Meeting Minutes
Health Information Technology Council Meeting
February 6, 2017
3:30 – 5:00 P.M.

One Ashburton Place, Boston, MA 02108

HIT Council Members

Name	Organization	Attended
Alice Moore	*Undersecretary of Health and Human Services (Chair- Designee for Secretary Sudders)*	Y
Daniel Tsai	*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*	Y
John Halamka, MD	*Chief Information Officer, Beth Israel Deaconess Medical Center*	N
Juan Lopera	*Vice President of Business Diversity, Tufts Health Plan*	Y
Justine Carr, MD	*Former Chief Medical Officer, Steward Health Care System*	Y
David Whitham	*Assistant Chief Information Officer for Health and Eligibility*	Y
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Y
Manuel Lopes	*Chief Executive Officer, East Boston Neighborhood Health Center*	Y
Michael Lee, MD	*Director of Clinical Informatics, Atrius Health*	Y
Patricia Hopkins, MD	*Rheumatology & Internal Medicine Doctor (Private Practice)*	N
Sean Kay	*Global Accounts District Manager, EMC Corporation*	N
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*	Y
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*	N
Lauren Peters	*Associate General Counsel & Director of Healthcare Policy, Executive Office for Administration & Finance*	Y
Margie Sipe, RN	*Assistant Professor, MGHIHP and Nursing Program Director at Brigham and Women's*	Y
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	N
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Y

Guests

Stephanie Giannetto	Community Care Cooperative
Sue Kaufman	Community Care Cooperative
Brian Pettit	EHS
Dave Bowditch	EHS
John Gilbert	EHS
Julie Creamer	EHS
Kathleen Snyder	EHS
Kris Williams	EHS
Lisa Fenichel	EHS
Nick Hieter	EHS
Ratna Dhavala	EHS
Jennifer Monahan	MAeHC
Mark Belanger	MAeHC
Gary Sing	Mass Health
Michael Chin	Mass Health
Dave Bachand	New England Quality Care Alliance (NEQCA)
Jeffrey Grant	Orion
Jerry Kilcrease	Orion
Kary Nulisch	Orion
Ryan Thomas	Orion
Seth Rosenberg	Orion
Cindy Lin	Patient Ping
Julia Sanders	Patient Ping
Sarah Moore	Tufts Medical Center
Joe Heyman	Wellport HIE

Discussion Item 1: Welcome

The meeting was called to order by Undersecretary Alice Moore at 3:33 P.M.

Undersecretary Moore welcomed the Health Information Technology Council to the February 6, 2017 meeting. The November meeting minutes were approved as written.

Discussion Item 2: HIway Regulations Update

See slides 4-15 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An update on the regulations was presented by Kathleen Snyder, Chief MassHealth Counsel and Gary Sing, Director of Delivery System Investment at MassHealth.

(Slide 4) *Background* - The HIway regulations went live last week. Today we will walk through what was proposed in the regulations, some of the comments received during the comment period, and then we will discuss what changes, if any, were made to the proposed regulations.

As a recap, the regulations were developed to accomplish two primary parts of Chapter 118I. The first one was to clarify the mechanism for opt-in and opt-out for the HIway and the second was to clarify what do we actually mean when we say providers must connect to the Mass HIway by 2017.

(Slide 5) *Overview of Public Comment Period*- EHS received about 20 comments from various individuals and entities. For the most part the comments were supportive; there were a couple of comments that raised questions about the opt-in and opt-out mechanism that we will talk about today. By in large the comments were supportive – some of those comments were provided by some members of the HIT Council.

On the following slides there are two boxes: grey boxes provide descriptions of what was proposed in the regulations and the purple boxes describe the feedback and any changes that were made.

(Slide 6) *HIway Direct Messaging*- The proposed regulations indicated that Mass HIway users can use Direct Messaging, just like they could a fax message or phone call - which is there are no additional opt-in/out-out requirements to send that message. Mass HIway users could implement a local opt-in or opt-out mechanism if they desire, but they are not required to do so. In general, there was strong support for this particular point within the regulations.

