lopera): Related to item two, is the requirement met if the health system talks within its own system – in other words, it does not talk outside of its own system because it does not need to? I know at the last meeting people agreed that it was important to interact outside of their own systems/organizations.
    - Response (Gary Sing): Issue five on the slide is related to provider to provider communication outside of the HIway- specifically those providers that could use their internal EHR to coordinate care in different settings. Let's say a provider organization has implemented a direct secure messaging use case that is 'off of the HIway' (e.g. telling someone that is communicating using Gmail that they must use yahoo mail instead, despite Gmail already working to meet current needs). We would consider a waiver if you are able to satisfy that direct sure messaging use case off of the HIway -but you still have the technical capabilities to interact with other HIway members.
- Comment (Daniel Tsai): I think the point Juan was getting at was if we are trying to get to a meaningful interaction between two provider types, and it happened to be that its multiple sites within your own system treating a patient, how will the regulations come into play. That is something on our minds- how to satisfy some of these existing principles without overburdening and overcomplicating the regulations. It is very helpful to hear the different points of view on this.
- Comment (David Seltz): Just to reemphasize an earlier comment - one can imagine a scenario where 80% of patients are going to the same system for care, and so if that system is effectively communicating within itself that can be a very good thing for that population so it's tricky.
    - Response (Daniel Tsai): My guess is that we are not going to try to solve any of the corner use cases otherwise it will be too complicated to manage but we are trying to get something that is as directionally accurate as possible

- Comment (Kathleen Snyder): One thing to follow-up on is - even if there is communication within the 4 walls, there is a requirement still for people to receive- so that you are able to take in and process someone who is not part of that system. As mentioned we are still in discussions, but we are fairly confident saying that the requirement will be to require you to receive a message from a HIway user.
- Comment (Juan Lopera): And again, without over-prescribing, because I understand that there is a balance in regard to managing leakage for any system. We want more integration, but it is hard to say specifically, here is what you should do.
- Comment (David Seltz): I agree – it's a balancing act. We wouldn't want to discount the coordination going on if they are in the same system-that it is meaningful especially on behalf of patient care coordination. But we do not want to close off and silo ourselves in systems - which is the balance to strike.
- Comment (Patricia Hopkins): I think the struggle is to identify whether it's the hospital as the driver or the physician groups outside the hospital- which magnet carries the greatest weight
- Comment (Kathleen Snyder): Some of this would be use case driven. It is being contemplated that the organization will explain their proposed use case, so that will give us some insight into how it is working so that we can make sure that outside of that there is still the ability to connect.
- Comment (Mike Lee): Going back to the measurement conversation, the operations metrics you put out around messaging over the HIway will answer your question. If no one is sending messages despite enabling all of it, the likelihood is that we are not providing value. If we are really providing something of value here the messages are going to cross because everyone wants to use it. I think trying to get to some arbitrary threshold like 10% probably doesn't make any sense at this level. One of the reasons relates to what was just said – one system wants to send everything internally, but to meet the requirement for the HIway sends 10 transactions to Atrius. It does not make sense at a certain point, we need both sides to be enabled. If this works everyone will use it – you are seeing it with the public health transactions increasing. The provider to provider is just not working because you need both sides enabled for sending/receiving.
- Comment (Audience- Joe Heyman): I wanted to point out that there are regional health information exchanges in the state that are connected to the HIway. For example, in the Newburyport area, which is not hospital driven, its physician driven, most of our transactions are in the system, even if we are connected to the HIway. When a referral is made it isn't really necessary to send a message because both physicians can look at the same record on the same patient at any time.
- Question (Laurance Stuntz): That relates to my question- are we thinking of direct messaging as binary- meaning you are using it in some sort of way or not? Or are you thinking of setting some kind of threshold? I had thought that we defined turning it on and actively using it - I had not heard before about the 10%, or other kind of threshold.
    - Response (Gary Sing): Yes, that was just an example – all of these things are still in consideration.

As discussed, issue 4 overlaps with some other initiatives going on. For Meaningful Use there is already the example requirement for sending, not necessarily receiving on the other end. At the Advisory Group we discussed whether this was sufficient. There were a variety of opinions, some people felt that in order to increase adoption it needs to be only sending, others felt it needs to be sending and receiving - that topic that is still being discussed internally.

