

# Health eNet Step-By-Step Registration Instructions

Step 1 Create User Account (Anyone completing Step 2 or 3) Step 2 Complete Participation Agreement (Signatory) Step 3 Complete Registration (Provider or Office Manager)

### Step 1 Create User Account (Anyone completing Step 2 or 3)

- 1) Click on URL https://healthenet-register.hawaiihie.org/
- 2) Select "Sign-Up"

Sign in	
Welcome to <b>Health</b> <i>e</i> <b>Net</b> ! If you are here for the first time, please sign up below.	
Email	
Email	
Password	
Password	
Remember me	
Sign in	
Sign up	ſ
Forgot your password?	

- 3) Enter required information
  - a) Email address (Where you will receive a confirmation email to activate the account)
  - b) First Name, Last Name, Practice Name
  - c) Password
- 4) Select Sign-Up

First name	
First Name	
Last name	
Last Name	
Practice name	
Password	
Password	
Password Password confirmation	1



6)

5) Check your email

	Hawai'i HIE online account confirmation instructions - We loome FTC Chan (fchan@h	3:47 pm
select the link in your conf	irmation email	
Hawai'i HIE online account confirm		
info@hhie.us to me ▼		
Welcome natalie pagoria (nataliepagori	ia@amail.com.)	

7) Log-in through the link in your email to complete activation of your account

## Step 2 Complete Participation Agreement (Signatory Only)

- 1) Log-in to <a href="https://healthenet-register.hawaiihie.org/">https://healthenet-register.hawaiihie.org/</a>
- 2) Select "Go to Participation Agreement"

elcome!	
Participation Application	Registration
If your practice/organization would like to utilize the Hawa'l HIE's <b>Heath -Net</b> adde of envices to accurate accurate elevation of the environments with providers community Heath Record for treatment purposes, phase fill out of Participation Community Heath Record for treatment purposes, phase fill out of Participation Participation Agreement button below to access the online and prinable versions of the agreement.	If you have completed and submitted a Participation Agreement to the Hawa'' Agreement tand accompanying business Associate Agreement) have been signed by the Hawa'i Hit — Han phese citics on the "Go to Registration" button accounts for your practice organization to utilize the Hewa'i Hit's Health -Net suffer the suffer.
IMPORTANT: Since the Participation Agreement is a contract, please only fill out and sign the Participation Agreement if you are a person with authority to enter into legal contracts for your practice/organization (e.g. corporate CEO, LLC manager, or other owner).	If your practice / organization is not yet a Hawai'l HIE participant, please click on the "Go to Participation Agreement" button to the left to begin the steps needed to become a participant.
C. Go to Participation Agreement	S Go to Registration

3) Read the instructions and explanation of the process and select "Start filling out Participation Agreement".

Step 1: Comp	ete the Pa	irticipatio	on Agreem	ent			
The first step in becoming a Hawa and its exhibits, describe our Hea	i'i HIE participant is compl th eNet system and the se	leting a Participation Ag irvices we provide, as v	reement: the contract betw rell as the terms and condit	een your practice/organiz ions of using our system t	ation and the Hawai'i HIE. access and exchange pa	The Participation Agreer tient information.	ment,
Participation Agreement. This	s the main contract formal	izing the business relati	onship between you and th	e Hawai'i HIE.			
Exhibit A – General Description	of the HIE System. This	document describes ea	ch component of the Healt	h eNet "Suite of Services"	available to Hawai'i HIE p	articipants.	
Exhibit B – General Terms and conditions.	Conditions. This docume	nt defines key words an	d phrases utilized througho	ut the Participation Agree	nent and exhibits, and incl	udes the specific terms	and
• Exhibit C – Business Associate a participant, entrust to us.	Agreement (BAA). This is	s a separate contract re	quired by HIPAA, and holds	the Hawai'i HIE accounta	ble to properly safeguard t	he patient information y	rou, a
Exhibit D – Scope of Work and	Fee Schedule. If applicab	le, this document lists t	he specific Health eNet set	vices the Hawai'i HIE will	provide you, and the costs	for those services.	
Exhibit E – End User License A	greement. This exhibit pro	ovides the terms and co	nditions for using third-par	ty vendor software utilized	within the Health eNet.		
IMPORTANT: Before proceeding, owner) should review, complete a	please keep in mind that o nd sign the Participation A	only a person with author greement.	rity to enter into legal contr	acts for your practice/orga	inization (e.g. corporate CB	EO, LLC manager, or oth	her
You may click on the "Download F (including the Business Associate	articipation Agreement" ta Agreement) here on our w	ab above to download t ebsite.	he Participation Agreement	and its exhibits; or compl	ete, review and sign the Pa	rticipation Agreement	
We just a need a few pieces of inf Start filling out Participation Age	ermation to complete the F	Participation Agreement	online. Please click on the	button below to get starte	d.		