(Slide 7) *Opt-in/Opt-out Mechanism*- The focus of this slide is on the op-in/opt-out mechanism as it applies to the HIway-Sponsored Services. As a quick refresher, the HIway functions were split into two general categories: the first is Direct Messaging, discussed on the pervious slide, and second are the HIway-Sponsored Services- which are population health services that are 'value add' things the HIway can offer. One example of such a service is the Event Notification Service (ENS) that we are beginning development on. For those HIway-Sponsored Services, the opt-in mechanism proposed is that

participants, such as provider organizations, must provide written notice for how their particular organization uses the services. Then the opt-out mechanism is that there would be a centralized opt-out system where the participant with an established relationship with that patient could either notify the HIway themselves that the patient decides to opt-out, or they could provide written instructions to the patient for them to opt-out themselves. Similar to Direct Messaging, if the provider wanted to implement a supplemental local opt-out process they would be allowed to do so, but it couldn't supplant this particular opt-in/out mechanism, it would have to be in addition to or supplement it. This is what was proposed and on the following slide we discuss feedback and changes.

(Slide 8) Opt-in/Opt-out Mechanism – Some of the feedback received around written notice included a comment that certain kinds of written notice are not considered sufficient for consumer education. In particular, the proposed examples of written notice had included 'visible posters on the wall,' and/or 'banners on a web portal.' EHS received feedback that this was not sufficient and in response has removed these particular examples and in fact will be requiring notice given to an individual patient in terms of what the services are that the provider would be using the HIway for. In addition to that there was some feedback regarding the need for resources to help with folks who, for example, English is not their first language, as well as a recommendation to allow participants to meet the requirement by complying with applicable federal law, as opposed to going above and beyond the federal language requirements.

On the last bullet, EHS made a minor modification to say that the written notice will need to be available in a language that is specified by EHS in the Policies and Procedures document. The HIway-Sponsored Services still have a way to go before being implemented- EHS will be releasing an example written notice, as well as those additional language requirements, closer to when the ENS will go live. Basically EHS has indicated that this language requirement will be specified in the HIway Policies and Procedures at that time.

For opt-out one of the comments received made it clear that we need to make sure that the community understands that currently the HIway is not a Clinical Data Repository (CDR) in the sense that it does not hold patient records. To this end EHS has added language into the regulations and the Policies and Procedures to indicate that at this time the HIway does not provide patient access to their records and if a patient wants access to their records they need to go talk to their provider organization, as those are the entities that actually do hold their records. In addition to that there were some questions related to the centralized opt-out – similar to the ENS, given that those will be launched at a later date, EHS did not update any of the regulations with details about the centralized opt-out because those are still forthcoming.

- Question (Deborah Adair): I am confused by the statement related to opt-out - users must implement their own version, and that might be supplemental? I am trying to understand what that means – you can do your own, but it is supplemental? Can you give an example?
    - Response (Gary Sing): One example could be that the opt-in for a patient might not just be the written notice, but that you would include an affirmative, or active consent process, similar to what was required for direct messaging before. For the opt-out it

could also be, for example, in addition to having a centralized process, the provider could manage their own local opt-out and then pass along those details to the centralized opt-out process. That is likely less efficient but it is an option for the provider to implement if they wanted to.

- Question (Justine Carr, MD): If someone opts-out locally, does that mean all of their data is opted-out? If it is communicated centrally, will the patient be out all together? There could be asynchrony in different settings.
    - Response (Gary Sing): Yes, and this is an important point the Council has considered previously. At this time, we are committed to the centralized opt-out where there is a single source of truth. Now if a patient opts-out in a particular location, whether that applies locally just at that location, or entirely out of the ENS across the state is still being discussed - EHS is exploring those pros and cons.