The last issue on the list relates to centralized opt-out for HIway sponsored services. As we think about the HIway and the current functions that it offers, we divided them into two services: direct secure transmission of messages, and then the 'HIway sponsored services' which are really more population health related services. An example would be an event notification system. Given that an event notification service, by nature, will require storage of patient health information, we want to enable patients to be able to opt-in and out of that. The proposal made is to have a centralized opt-out mechanism that EHS would administer. In general people agreed that this was the right approach, but that there are some details that need to be worked out. For example, if the patient opts out at one particular institution, will that opt-out apply to the entire institution or does it only apply to that particular provider. Pros and cons for both of those approaches were discussed and are still under discussion. We appreciate everyone's thoughts on this. In order for us to be able to make a decision on this, there is a need for some additional analysis to be done from a policy perspective, technical capabilities perspective, cost perspective, and so forth.

- Comment (Alice Moore): It might be helpful for us to walk folks through an expected timeline for those folks that are not used to the regulatory process – and exactly what that process calls for.

(Slide 5) *HIway Regulations Plan* - A regulations timeline was provided. A high level summary of the timing of the regulations is being developed right now- the timeline aims to promulgate regulations by January 2017, with an anticipated public hearing and public comment period during Fall 2016. In order for regulations to be promulgated there must be a public hearing and a public comment period- EHS will continue to discuss with various stakeholders and encourage them to reach out and share thoughts.

- Question (Mike Lee): When there is a public hearing who attends that? How does that work?
    - Response (Alice Moore): It's an EOHHS public hearing, Council members can attend and I do expect some members will want to participate so we will communicate information as it becomes available.
    - Comment (Gary Sing): As part of that public comment period we will be posting an advertisement in local newspapers- it will be a very public process.

Discussion Item 3: Deep Dive Program

See slides 6-12 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.

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

(Slide 7) *Mass HIway Customer Lifecycle* – The goal of the deep dive program is to improve patient transitions of care and their exchange of digital information between providers across the HIway. The approach is to support technology and clinical workflow improvement – part of that is making sure providers are not just technically ready, but also have engagement and alignment on clinical and business leadership needs. The program is not just about technical assistance, but also making sure providers are prepared for different workflows to get information.

Currently there are 6 organizations involved in this program, and 17 others have indicated interest. These organizations have indicated that they have some high priority clinical goals and aligned use cases. Maybe exchanging information to meet a medication reconciliation measure or satisfy an accountable care contract. We want to make sure that the inter-organizational workflow is mapped out. Examples of the clinical workflows were provided: patient discharge, patient admission, patient referral, or administrative simplification are a few examples.

- Question (Ray Campbell): A few years ago there was a project called IMPACT which focused on these care transitions, is that work helping or influencing HIway discussions?
    - Response (David Whitham) As far as I know, and I will hand this off, this is an engagement we are partnering with the Massachusetts eHealth Collaborative on – some of those resources might be utilized but I will turn to Dave Bowditch –
    - Response (Dave Bowditch): We certainly learned a lot from the work Dr. Garber has done with the IMPACT project - some of the approaches we are using as we reach out are coming from lessons we learned there. Our teams are really working individually with these organizations to help them figure out what will work best for them.

The first example provided is from Southcoast – their goal is to reduce the number of re-admissions to eliminate medication errors at care transitions. The team is engaged in a rapid cycle of feedback around the quality of CCDs being transferred between Southcoast and its trading partners. The organizations realized the HIway was a key way to improve coordination but the finding here was that there was an issue tied to the completion of the physician note - how discharge notes are signed in their Epic system. This was an issue on the vendor side, not the HIway – overall a good learning experience.

The next example is Cambridge Health Alliance (CHA)- this group is working on improving patient transitions between the skilled nursing facilities (SNFs) and the Emergency Department (ED). The workflow looks at how SNFs can send a CCD to Cambridge Health Alliances Emergency Department so that when a patient arrives their information is already there, ready to be integrated into the patient record. This is a good example of how we are flipping the paradigm- making sure the community can communicate to the emergency room when patients are being sent to them. We were able to setup an ED intake box for direct messaging at CHA along with a triage process to get those into the EHR more efficiently. As indicated, those are two examples of 6 current projects that are going on. We are looking

for any organization that has the appropriate resources aligned internally – if you are interested in participating please reach out to Mark Belanger (mbelanger@maehc.org).