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Email: info@hawaiihie.org Web: www.hawaiihie.org



4) Enter all required information and select "Save"

Online Part	ticipant Agreement	
Signing	Participant Agreement	
Local Fat	•	
* Name of Pract	ty: tice's / Organization's Legal Entity (as registered with the government)	
* Address		
Owner or	Other Person with Signing Authority for Legal Entity	
* Name		
* Name * Title		
* Name * Title * Phone		
* Name * Title * Phone		
* Name * Title * Phone * Email		
* Name * Title * Phone * Email		
* Name * Title * Phone * Email Legal Atte	ntion:	
* Name * Title * Phone * Email Utegal Atte (The person (e.g.	ntion: privacy officery to whom the Hawa'' HE about communicate regarding the HIPAA business asso	ciate agreen
* Name * Title * Title * Phone * Email Legal Atte (The parson (e.g. * Business Asso	ntion: privacy officery to whom the Hawa'' HE should communicate regarding the HPAA business asso clasts Agreement Point of Contact	ciate agreen
Name     Title     Title     Phone     Email     Ute person (e.g     Business Assoc     "     Email     The and the person (e.g     Compared the person (e.g     The person (e.g     Compared the person (e.g     The person	ntion: privacy offordy to whom the Hawa'' HE should communicate regarding the HPAA business asso cable Agreement Point of Costact	ciate agreem
Name     Title     Title     Phone     Email     Che person (e.g     Business Assor     Email     Email	ntion: princy office) to show the Hawa'' HE should communicate regarding the HIPAA business asso cluster Agreement Point of Contact	ciate agreem

5) Electronically sign your Participation Agreement by selecting "Submit My Agreement" OR if you would rather print you may download and print the individual copies





6) Review the completed Participation Agreement and Exhibit

Check each box, type your name and select "Submit My Participation Agreement"



7) Enter password and select "Submit My Participation Agreement"

* Please check all above agreements and sign	
please re-enter your password	
Close & Submit My Participation Agreement	c

8) A confirmation email will be sent including a confirmation token





### **Step 3 Complete Registration (Provider or Office Manager)**

- 1) Log-in to <u>https://healthenet-register.hawaiihie.org</u> If you have not already signed up for an account, follow directions in Step 1.
- 2) Select "Go To Registration"



3) Select "Start New Application"- If you have already started an application select the draft





#### 4) Enter all Participant Information

\*Complete the legal name text box as required. If the practice is a part of a larger organization, then enter the department name in the next box.

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Draft 📀	Submit	tted >	Pending Review >	Fir	nal Status				
ne Participant	Contacts	Providers S	Staff Confirmation						
articip	ant								
Participant f practice is a part Example: Legal Na Legal Name	of a larger orga me: Hospital X	<b>ation</b> anization then ti YZ Departmen	he individual practice or <b>nt:</b> Wound Care <b>Department Nan</b> hospital or health	departn <b>ne</b> (If a p system)	nent should be listed unde	er Department Name. * Organization N	IPI		
Dhusiaal Address	3		* City			* State	* Zip		
Physical Address						1 January 2			
EMR/EHR Vendor	0				Practice Managemen	t System	•		
EMR/EHR Vendor	0			¢	Practice Managemen	Hawaii	×		\$
EMR/EHR Vendor None * Designated Sign	Authority			\$	Practice Managemen None * Signing Authority Tit	t System	Y		\$

- **5)** Are you registering as a current contractor or part of providing clinical services to: *(select all that apply)* 
  - □ Queen's Clinically Integrated Network (QCIPN)
  - □ Hawaii Department of Health (DOH)
  - □ Castle Health Group (CHG)
  - □ Hawaii Primary Care Association (HPCA)
- 6) Registration Type: (select all that apply)
  - □ CHR (Community Health Record)
  - □ CHR with Referrals
  - □ Direct Secure Messaging (Standalone)
  - Direct Secure Messaging (Integrated into the CHR)



### 7) Choose Participant Type

#### \*Participant Type

Please choose only one of the following options:

O Individual state-licensed provider practice - Led by a doctor of medicine (MD), doctor of osteopathy(DO), advanced practice registered nurse (APRN), etc.

