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

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

|   | Name | Organization | Attended |
|---|------|-------------|----------|
| 1 | Marylou Sudders | *Secretary of Health and Human Services* | N |
| 2 | Alice Moore | *Undersecretary of Health and Human Services (Chair)* | Y |
| 3 | Dan Tsai | *Assistant Secretary – Mass Health* | N |
| 4 | Charlie Desourdy | *Acting Commonwealth Chief Information Officer* | N |
| 5 | David Whitham | *Assistant CIO for Health & Eligibility, EOHHS* | Y |
| 8 | David Seltz | *Executive Director of Health Policy Commission* | Y |
| 9 | Aron Boros | *Executive Director of Massachusetts Center for Health Information and Analysis* | Y |
| 10 | Laurance Stuntz | *Director, Massachusetts eHealth Institute* | Y |
| 11 | Patricia Hopkins MD | *Rheumatology  & Internal Medicine Doctor (Private Practice)* | Y |
| 12 | Meg Aranow | *Senior Research Director,  The Advisory Board Company* | N |
| 13 | Deborah Adair | *Director of Health Information Services/Privacy Officer, Massachusetts General Hospital* | Y |
| 14 | John Halamka, MD | *Chief Information Officer, Beth Israel Deaconess Medical Center* | Y |
| 15 | Normand Deschene | *President and Chief Executive Officer , Lowell General Hospital* | N |
| 16 | Jay Breines | *Executive Director, Holyoke Health Care Center* | N |
| 17 | Robert Driscoll | *Chief Operations Officer, Salter Healthcare* | Y |
| 18 | Michael Lee, MD | *Director of Clinical Informatics, Atrius Health* | Y |
| 19 | Margie Sipe, RN | *Assistant Professor, MGHIHP and Nursing Program Director at Brigham and Women's* | Y |
| 20 | Steven Fox | *Vice President, Network Management and Communications, Blue Cross Blue Shield MA* | Y |
| 21 | Larry Garber, MD | *Medical Director of Informatics, Reliant Medical Group* | N |
| 22 | Karen Bell, MD | *Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED* | Y |
| 23 | Kristin Madison | *Professor of Law and Health Sciences, Northeastern School of Law, Bouve College of Health Sciences* | Y |
| 24 | Daniel Mumbauer | *President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA* | Y |

# Meeting Attendees

# Guest

| Name | Organization |
|------|--------------|
| Pat Bass | Boston Medical Center |
| Wendoly Langlois | Boston Medical Center |
| David Bowditch | EOHHS |
| Kathleen Snyder | EOHHS |
| Kris Williams | EOHHS |
| Nick Hieter | EOHHS |
| Ratna Dhavala | EOHHS |
| Stacy  Piszcz | EOHHS |
| Sharon Pigeon | Harvard Pilgrim Health Plan |
| Jennifer Monahan | MAeHC |
| Jessica Hatch | MAeHC |
| Len Levine | MAeHC |
| Mark Belanger | MAeHC |
| David Smith | Mass Hospital Assoc. |
| David Bachand | NEQCA / Tufts MC |
| Sarah Moore | Tufts Medical Center |

## Discussion Item 1: Meeting Called to Order

The meeting was called to order by Alice Moore at 3:32 P.M.

The Council reviewed minutes of the September 14, 2015 HIT Council meeting. The minutes were approved as written.

The Mass HIway received honorable mention by the National Association of Chief Information Officers (NASCIO). David Whitham thanked the strategic planning workgroup, HIway Advisory Groups and the HIT Council for their hard work and support.

## Discussion Item 2:  Consent Workgroup Update

*See slides 5-13 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.*

**Mark Belanger shared the recommendations of the Consent Workgroup regarding consent for Direct Messaging.**

(Slides 6&7) *Consent Workgroup Update-* Over the summer and fall the Consent Workgroup met to discuss HIway consent policies. The group focused on consent for Direct Messaging. In addition the group looked at other consents invoked when an organization begins exchanging information electronically that do not necessary implicate the HIway, like 42 CFR part 2. The group identified 3 recommendations for the Council to discuss today:

1. Mass HIway Direct Messaging should not have a consent requirement that goes above and beyond HIPAA

2. Mass HIway should provide additional education, clarification, and guidance to providers about health information exchange generally as well key consent requirements related to the HIway specifically