- Question (David Seltz): What is the level of intensity of support being provided?
    - Response (David Whitham): The teams work together directly in person and/or via phone as much as possible whether it be weekly, bi weekly or monthly. The goal is to engage as intensely as the organization is able to given resources etc.
- Question (Laurence Stuntz): As a core part of the engagements, what kinds of outcomes are you documenting out front and then at the end as a lessons learned pathway?
    - Response (David Whitham): The start of the engagement is defining the use case, our expectation is that organizations define a specific use case and work with our team to document the process along the way.
    - Response (Laurance Stuntz): I think an important piece is looking beyond asking what are you doing to use this for, but also asking what are the benefits you expect - looking at goals and documenting lessons learned.
    - Response (David Whitham): We are documenting that and we can bring that to a future meeting.
- Question (David Seltz): What are you thinking in terms of second round of engagements?
    - Response (David Whitham): Another six or so would be great - we are open to anyone that is willing to work with us in the capacity described above.
- Question (Daniel Mumbauer): How does this overlap with the Connected Communities program grants?
    - Response (Laurance Stuntz): The Connected Communities grants are firstly, more funding, but focused on similar activities. The Connected Communities program looks at a particular set of outcomes, not just use of the HIway- but they have a lot of the same overarching goals.
- Comment (Juan Lopera): One comment as you think about the deep dives, and maybe to state the obvious, but this is a phased roll out of the HIE, so folks are going to live in two worlds – the HIE world and the non HIE world. The workflows will have to account for that in some way- if you are transacting with these systems use the HIE, else use the fax machine in the corner. Is mapping out those workflows part of the support program?
    - Response (David Whitham): I can touch a bit on the latter piece, who is on and who is not on the HIway, you call out a clear tension we are experiencing in the deep dives is that if they do have multiple trading partners
- Comment (Deborah Adair): It would be great to get this information published somewhere – maybe use some of what is on the website already- list the candidates and their attributes. We want people looking to participate think 'yes I can do this'.

(Slide 12) *New HIway Directory* - In partnership with MeHI we are putting together an interactive map of participants on the HIway- those that are either connected or enrolled will show up. If you click on one of the participants, you will get some rough information on them. This will be a great first step for organizations that are interested in seeing if their trading partners are participating.

- Question (Mike Lee, MD): Can we do an individual provider search using the map? Some providers could be hidden by what organization or network they are behind- that is one of the tricks we are trying to figure out.
    - Response (David Whitham): That is not in play right now but is certainly one of the goals.
- Question (Laurance Stuntz): What exactly do you mean by 'hidden behind a network?'
    - Response (Mike Lee): If I looked up Laurence Stuntz at Partners, it just says Partners is connected. It would be nice to know that Laurance is able to receive messages there. It becomes a real challenge when you have a doctor with more than one office- e.g. someone that operates a private office and works in a hospital organization on the weekends- understanding where that provider receives messages would be really helpful. We do not know, is that provider connected to the HIway under their private office, or a hospital address. When we send a referral it would be nice to know it's going to the right person, at the right address, to the place the patient is actually headed.
- Question (Katie Stebbins): Earlier we talked about other Regional Health Information Exchanges, if you have these networks built and in that setting people are talking to each other, I am trying to understand how that intersects with the HIway. So if I am there (in another HIE) but I may want to join the HIway because patients are going out to other locations outside of that region and there is a reason to connect- but do we have good insight into the volume of communication that is happening within regional networks. Trying to understand that regional communication network against that backdrop of what we are asking you to do as a state HIway system. Do we know who is in a regional system now, already communicating?
    - Response (David Whitham): That is a good question. We do not have insight into the HISP volume yet – we were very aggressive and making sure we can connect to any and all HISP's in the states, we want to make sure the road to exchanging health information is as smooth as possible. The landscape analysis around other HIEs is a good point. We talk to the Pioneer Valley Health Information Exchange (PVIX) and Northshore regularly and we try hard to not leave any providers unconnected.
- Comment (John Halamka, MD): Nationally we have seen this - we end up with a network of networks, subnetworks provided by vendors, subnetworks provided by specialty society's and others, but at the moment there really is not any glue to put these subnetworks together. They really need to think about the HIway as either their primary HISP or as a connector for those already exchanging information via subnetworks.
- Question (Alice Moore): I wonder if there is an opportunity to survey, not sure who would do this, but survey to get a sense of what that inventory is to answer Katie's question?
    - Response (Laurance Stuntz): I think we have a decent sense of the inventory in terms of what those networks are, the regional networks have generally developed around a specific value proposition around a shared clinical record. The HIway has purposefully stayed away from that shared clinical record and thought of it more for exchange across different organizations.