(Slide 9) *The HIway Connection Requirement* – The proposed regulations describe a phased- in approach for which providers actually need to connect to the HIway at least initially-in other words who will be in the first cohort or wave. Initially it will be acute care hospitals, medical ambulatory practices with 10 or more licensed providers and Community Health Centers; the date changes depending on the size of the Community Health Center. In terms of when EHS will notify organizations that they need to connect, those organizations will be notified in future guidance, it would not be earlier than January of next year but with at least a one year notice.

(Slide 10) *The HIway Connection Requirement*- In terms of feedback received, people were generally supportive of this phased-in approach, especially representatives from the behavioral health community, dental community, podiatry and other professional societies.

There were two comments received about the provider threshold for the Medical Ambulatory Practices and the Community Health Centers. There is a 10 provider threshold and there was a request to make that 15 in order to align with some of the Medicare Access and CHIP Reauthorization Act (MACRA) and Merit-Based Incentive Payment System (MIPS) thresholds for participation. EHS did not make any changes to the draft regulation; maintaining the 10 provider threshold will help to increase the number of providers connected to the HIway.

(Slide 11) *Phased-in Connection Requirement* - The proposed regulations describe another phased-in approach related to connecting. In other words- what does connecting actually mean? In the first year providers would be able to satisfy the connection requirement if they send or receive direct messages for at least one use case within any category. Those categories include provider-to-provider communication, public health reporting, and payer case management for example. In year two the requirement would be that the provider must send or receive direct messages for at least one use case within the provider-to-provider communication category. This is really to help promote the idea of improved care coordination, especially with all of the payment reform activities that are going on right now that are really centered on improving and increasing care coordination amongst providers, especially across different silos of care such as physical health, behavioral health, long term support services (LTSS) etc. In year three it is no longer sending or receiving- you have to send and receive direct

messages for at least one provider-to-provider communication use case. Year four is when the penalties would begin if those connection requirements are not met in the previous years. There is a phased-in ramp-up approach to the connection requirement and these penalties are required by statute. One additional connection requirement is especially for Acute Care Hospitals- within one year of the launch of the state-sponsored ENS, Acute Care Hospitals would be required to submit Admission, Discharge and Transfer (ADT) notifications to the ENS in order to drive the data foundation for the ENS. This will be discussed in a subsequent slide later on. EHS is currently anticipating that the state-sponsored ENS would go live in April of next year. If we are able to maintain that date then this particular ADT submission requirement would kick-in in April of 2019. However, that will be contingent on when the state-sponsored ENS actually goes live. In terms of feedback, overall people were supportive of this phased-in approach- as a result no changes were made to the draft regulations.

- Question (Laurance Stuntz): Is the requirement the beginning of the year or the end of the year? Is this effectively a four year or a five-year timeframe?
    - Response (Gary Sing): I believe it is the beginning of the year.
    - Follow-up question (Laurance Stuntz): So as of right now, or last Friday, all of the Acute Hospitals should be doing one use case? Technically if they are not they are in violation- understanding there are no penalties yet?
    - Response (Gary Sing): Yes, correct. There are some nuances around the dates, but the regulations will make that clear.

(Slide 12) Implementing a fully interoperable EHR – The language in Chapter 118I says that providers must implement fully interoperable electronic health record systems that connect to the statewide HIE by a certain date. So that phrase 'fully interoperable electronic health record system' is a key one- EHS has indicated that the date by which providers must adopt or achieve this full interoperability shall be met by implementing HIway Direct Messaging- and the date by which they need to submit this information is the same date as their initial HIway connection. For example, say you are a medical ambulatory practice of 10 or more licensed providers and your connection date is January 1st 2018, you would need to indicate that you have implemented HIway Direct Messaging prior to January 1st of 2018 to satisfy the requirement in the statute. Some of the feedback received in the public comment period indicated that there are quite a few ways in which providers can connect to the HIway that would not require the purchase of an expensive EHR system - one of the examples is through HIway webmail. This route of connecting to the HIway through webmail is actually something that we had contemplated and actually planned on from the very beginning. EHS has tweaked the regulations to make it clear that there are several different ways to connect to the HIway such as the EMR's Direct connection, Webmail, or Local Access for Network Distribution (LAND) connection. In terms of how a provider would attest to doing this, the HIway Policies and Procedures include the attestation form that will be used by providers to let EHS know that they are connected to the HIway and how.