- O Ambulatory Surgery Center
- Care Coordinator
- O Community Health Center
- Diagnostic and Treatment Center
   Emergency Medical Services (EMS)
- Employed Provider Practice Providers employed by hospital or health system
- Health Plan/Insurer (including self-funded plan) for treatment only
- O Home Health Agency
- OHospice
- O Hospital including critical access hospital
- Laboratory
- O Nursing Home
- O Pharmacy
- O Public Health Direct Care Provider
- ORadiology Group
- OUrgent Care Center
- Participating entities must be permitted to receive PHI for the following choices...
- $\bigcirc$  Business Associate (BA) of Healthcare Provider or Health Plan
- O Business Associate Subcontractor
- O Public Health Authority (i.e. public health agency or entity under the agency's public health authority, e.g. a registry)
- $\bigcirc$  Other Third-Party Recipient of Protected Health Information (PHI) (e.g. health data organization)

### 8) Choose affiliated hospitals and select "Create Participant"

Affiliated Hospitals	
None	÷ <b>a</b>
+ Add Hospital	
How did you hear about us?	Please Specify Physician Name:
None	\$
	Please Specify Other Source:
	Create Participant



9) Select "Add Point of Contact"



10) Enter required Point of Contact information and select "Add Point of Contact"

Add Point of Contact		×
* Contact Type		\$
* Name of Contact Mailing Address (if different from practice a	ddress)	
* Phone	Extension	
Fax		
* Email Address		
	Cancel	Add Point of Contact

11) After completing the contacts, click "Save" to advance to the organization's providers information





12) Add all practicing providers and complete all provider information.

The information allows Hawai'i HIE to verify that all Providers are licensed professionals in good standing and not excluded by CMS or the State of Hawai'i:

New Provider		×
* First Name		
* Last Name		
* Credential		
MD		\$
* Date of Birth 🖲		
01-01-1970		Ħ
* NPI		
HI License		
* Specialty		
Select Specialty		\$
* Phone		
Work Email		
Direct Address (ex. John@direct.Hawaiihie.net)	0	
* CHR Role		
Emergency Department Physician - This provi	ider has the ability to vie	w any
patient and can "access additional records" to vie - Established Provider - This provider has the ab	w confidential records.	vith
whom they have an established relationship, can a	access additional record	ls, and
can formally establish relationships with new patie	ents allowing their staff v	vithout
geory to their one partonic ordina renariality, of requi	ees wordfalling.	
	Cancel Add Pr	ovider

13) Once the providers section is completed, click "Save." This will allow you to proceed so you can add the staff members who will need access.

<b>W</b>	h eNet				A Home	L Hi, Ashley
Draft C	Submitted	Pending Review > Final	Status			
Home Participan	t Contacts Providers	Staff Confirmation				
Add in any provide	ers in your clinic that will be	needing access to the community	nealth record for clinical data infor	mation gathering, referral comp	letion, etc.	
+ Add Provider						
+ Add Provider	Name	Specialty	DOB	Npi	HI License	Role
+ Add Provider Action	Name Test, Test	Specialty Anesthesiology	DOB 01-01-1970	<b>Npi</b> 0127349878	HI License	Role
+ Add Provider Action C Save	Name Test, Test	Specialty Anesthesiology	01-01-1970	<b>Npi</b> 9127340878	HI License	Role

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14) Add all staff users by entering staff information, selecting access role, and clicking "Add Staff User".

New Staff User		×
* First Name		
* Last Name		
* Job Title		
* Date of Birth <b>1</b>		
01-01-1970		i
Work Email		
* CHR Role	the chility to course for actionts in the	
community health record and "access addit already associated with providers within the etc.	onal records" for patients that are not ir organization in order to create referra	ils,
Staff Without Query - This staff member already associated with providers within the who are not already associated with their or	can access records for patients that ar ir organization, but cannot access patie ganizations providers.	ents
	Cancel Add Staff Use	er

15) Once you have completed adding staff members, click "Save." You will proceed to the summary of all the information you have entered. Review the materials carefully.

🕁 Hean	th <i>e</i> Net				A Home	L Hi, Ashley
Draft	Submitted	Pending Review > Final	Status			
Home Participa	nt Contacts Providers	Staff Confirmation				
Add Staff Use	embers who assist you in y	rour clinic. For example, this could b	e your medical assistant, front de	sk staff for referrals, or office ma	nager.	
Insert your staff n + Add Staff Use Action	embers who assist you in y r First Name	rour clinic. For example, this could b Lest Name	e your medical assistant, front de Job Title	sk staff for referrals, or office ma DOB	inager. Email	Role
Action	rembers who assist you in y T First Name Test	Last Name	e your medical assistant, front de Job Title Medical Assistant	bos 1970-01-01	Inager. Email	Role Staff With Query
Insert your staff n + Add Staff Use Action	First Name Test	Cour clinic. For example, this could b	e your medical assistant, front de Job Title Medical Assistant	six staff for referrals, or office ma DOB 1970-01-01	nager. Email	Role Staff With Quer