3. Mass HIway should provide education and guidance to patients about the HIway including a statewide education and outreach campaign

(Slide 8) *Recommendation 1* – The Consent Workgroup agreed that Phase 1 functionality for Direct Messaging should be covered by the Health Insurance Portability and Accountability Act (HIPAA). Direct messaging is functionality equivalent to faxing, or emailing patient information. There is concern that Phase 1 consent is difficult to operationalize and providers may choose to stay on, or utilize, other legacy mechanisms for sending health information. Opt-in consent is confusing for consumers who often confuse consent to send information over the HIway with consent to disclose patient information and may not realize declining participation in the HIway still allows providers to exchange the same information in different ways (e.g., fax).

(Slides 9&10) The list of the laws reviewed by the Consent Workgroup was provided. Electronic protected health information (ePHI) that is produced, saved, transferred or received in an electronic form is covered under HIPAA. Psychology note disclosure, substance abuse treatment and others are all protected by the current laws, regardless of transport channel. The group also discussed Superscripts and Epic as leading private models in the market.

(Slide 11) *Recommendation 2: Provider Education* – The second recommendation is that providers be better educated. Over the summer the group discovered that going from legacy transport ways to electronic disclosure raised a whole bunch of issues around the general disclosure of information, compliance with 42 CFR, etc.… HIway consent is just one of several things that providers must figure out before sending information electronically.

(Slide 12) *Recommendation 3: Patient Awareness* – Patients are confused by the many laws and regulations around the disclosure, storage and transport of their health information. Patients can be a driver for [HIway] adoption if they are included and engaged. Misunderstanding and mistrust by patients can undermine the benefits Mass HIway is trying to bring.

- Comment (Deb Adair): It was my understanding that some people felt a more robust education effort across the state was in order to avoid going to an opt-out model. Partners does not feel

changing consent is the right thing to do. Many hospitals in the state still get consent for fax or email. Our forms explain that if you do not agree to HIway we will still be sending your information in other ways (fax or email). There are some shades of other issues in there, some people felt we needed to look at increasing education around opt-in, but it sounds like this is saying increased education after changing the regulation?

- Response (Alice Moore): No, that is not what we are saying. I may be missing something because I am not from the Consent Workgroup, but we had a whole discussion in this meeting about examining the consent policy; there is no decision being made today.

- Comment (John Halamka): Having said this earlier in the process, I felt we divided into Phase 1 push and Phase 2, push and pull. Point to point transactions between two organizations should be handled by each organization because each organization has an existing process. That could be verbal consent or some may feel this part of HIPAA. The answer was, if you are going to push electronically follow whatever is best for your patients. As is, HIPAA is fine for push and opt-in makes sense for pull.

- Comment (Deb Adair): That is how Epic does it as well for Partners.  If you look at the state requirement it is very broad.

- Comment (Alice Moore): This meeting today is not about getting rid of the consent requirements, this is just saying it will not go above and beyond HIPAA.

- Comment (Deb Adair): The state requirement says patients will opt-in or opt-out of the HIway; that is all it said so there is no differentiation between Phase 1 versus Phase 2. I know we are binging HIPAA into this but this is the way Partners has interpreted that.

- Comment (Alice Moore): There is a distinction between HIPAA and the regulation, maybe you need to move above that.

- Comment (Mark Belanger): I think what Debbie is getting at is that the Partners attorneys do not see how you could implement recommendation 1 without a change in statute. EOHHS decided that the recommendation for consent was the responsibility of the multi-stakeholder workgroup and the "how to implement the recommendation" would be figured out by EOHHS.

- Comment (John Halamka): So maybe an amendment says something like - It was never our intent, even though the regulation may be interpreted otherwise, to offer an extra level of written consent.

- Question (Karen Bell):  Is there any data available on the amount of DSM that happens outside of the HIway? The reason I ask is because there is a lot happening outside of the purview of HIway. It seems to me that the same laws should govern Direct Messaging as opposed the mode of transport.