- Question (Ray Campbell): You talk about the provider organizations having to submit information regarding their EHR, in addition to other required information. Do you already know what questions you will be asking, or what specific data you will be requesting?

- Response (Gary Sing): In addition to releasing the regulations we have worked on updating the HIway Policies and Procedures- one of the appendices in there is the actual attestation form providers will be using.
- Follow-up question (Ray Campbell): And that is what you were referring to when you said collecting information about the provider EHRs?
- Response (Gary Sing): Yes, correct.
- Comment (Ray Campbell): I am interested in that because of my prior life in the EHR space, but also in my current life as a data collector – I was thinking about quality metrics and who is doing quality reporting in the Commonwealth. That is information that would be very useful to have and to be able to associate organizations that do or do not have EHRs. If you are collecting that data it would be interesting to have access to that as a sister-state agency, or if you are interested in exploring what data points to collect in the future I think there would be interesting information to get at in that area.
- Response (Gary Sing): That is one of the main reasons we wanted to go down this route- right now there is not a robust database of what EHRs are being used across the state. We think this will be a valuable tool to get some insight into that.
- Comment (Ray Campbell): The Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC) are already collecting data from provider organizations, they may be doing this kind of data collection already, I am not sure how much of that we get to see here but it is certainly another way of getting at data related to what technologies are being used throughout the state.
- Response (Gary Sing): I know MeHI/Laurance has a database of EHR systems but it is not comprehensive- it is based off of the one-off interactions they have as part of their grant engagements. We are working together to think through ways of collecting this information.
- Comment (Ray Campbell): Yes because the RPO data collection requirements for any provider organization in the state that does $25 million a year in booked business, which I think covers most, so that is a vehicle potentially for collecting some of this information.

(Slide 13) *Other Feedback Received* - There were additional pieces of feedback received related to the importance of patient privacy - EHS has added language to clarify that unauthorized access or disclosure of patient information is prohibited and may be subject to punishment under state and federal law. In addition to that, in the HIway Policies and Procedures EHS has highlighted that if this unauthorized access occurs it is potential grounds for being removed from the HIway. As mentioned previously, one commenter recommended clarifying language around allowing patients to access information on the HIway. No changes were made to the regulations right now because the HIway does not store any information, but as we continue moving on and pushing forward with HIway-Sponsored Services that will definitely be something that is under consideration.

- Question (Katie Stebbins): Thinking about my own experience going to a doctor's office- I sign all of the forms quickly, sometimes without reading them closely, just because I want to get to my

appointment. As we are asking people to sign things, and we are talking about patient privacy and security, how are we educating them? This makes sense to all of us who are in it, but it seems like there needs to be some kind of proactive public education process.

- Response (Gary Sing): I would actually be curious to hear what the Council has to say about this.
- Response (Alice Moore): I know Katie is newer to the group, this has been an ongoing issue even before I came on board, the opt-in/opt-out scenario and the success really of the HIway going forward, and so we are very much concerned about patient security, confidentiality and patient awareness of how they are participating in the system. The HIway at this point allows doctor to doctor communication, like faxes or emails for example, that currently occur on a daily basis. The HIway does not store any information- it is not a Clinical Data Repository (CDR).
- Question (Katie Stebbins): So I as a patient do not have to give permission for my doctor to use this?
- Response (Alice Moore): This is a change and allows for local participation and engagement as well – I am happy to have a conversation about the pros and cons. I think consumer education is always an important thing to do, will continue to be important as we implement and understand exactly what the possibilities are for the HIway to continue. As we understand, the HIway was basically stagnant without making this change and encouraging folks to allow their doctors to communicate.