Discussion Item 4: Operations Update

See slides 13-19 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Dave Bowditch provided an update on HIway operations.

(Slides 13&14) *HIway Transaction Activity* - The overall transaction volume was presented – the numbers are trending up - 6 million a month. Occasionally we see a month go down a bit but that is either because it's a shorter month, or others have found a more efficient way for doing transactions.

The line on the top of the use graph is the public health reporting, that is at the core of what is driving the increase in transaction volume which is exactly why we are going through what David went through with the deep dive program. The focus is on increasing provider to provider transactions now – but there are hundreds of thousands of messages going between providers each month- the line looks small in comparison to the public health numbers.

(Slide 16) *Customer Status Dashboard*- An updated status dashboard was provided. This is used for tracking who is connected and actively using. The key things we are looking for on the connected metric is whether they have a technical connection in place, not whether they can send and receive - it just means they have tried it out. More important is the active use metric- this means that they have connected and are using the HIway for a particular use case

- Question (Ray Campbell): I noticed for public health reporting it says 120 senders and 120 receivers- I assume that is not just the department of public health – it must be municipal departments and other parts of the state – correct?
    - Response (David Bowditch): The transactions are bidirectional, so the receivers are also the senders.
- Question (Juan Lopera): Is there a way to get a sense of the volume from that 10%?
    - Response (Dave Bowditch): Correct, if you look at the numbers for larger organization, its near 100%, smaller organizations have a lower uptake in terms of connection to the HIway. The feedback we have heard is that it is due to the consent requirements ,which is one of the barriers we are removing for smaller organizations.
    - Response (Juan Lopera): My point is 10%- given that it is concentrated in larger systems- in year 1 we are likely talking about 80% of the healthcare transactions that are out there. In other words, 10% seems like a really low number, but is representing a large part of the state.
    - Response (Dave Bowditch): That is correct - each organization is not weighted in terms of size. That picks up a lot when you think about an organization such as Partners- they show up as only one organization but have several ambulatory and specialty sites. At the same count you are looking at participants with one or two providers.
- Question (Patricia Hopkins): For the public health reporting, can you give a better picture of that landscape? What is it exactly, and how complex is it?

  - Response (Dave Bowditch): There are 9 different state registries connected right now – Immunizations, Syndromic Surveillance, and ELR have the biggest volume. We are working on collecting the data now so that we can break this slide into two parts- two separate charts.
- Question (Laurance Stuntz): If you are going to close that, a few other things that would be helpful to graph is senders and receivers so we can get a sense of how that is trending. For example, are we getting more transaction volume with existing participants, or new folks just joining? It would be great to understand the deep dive initiatives impact as well and look to identify potential changes as part of that program.
  - Response (Dave Bowditch): That is a great point, and as we get into the deep dives ,we will be able to do some real analysis with that. Even at 3% that's 244 organizations sending and almost as many receiving - these are physicians sending referrals and that number of sending and receiving is growing, it's so small on this graph but its real volume and it's working.

(Slide 17) *HIway Participation Update*- An updated list of participants was provided. Most of the growth is coming in via HISP connections now. As new organizations come on we are finding that they are not necessarily using the HIway because they use a vendor HISP and are automatically connected via another system.

(Slide 18) *HISP Connection Update* - An updated list of the connected HISPs was provided. The list covers most that are operating in the state-most are in the process of testing and some are tied up in some contracts.

- Question (Gary Sing): Do we know how many HISP's are operating in the state?
  - Response (Dave Bowditch): Not sure there is an accurate count – it is rare now that they do not have an existing relationship with the HIway via their EHR vendor.

(Slide 19) *13 Month HIway Availability Trends* - HIway availability trends were presented. We are consistently meeting the uptime goals. When there is an issue the team does a root cause analysis, looks at the processes and works through what can we do as a backup and use it to forecast.

Conclusion

See slide 21 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 7, 2016 3:30-5:00 PM**. Meetings will be quarterly in 2017 – those dates will be announced well in advance.

The HIT Council was adjourned at 5:00 PM.