- Comment (Mike Lee): We are exchanging millions of messages back and forth. They are not all Direct in regard to the Direct standard.  Clinicians from Partners use a box in their offices to email their consulting notes to me, which is the opposite of what I want because it lands in my email and the only way I can get it into the medical record is to print, scan and upload. As we use more automated modes of transport we rely on things like FolioMed which provides us information on where other providers are. There was an error last week with the product and we were sending confidential patient information to the wrong place. They are clearly less

secure methods of transport than using Direct Messaging through the HIway. In the Epic community you can use Care Everywhere to send and receive information from other Epic clients. In most communities with that type of capability no additional consent is requested, which I think is where John is going; requirement for Query and Retrieve consent is appropriate for those patients because there is query-able patient demographic information stored in the Relationship Listing Service (RLS). I do understand where Deb is coming from, the state law clearly says opt in or opt out of the statewide HIE, but it sounds like the consent recommendation is that we do not want to go above and beyond HIPAA.

## Discussion Item 3: Overview of Strategic HIway Initiatives

*See slides 13-15 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.*

**David Whitham provided an update on the Mass HIway strategic planning efforts**

(Slide 14) *Summary of the Strategic Planning Process* – The HIway strategic planning workgroup reviewed findings from MeHI, HPC and MassHealth to identify areas of growth. Simplifying the connectivity process to decrease the length of time between sign-up to active use and implementing HIway consent policies continues to be an on-going challenge. There is also a need for the HIway to increase functionality to appropriately accommodate the increased demand for sharing data.

(Slide 15) *Near-term Initiatives* - The strategic planning workgroup is planning three near term initiatives to address key challenges: The Fast-Track initiative to simplify the onboarding process, a consent initiative to pursue the consent workgroup recommendations and a pilot functionality initiative which includes an Event Notification Service (ENS). The Fast-Track initiative has already started to address the complexity of connecting to the HIway.

## Consent Initiative & Event Notification Service Initiative

*See slides 16-40 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.*

**Ipek Demirsoy, Director of Payment and Care Delivery Innovation at MassHealth, provided background information on the current consent and Event Notification Service (ENS) initiatives**

(Slides 18&19) Prime reasons EOHHS is looking at these two issues is because a lot of providers in the context of overall payment reform need to think of HIway as a robust option to exchange data, especially for MassHealth providers. It was noted that most community health centers are operating on limited budgets

Consent has been a barrier to HIway adoption and use. The need to facilitate clinical information exchange is increasing as organizations implement alternative payment models. To the point Dr. Halamka made earlier, there has been discussion around Phase 1 and Phase 2; Direct Messaging versus a query for information. Today the strategic workgroup would like to get input on whether this is even something we should consider pursuing.

In regard to the current consent model, the query and retrieve pilot sites, like Atrius, Beth Israel Deaconess Medical Center (BIDMC), and Partners, have come over the consent hurdle, while others have not even started. There is a need to consider how to respond to stakeholders with fewer resources. Many of these issues have been discussed as the state and national healthcare landscape is changing to support alternative payment models. Later in the presentation lessons learned from other states will be shared. Some opt-in states have moved to opt-out states to address the barriers an opt-in consent model creates. HIway stakeholders have identified potential benefits and drawbacks for removing consent. At the end of the day the question to keep in mind is - is this the best option for the patient's care and for the patient's privacy.

**Mark Belanger provided an overview of where we are today with Mass HIway Phase 2 consent.**

(Slides 21-23) *Consent history-* Originally the goal of the HIway was to build something that was a market enabler, and to stay out of the business of storing and aggregating clinical information. In addition to a secure messaging service, HIway stakeholders, including the 4 Advisory Groups and HIT Council, vetted a second service (Phase 2) called the Relationship Listing Service (RLS) which allows providers with consented relationships to query for and request information from the data holder. In both Phase 1 and 2 the provider maintains control over the disclosure of the patient's records.

A diagram of the RLS service was provided along with a list of the patient demographic information collected and stored.  There is no clinical data shared. This design was vetted by the Advisory Groups and HIT Council over the last several years.

A provider can only view where a patient has a relationship if he or she has collected consent from the patient. Consent is collected at each organization so a patient may opt-out of having a particular provider or organization listed. After checking the RLS to see if the patient has been treated elsewhere the provider can choose whether or not to make a request to the other provider involved in the patient's care. If the data holder would like to respond to the request by sending the patient's most recent Continuity of Care Document or other relevant clinical information he or she can send it back in a number of different ways, not exclusively via the HIway. This is in pilot with BIDMC, Atrius, Holyoke, and Tufts today.