- Comment (Kathleen Snyder): And just to add to that, we are in the process of revising the patient fact sheet that was developed around this – we are updating that to reflect the new reality of the HIway and the opt-in/opt-out mechanism. As we move forward developing HIway-Sponsored Services I do expect that there will be additional educational efforts to explain how those services help facilitate better coordination of care.
- Comment (Alice Moore): One thing that is fascinating, the law actually anticipated that patients would have access to their records which is certainly a goal – but a longer, far out goal.
- Comment (Deborah Adair): We were worried about this at Partners with the fact sheet- one thing that really helped us was to make this available online, on the patient portal – so they have all of the information there at home, they can read all about it at their leisure, not just at the time they are checking in with the provider.

(Slide 14) *Stay Informed* – The regulations went live last week and EHS will be releasing a couple companion documents. One of them is a summary of the regulations, an FAQ document about some of the changes that were made. As Kathleen mentioned, there will be an updated fact sheet for patients along with the updated Policies and Procedures forms that will include the attestation form providers will use to show the state that they are connected to the HIway. EHS will continue to blast information over the HIway newsletter. If you do want those updates, please sign up for the HIway email distribution list. These regulations were developed with close collaboration from stakeholders, including the HIT Council. The Regulations Workgroup is looking forward to seeing how providers are using the HIway to improve care coordination for their patients.

- Comment (Alice Moore): I wanted to give a big thank you to the team, including Gary, Kathleen, David, Michael and others who have worked a long time on this – and in a constrained amount of time.
- Comment (Joe Heyman, MD - Chief Medical Information Officer at Whittier IPA): We support a Regional Health Information Exchange which is quite robust- and does most of the things you are thinking about doing in the future. We gave both oral and written testimony, which I thought was quite positive. One point we made in both oral and written testimony, and maybe it will be addressed later as this point is not just for us, but also for the HIEs out in the western part of the state as well as Winchester Hospital and Reliant, but anything the state can do to make it clear that the opt-out process for regional exchanges is both needed for consistency with the HIway and legally- it would be most appreciated and there is no apparent guidance in Massachusetts Law for regional exchanges - we are concerned about the inconsistency. As we are opting-in a patient to the regional exchange, we are now also trying to explain that they can opt-out of the Mass HIway. Right now we opt-in patients to both using a single consent form. Knowing how flexible you can be with the regulations as opposed to the actual law- even just an example of how it could be done will help give us some cover so that we can use the same procedure as the Mass HIway- for the same reason the Mass HIway is stagnant because of the opt-in. I wanted to reemphasize that problem for those of us who are connected to the HIway as regional HIEs. Thank you.
    - Response (Alice Moore): Thank you, we will continue to take those comments as we proceed.

Discussion Item 3: Event Notification Service (ENS) Update

See slides 22-25 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An introduction to the ENS was presented by David Whitham and John Gilbert

(Slides 16&17) *Recap: HIway ENS Demand*- David echoed the praises of the team for helping us move forward with promulgating the regulations over the last 12 months. These regulations really are central to what we are doing and how we are responding to conversations that took place back in the summer of 2015 around the desire of a majority of members on the HIway to implement a statewide ENS service. EHS had a number of meetings with stakeholders and an Event Notification Service really hit the top of the charts for a service that would be valuable to all members of the Commonwealth. The team saw that private ENSs are already making their own roads- not only nationally, but also within our Commonwealth as a viable tool to support payment reform and payment delivery reform.

The HIway ENS would be able to improve care coordination, and be service that we are looking for in real time. EHS heard very clearly that this type of messaging regarding patients in real time is going to be a game changer for providers- providing that information that is going to allow them to react and manage populations, manage continuity of care and provide an enhanced experience for constituents in the Commonwealth and their patients.