16) Carefully verify all information is correct and complete. Once the information has been carefully reviewed, click 'Submit My Application"

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Dran	Jubr	inteu /	rending neview	FI	nai Otatus			
ome Participar	nt Contacts	Providers	Staff Confirma	tion				
Applica	ation S	Sumn	nary: Te	st				
	Legal Name of	Entity: Test						
	Department	Name: Test NPI: 1293	7329879					
	Physical Ac	idress: 900	Fort Street Mall					
		City: Hon	olulu					
		Zip: 9876	35					
	EMR \	fendor: Adva	anced Md					
Practice	Management S	system: Adva	anced Md					
S	Signing Authorit	y Title: Ceo	1031					
	Participan	t Type: Indiv	vidual State					
		Lice	nsed Provider					
nooualeu	noopitaio							
				lame				
			Castle M	edical Center				
- Associated	Contacts							
- Associated Contact Type	Contacts	ame of Contr	ict Mailing	Address	Phone	Ext Er	nail Adress I	Fax
- Associated Contact Type Site Administrate	Contacts N or Te	ame of Conta	ect Mailing	Address	Phone 555-55 5555	Ext Er	nail Adress I st@hhie.us	Fax
- Associated Contact Type Site Administrate	Contacts N or Te	ame of Conta	ict Mailing	Address	Phone 555-55 5555	Ext Er i5- te	nail Adress F st@hhie.us	Fax
- Associated Contact Type Site Administrate	Contacts N or Te Providers	ame of Conta	ect Mailing	Address	Phone 555-55 5555	Ext Er 55- ter	nall Adress I st@hhie.us	Fax
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- Associated A Contact Type Site Administrate - Associated I First Last Name Nam Test Test	Contacts N or Providers Cred. MD	ame of Conte 1st DOB 01-01- 1970	NPI HI Licen 1234567890 MD 123	Address Addres	Phone 555-55- 5555 Phone 555-555- 5555	Ext Er 55- ter Email	nail Adress I st@hhie.us Direct Address test@direct.han	Fax s
- Associated of Contact Type Site Administration - Associated I First Last Name Last Name Test Test	Contacts N N or R Providers N Cred. MD	ame of Conta 1951 DOB 01-01- 1970	NPI HI Lice 1234567890 MD 123	Address Addres	Phone Phone 555-555 5555 5555 5555	Email	nail Adress I st@hhie.us Direct Address test@direct.hav	Fax s walihie.ne
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17) Confirm accuracy of information provided by checking boxes, type in name and select "Submit My Application"

Confirmation			×
I attest that the in knowledge.	nformation provided on this requ	est is true to the best of my	
<ul> <li>I confirm the Use my practice users.</li> </ul>	r List is accurate and represents	the roles and access levels of	
I am aware that n responsible for their	ny staff will be trained on the <b>He</b> use of <b>Health</b> e <b>Net</b> .	alth eNet system and that I am	
please type your n	ame here for signing		
	* Please check all above conditions	and sign Dilication	1
	900 Fort Street Mall, #1305	Phone: 808-441-1346	Email: info@hawaiihie.



18) When the information has been successfully submitted, you will return to the home page.

W	elcome!	
	Participation Application	Registration
	If your practice/organization would like to utilize the Hawaii HIE's Health eNet suite of senices to securely exchange referral information with providers involved in your patients' care, and access information about your patients in our Community Health Record for treatment purposes, please fill out a Participation Agreement and submit it to the Hawaii HIE. Please click on the 'Go to Participation of the agreement'. Like Please click on the 'Go to Participation of the agreement. INPORTANT: Since the Participation Agreement is a contract, please only fill out and sign the Participation Agreement if you are a practice/organization (e.g. corporate CEO, LLC manager, or other owner).	If you have completed and submitted a Participation Agreement to the Hawaii HIE - and received confirmation from the Hawaii HIE that the Participation Agreement (and accompanying Business Associate Agreement) have been signed by the Hawaii HIE - then please click on the 'So to Registration' button below to begin the registration process. This will allow us to establish user accounts for your practice/organization to utilize the Hawaii HIE's Health eVelt suite of services. If your practice / organization is not yet a Hawaii HIE participant, please click on the 'So to Participation Agreement' button to the left begin the steps needed to become a participant.
	C Go to Participation Agreement	