- Comment (John Halamka): One technical subtlety with the current RLS model- there is no master database that could be hacked by hackers, when a 'yes' changes to a 'no' they are completely deleted from the ADT repository. There is no information to disclose even if there were a hack.

*Clarification was provided after the meeting: When a 'yes' changes to a 'no' the HIway 1) retains the historical record of that change for auditing purposes, 2) ensures that none of that historical data is displayed or searchable, and 3) stops collecting any new data.*

**David Seltz walked the group through lessons learned from other states.**

(Slides 25-27) Over the summer the HPC identified 8 states to interview based on these states' established HIE efforts in defined use cases of interest: Event Notification Services, Advance Directives, Consent Management and Centralized Patient Portals, Continuity of Care Document and Discharge Summaries. There was a range of different governance models, consent options, and technical architecture.

Survey data on consent models in other states was provided; 5 out of 8 states were opt-out models. Rhode Island was the only state surveyed with an opt-in model, offering patients three levels of consent: 1) Current and future providers who are participants of the HIE have access, 2) only named healthcare provider organizations have access, or 3) healthcare providers that may care for the patient in emergencies have temporary access. Providers are able to receive basic alerts under HIPAA (functioning as opt-out relative to the HIE); authorizing treatment equates to authorizing view of record to properly treat. A suggestion was made to analyze the Surescripts Relationship Listing Service; Surescripts is able to provide the names of the organizations that sent the prescription.

HPC concluded that most HIEs, regardless of consent model, have challenges managing consent. However, most states see opt-in models as a barrier to adoption and use. A robust educational campaign is needed for opt-in HIEs to be successful.

- Comment (John Halamka): The state of HIE across the country is still pretty embryonic so we must be careful in interpreting the historical results. If we look at the transaction volumes in these states they are very low. There may not be 'one size fits all' answers. We at BID feel we're a pretty patient-centric place; the current consent design was vetted with them. In Indiana there attitude is 'sure put my health information on a postcard in the mail' – the attitude is different.
    - Response (David Seltz): That's a great point. The history of how they have evolved is unique. The culture, consumer level of feeling secure and safe, was different in each of those contexts.
- Comment (Mike Lee): I get all of the patient inquiries for Atrius and currently all of the HIway related ones I get are around insurance company access to information. No one has voiced concern about sending information to BID or Partners or anywhere else. It's all about what is being sent to the insurance company which lends itself to a general patient education issue.
- Comment (Sharon Pigeon): I agree. Harvard Pilgrim has rights to clinical data through [HIPAA] Treatment, Payment and Operations (TPO). Clinical data sharing is happening all the time. The HIway is just a transport mechanism and adding consent for Direct Messaging has raised that level of concern. I am not sure to what degree the public knows that clinical information is shared already.
- Comment (Steve Fox): As a representative of Blue Cross Blue Shield  I think it's great that patient education is there because that is really the issue. They get nervous about what is being sent to insurers, not to other providers. We are in our own way and we need to get creative about our ways to engage the community.
- Comment (Deb Adair): I think we should focus on the patient and provider education and look at what impact it has before removing the consent requirements.

- Comment (Ipek Demirsoy): I think we heard that others do not see the value add of the HIway; there needs to be enhanced functionality built into the HIway. Information from other states that supported ENS reflect the variation in IT sophistication/exposure by group. One of the reasons we started talking about some basic functionality as a public option was so everyone could have access.
- Comment (John Halamka): At BID Plymouth I have heard providers say they must consent all of their patients in blood before they send a fax. I have tried to explain to them over and over again-HIPAA covers these types of clinical data exchange. Patient and provider education are currently our most important focus.

**Expansion of Query & Retrieve Services with Event Notifications: Ipek Demirsoy**

(Slide 29) *Reasons the HIway is planning an ENS*- The potential for a HIway ENS service has really been the trigger to talk about consent. If we want to enhance functionality we need to talk about consent first. The need for Event notifications is something the strategic planning workgroup is consistently hearing from providers. MassHealth sees this as a real opportunity to improve care coordination for all patients across the state; great potential for a robust public option.