The needs identified for the ENS – it is an increasing result of payment and care delivery reform. There have been other statewide HIEs that have been implemented in other states- as mentioned before we also have some providers piloting their own Event Notification Services through private vendors. A number of providers indicated that a robust public option of an Event Notification Service will allow the HIway to ensure that all providers throughout the state would benefit.

(Slides 18&19) *Current Key Considerations for ENS*- EHS did an analysis of MassHealth and found that an average of 50% of acute inpatient hospital activity was out of network. The ENS would respond, and hopefully provide the solution to this gap and provide that care continuity not only for the patient but also the providers. We heard this loud and clear, as we were drawing the regulations to a close this year we started to move quickly to be able to respond to this demand to setup the ENS. To that end EHS has hired John Gilbert, our policy analyst for Event Notification Services.

(Slide 20) *ENS Pre-Work Activities* - John was brought on as the ENS policy analyst in December of 2016. He has been scanning the regional landscape, as well as at the national and local level, including some of the organizations represented here.

As it is currently contemplated we are looking at an Event Notification Service that would be efficient in the context of admission, discharge and transfer type information. The ENS would be built upon those particular data elements. As Gary mentioned earlier the opt-in and opt-out mechanism is akin. Some of the feedback that was provided raised a question regarding clinical information being included in the notifications, such as a reason for a visit or a diagnosis. It was noted, and has been noted, that there is disagreement among stakeholders on clinical information being included in that notification. A list of the activities and organizations that the group has been in contact with was provided. John has regular conversations with the Office of the National Coordinator for Health IT (ONC) and is working with the Massachusetts eHealth Institute (MeHI) and the Massachusetts eHealth Collaborative (MAeHC). In all of those conversations the focus is on requirements gathering, knowledge gathering and then also planning stages with stakeholders that involve a regional approach to the ENS in Massachusetts. John is gathering information around what would providers prefer within an ENS and also researching functionality that exists out there and documenting use cases. Going back to what we just talked about, the out of network scenario is the example that continues to come up as an example.

(Slide 21) *Sample: Other States' Experiences*- An example of information gathered from other states was provided (VT, NH, NY). This is just a sample of some of the information gathering being done. A lot of what was being conveyed was that opt-in is a challenge so these regulations are obviously going to benefit health information exchange as well as future services such as an Event Notification Service. There was a lot of expression around data quality- for the most part that revolved around demographics and patient matching when there are various spellings for example. Just about every state had an administrative component for folks who are called or termed 'data stewards' – they would find outliers that systematically could not be proven matches – they will look at the data and try to manually mediate that.

(Slides 22&23) *MassHealth Pilot ACO Interviews* - Recently some colleagues have completed interviews with pilot Accountable Care Organizations- there are some interesting high level data points and findings on the slide. The most interesting was the fact that there are, as we all know, disparate EHRs in the marketplace and getting those to be connected and to be interoperable, is always a challenge. There are any number of products that are being utilized currently for ENS.

(Slide 24) *Key Takeaway from Initial ENS Research* - Some of the key take-aways revolve around the quality of the data- a lot of that has to do with the demographics and the need for accuracy. Also the need for successful implementation of the opt-in/opt- out mechanism and any HIway service offered, specifically in this case Event Notification, really needs to benefit from that. Also, as mentioned earlier there are various Event Notification Systems already in place, however certain individual providers may not be able to maximize those, and a value add would be the statewide ENS.

(Slide 25) *Anticipated ENS Milestones Timeline* – The anticipated milestones/timeline was provided- the goal is to go-live with the ENS in April. John will be reaching out to a number of stakeholders across the state in the coming weeks and months.