(Slide 30) Key Considerations for ENS- Building off of the current RLS to utilize some of the information contained in the current ADT's is being considered. Some stakeholders have mentioned that the current ADT messaging, which contains non-clinical information, could be more valuable with a limited amount of clinical information.  Reconsidering the current consent policies may be necessary if we are going to change the way the ENS will be operationalized. Another piece is around how to create a true market around this – mandate that every hospital needs to send ADT messages –or leave it open to market incentives?

- Comment (Patricia Hopkins): We just had a South Shore Hospital meeting, and one issue discussed was the timeliness of information, and where the best place to receive that information is- we cross over 9 provider organizations. If discharge information is sent to the Primary Care Provider whom they haven't seen in 3 years, and not to the Gastroenterologist provider they see weekly, it doesn't add value. It would be more important to see the identifier on the admission. There is tremendous liability in putting clinical data in the ADT. At South Shore we are looking at having a ranking- whether you need to discuss something with the patient (e.g., mid-levels entering the data versus a provider) to protect the person receiving the messages. There is a liability law for specialists. My preference is no clinical data.
- Comment (Deborah Adair): We are not comfortable with sending clinical information at this point. Maybe down the road if there is more of a development but I think patients are still leery of sending anything.
- Comment (John Halamka): As we become more mature, a public subscription model makes sense; the RLS is simply an enumeration of all of the providers that have taken care of you. However, if I go see an orthopedist once every 10 months, but my Internal medicine physician every month, it makes more sense to get the information to the internal medicine provider.

> There is a maturity that needs to evolve in the market place with patients choosing what to disclose and to whom.

- Comment (Karen Bell): It seems to me that if we are not using clinical data, but there are providers paying for that, it's clearly very valuable to them. Perhaps adding more clinical information will be another step for the future.

- Comment (Lawrence Stuntz): There were 25 pre-applications submitted for the Connected Communities program; we selected down to 8 or 9 and now 6 or 7 are implementing with follow up of information delivery for consented patients. We will learn a lot about that from those groups. I think it makes sense to have as many ADTs as possible in a single repository. Then we can decide about the subscription model- important to have one place for people to get information. Great use of public information rather than silos of ADT messages. I think we will learn a lot from the grantees.

- Comment (Steven Fox): We have a mature risk model which is a very different conversation. If I am in an ACO, I may want to know if someone was admitted, but another organization may want to know when someone is admitted somewhere else. It would be great if it were all in one place, but there are plenty of companies doing this already and selling the data back. Most organizations are getting some level of this from us [BIDMC] today, we need to make it clear that this is something that is happening.

- Comment (Steven Fox): In regard to ACO delivery, we are discussing what the acceptable amount of leakage is; should it be the same for every organization. It is a different level of conversation and there are certainly small un-affiliated providers to account for, but in large most of the data from larger organizations is already flowing. Many of the community health centers get support from larger health systems, or at least data is flowing to those systems already. All I am saying is that we want to make sure the conversation is balanced. We are building all of these capabilities today and the conversations are not around these kinds of barriers.

- Comment (Deborah Adair): I have not heard of the last bullet- requiring all hospitals to send ADT's. Overall there are a number of considerations in addition to this - the data management and the patient matching piece alone. We have 12 people that work just in the eMPI area to make sure the data is matched up and clean. There are a million questions that flood my mind right now.

- Comment (Alice Moore): The choice of words on the slide is probably more definitive then where Mass Health and EOHHS are right now. We are at the very beginning of discussing these ideas.

**Ipek Demirsoy led a discussion of consent model options.**

(Slide 32) *Recap: Drivers for Reconsidering HIway Phase 2 Consent*- make it clear this is the first conversation we are having about this topic. We owe it to ourselves to explain the pros and cons and ask for feedback.

(Slide 33) *Consent Options under Consideration-* The first option is the current model - opt in to send information to the HIway and to disclose a relationship with a provider to the HIway. Consent is required to disclose the data to the RLS. The second option put on the table is opt out to disclose where the consent collection still resides with the participant. The 3rd option is opt out to share where consent is centralized at Mass HIway and disclosure of information to the RLS and ENS is managed by the HIway.