- Question (Daniel Mumbauer): Is part of the plan to loop in the post-acute providers? I know this is pretty much all hospital right now?
    - Response (John Gilbert): Yes, that is the goal over time – we anticipate going to other provider types.
    - Response (Daniel Mumbauer): I would suggest that it should be sooner than later because if we miss the post-acute world you've missed a huge slice that is trying to connect everybody.
    - Response (David Whitham): The way I envision it is as a service – obviously the service has some language in the regulation about mandated connectivity but then that service would be open for voluntary connectivity for other provider types.
- Comment (Mike Lee, MD): Related to the opt-in/opt out timing- for many organizations such as ours, where we have notifications setup- that if we do this in a sort of slow approach with a slow uptake you are stuck in a double workflow scenario where you are getting state notifications and you are not sure exactly how many you are getting so therefore you are retaining the previous ones you've setup and therefore you are getting redundant notifications, which would drive everyone crazy. We currently have that as an example with one of our hospital systems that just installed Epic, which is the same software we use, so they are sending summaries out of Epic but then also have a pre-existing fax server setup so we are getting both. They do not have the ability to intervene in that at this time. It creates a tremendous problem when you create dual workflows and will really handicap the setup. I am totally in favor of this, I think it is great because it will prevent all of these one to one things as long as we get it right. I think trying that phased in opt-in will kill this before it gets going- there are already things like this going on in the state. I know there are places like Partners that have looked at Patient Ping and others - we do not want them jumping into that private sector space because they are worried that this isn't going to standup correctly.

- Question (Katie Stebbins): Going back to slide 18, I am struggling with understanding the in-network/ out of network balance, and how implementing the ENS impacts that. I am having a hard time understanding that link between the two?
    - Response (David Whitham): Our supposition is that the out of network number represents the gap in communication. In-network is something within an entity and therefore communication will be transmitted there, but we cannot make any assumptions with the out of network. In fact, what we have seen in the marketplace is that does represent a lack of communication.
    - Response (Katie Stebbins): I was confusing the word "network" – I was thinking about insurance networks.
- Response (Daniel Tsai): I think we should clarify terms in-network/out-of-network on this slide. The broader point is that this is just on the acute inpatient side, within a handful of potential ACOs, where to David's point we have many different acute care hospitals interacting around a particular population – when you intersect this then with say, primacy care, or post-acute providers, that multiples this thing exponentially – I think that is the point we are trying to get at. The ENS will hopefully help solve the communication of when folks are coming in and out of the hospital. That is a very good point on the terminology.
- Comment (Justine Carr, MD): Related to the independent providers, or commercial initiatives, I learned today that MHA is offering a first year free coverage for a program called EDIE or Pre-manage ED. Again as everyone is going towards the common goal, but if we are doing it asynchronous your point is well taken.
- Comment (Ray Campbell): David this is great stuff- and I know it is hard to do everything you have laid out and I do not want to bridge too far – and I know the Mass HIway is not about collecting data for the state's own purposes, but it would be fascinating for the state to have access to this sort of admission, discharge and transfer information for a lot of reasons. You could be looking at the flow of people between nursing homes and hospitals, so on and so forth. Some of that we get at in our case-mix data, but it does not cover for instance nursing home/hospital transfers. Even on a de-identified basis there would be incredible value in having access to the data. Just getting at some of the basic boarding questions- the time that people spend in one location versus the other – I think there is a lot of value in this data even if it is de-identified. We get case mix data that is not de-identified, so certainly the state collects this type of information with names and other things associated with it, but this data would be a great asset to add down the road.
    - Response (Alice Moore): Those are the conversations we want to start to launch now that we have opened up a lot more activity possibilities on the HIway.
- Comment (Deborah Adair): I just wanted to say that I am very pleased to see that this has been developed further and there is a timeline. Thank you!
- Comment (Alice Moore): I agree; this is exciting- great work everyone!

Conclusion

See slides 26&27 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Alice Moore provided closing remarks before adjourning the meeting

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

The state is looking for a Mass HIway Executive Director- the Council was encouraged to think about/pass along the job description to any potential candidates. There will be an opening for a Policy Analyst as well. The state is looking forward to broadening the conversations now that the regulations are effective.

The HIT Council was adjourned at 4:33 PM.