(Slide 34) *Current Model* – The current model for Phase 2 opt-in consent was presented.

(Slide 35) *Option 3: Centralized Opt-Out -* An overview of participant and patient workflow was shown. The provider consents for the ADT to be sent to the HIway and the patient can contact the HIway if they want to opt out.

(Slide 36) *Option 3: Centralized opt-out – Considerations -* In terms of some of the considerations- this obviously may require legislative changes. One of the things we need to consider is the initial patients contacting the HIway. A potential enhancement would be a provider contacting the HIway with patient preference. If we were to go down this mode, 42 CFR part 2 information would be excluded to begin. The model could be global, that is still one of the design choices.

(Slide 37) *Design Details to Consider -* A list of issues to resolve was provided which included identity proofing, patient matching, and synchronizing data among the HIway and Participants.

(Slide 38) *Potential Benefits of Centralized Opt-out Consent-* Potential benefits include: decreased administrative burden on Participants to collect and manage consent; less cost for Participants to implement consent; and less confusion for most patients.

(Slide 39) *Potential Challenges of Centralized Opt-out Consent* – Potential challenges include: less direct contact between Participants and patients to educate them on consent; and some patients might want to choose specific participants to opt-out [rather than a global opt out].

(Slide 40) *Discussion Question's & Next Steps* –

- Comment (Alice Moore): We can continue this conversation December.
- Comment (John Halamka): Our Patient and Family Council has firmly stated that we cannot send information to a state database without consent.
- Comment (Deborah Adair): As a patient I would be furious if I had to call the state to opt-out.
- Comment (John Halamka): Our answer to this was using the patient portal to let people decide if they want to opt out. It is the first question patients are asked.
- Comment (Mike Lee): We [Atrius] do event notifications already; for us it's just a direct message. We have it set up with 14 institutions right now who are all sending notifications for certain patients because we are in an Accountable Care Organization. The whole thing is set up using HL7 interfaces.
- Comment (Mike Lee): I think managing the opt out at a state level sounds great. Essentially on day one everyone will be in then you will be sending [ADTs to the HIway] and [the HIway] will have to delete it afterwards.

- Question (Margie Sipe): Given the time and the fact that we will be revisiting this in December, would you be the person to give comments to?
  - Answer (Ipek Demirsoy): Yes, anyone on the strategic planning workgroup.
- Comment (Deborah Adair): I was a little taken aback that it [opt out consent] was brought up at the last Council meeting. I do not know where it came from.
- Comment (Alice Moore): This was all presented to us at the last meeting. This group wanted to have a study on whether opt out was something to consider. One of the reasons I am trying to state this repeatedly is because you are not understanding that this is the beginning of the discussion. The goal is to make sure we have vetted everything, well beyond this group.
- Comment (Deborah Adair): We started talking about the legislation, then the next things I knew we didn't go there so if we talked about opt-out here I missed that.
- Comment (Ipek Demirsoy): The Council only identified the need to review the current consent policy.
- Question (Kristen Maddison): It does feel like there are a lot of people working on it [opt out consent] and it kind of came in front of us quickly. I did not see in option 3 any prohibition to get consent to push the data to the repository. I think you said consent to share. To clarify, that means that when someone comes to the state and says they do not want to participate they are removed from the database or does that mean the state rejects messages from that provider? In other words it is not just consent to share, it is consent to remain in the database. Is there a potential hacker problem?
  - Answer (Ipek Demirsoy): We are very early in the process and there are still a lot of things to work out.
- Comment (Deb Adair): I hope we get as much time as we need.
- Comment (Steve Fox): It is difficult to get this [HIT Council presentation] the day of the meeting and provide valuable feedback. Having materials earlier helps us to digest this.

## Discussion Item 5:  Operations Update

*Due to time constraints the operations update was not presented. Please refer to slides 47-59 of the presentation to review the HIway's current status.*

## Discussion Item 6:  Conclusion

Alice Moore thanked the team for their hard work and reiterated that the goal is to keep the council informed. Members are encouraged to participate in planning activities along the way.

**2015 Meeting Schedule**

- Monday December 7, 2015
- 2016  Calendar: TBD

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

The HIT Council meeting was adjourned at 5:03 P.M.