

VERBATIM PROCEEDINGS

HEALTH INFORMATION TECHNOLOGY AND EXCHANGE ADVISORY  
COMMISSION

AND

DEPARTMENT OF INFORMATION TECHNOLOGY

DR. ROBERT GALVIN, COMMISSIONER

MAY 3, 2010

DEPARTMENT OF INFORMATION TECHNOLOGY  
101 EAST RIVER ROAD  
EAST HARTFORD, CONNECTICUT

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 . . .Verbatim Proceedings of a meeting of  
2 the Department of Information Technology and the Health  
3 Information and Technology Exchange Advisory Committee  
4 held on May 3, 2010 at 1:10 p.m. at the Department of  
5 Information Technology, 101 East River Road, East  
6 Hartford, Connecticut. . .

7  
8  
9  
10 COMMISSIONER ROBERT GALVIN: And we're  
11 going to turn the meeting over Frank Petrus.

12 MR. FRANK PETRUS: Well, good afternoon.  
13 Good afternoon. Before we start, let's go around and have  
14 you reintroduce yourself for the process. And also, you  
15 got this on Friday. Some of you may have had a chance to  
16 take a look at it. What I'd like to hear from those of  
17 you that have been heading up the committees, if you have  
18 had any discussions with the committees since our last  
19 meeting when we did the visioning exercise and talked  
20 about the goals, the guidelines, the imperatives. Any  
21 thoughts, impressions that you have before we start today  
22 to take a look at what we're going to share with you as  
23 our findings to date, and our sense of where some of the  
24 gaps are. And then we've also prioritized some of those

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 gaps to say to you all, here is the base that you really  
2 need to start looking at as we move forward with the  
3 strategic plan.

4 So let's quickly go around and hear from  
5 you. Do speak loudly because the folks on the phone may  
6 not be able to hear you if you don't speak really loud.  
7 And we'll go around and just introduce yourself and just  
8 some brief thoughts about what your impressions are and  
9 where we are in the process for the Health Information  
10 Exchange planning.

11 COMMISSIONER GALVIN: I'm Dr. Bob Galvin  
12 from the Department of Public Health. I am not the  
13 project manager. Lynn Townshend, who is directly across  
14 from me, is the project manager. I have a sense that  
15 we're beginning to talk about a lot of things that are  
16 very worthy of being discussed and have not been clearly  
17 elucidated. We hope we will get some legislation passed  
18 in the next 72 hours, which will establish a HIE  
19 authority in Connecticut. Failing that legislative  
20 initiative we will have to fall back on our internal  
21 resources, which are greatly depleted, and which are not  
22 particularly orientated towards informatics except in  
23 Lynn's case, who is completing a Master's degree in  
24 interactive communications.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   And with that I will ask Lynn Townshend to  
2                   give us a few words, if you will, about where you see the  
3                   process. I still --

4                   MS. LYNN TOWNSHEND: -- well --

5                   COMMISSIONER GALVIN: -- I'm sorry, I  
6                   stepped on your opening line. I still think, and I will  
7                   be glad to persuade, be persuaded that my point of view  
8                   is not correct, but I still think that two things have to  
9                   happen. One is we need to have an idea of what is this  
10                  going to look like when it's finished. You know, we  
11                  could talk about opting in, opting out, up, but I think  
12                  we have to get a clear vision about what we want this  
13                  thing to look like. I also think that if we don't come up  
14                  with very good mechanisms to get buy in from those who  
15                  practice medicine, who are licensed of all ilk, I think  
16                  if we cannot get a significant buy in on the part of  
17                  those individuals, particularly the ones -- the one  
18                  person, two person, three person practices, which is over  
19                  80 percent of Connecticut, we will fail.

20                  And I think it's -- I see this as perhaps  
21                  we should be looking at the end users as we design the  
22                  program because we design the best program in the whole  
23                  world, but if we don't get significant buy in from the  
24                  practitioners then we're really sunk. There is some

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 thoughts that have been expressed to me, and you've heard  
2 me talk about this before, the idea that a physician who  
3 has got a few years left in practice isn't going to do  
4 this. And that's not the problem. The problem is getting  
5 a guy or two people to come in and take a practice over  
6 that's not connected. And no one is going to come in, is  
7 going to come in and do that.

8 I'm also very concerned about penalties  
9 assessed to those who don't have health informatics or an  
10 EMR who treat Medicaid and Medicare patients. And I think  
11 that will encourage practices not to treat Medicaid and  
12 Medicare patients and become semi-boutique, if you will,  
13 and that will not serve the purpose of getting good  
14 quality medical care to the people we want it to get to.  
15 It will also throw that population onto those individuals  
16 who already have EMR's and they will have  
17 disproportionately large numbers of low or subpar payers.  
18 And it will have a very different, a very difficult  
19 situation.

20 So I think it's incumbent on us to sell  
21 this and find business ways and to sell it as if we were  
22 selling a cable show, or a cable service, or whatever.  
23 And you've got make it appetizing to guys like Ken  
24 Dardick, who are out in the trenches, or they won't buy

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 into it.

2 MS. TOWNSHEND: Thank you. And actually it  
3 leads very nicely into what I will just briefly say is  
4 that trust is -- has got to be part and parcel to what  
5 we're doing here, openness, trust, the trust not only of  
6 the providers, the physicians, but the customers who are  
7 the patients, who are part of this process. And we are  
8 starting that now. We started it when this Committee  
9 began. It started with the legislation that was passed  
10 last year and hopefully will be passed this year. And  
11 that we do this in an open and transparent manner, and in  
12 a secure and private manner, be the stewards of the  
13 information that we're entrusted to exchange.

14 So, by opening this process to all, by  
15 having everyone on board now, and if there are  
16 constituencies that are missing please let me know  
17 because they need to be part of the process from this  
18 point forward. The more that we get the buy in of the  
19 physicians, and the patients, the consumers at large the  
20 more likely we are to have success.

21 MR. KEVIN CARR: So I'm Kevin Carr. And  
22 you asked to give an update on the activities since the  
23 last time we chatted.

24 MR. PETRUS: Yes.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. CARR: I had the opportunity to talk  
2 to Dr. Matt Carter, who is the state epidemiologist, and  
3 get a little bit of the history of public health  
4 reporting in the state and the systems that support that.  
5 And I thought it was rarely, really interesting to hear  
6 that story because they have been challenged with funding  
7 and, you know, priorities at the state level around what  
8 money -- what money should be spent on what within the  
9 state government. And even the same story from providers  
10 and payers, right, so let me take care of my own business  
11 before I start exchanging information because I can't  
12 exchange and I can't receive, and I can't be  
13 interoperable.

14 And so I thought that that was interesting  
15 because really my biggest concern, I think here in the  
16 State of Connecticut, is that shared vision and the  
17 ability to work across both public and private parties to  
18 implement that vision. So I started hearing from him, you  
19 know, we've got very -- several systems that are in the  
20 process of being implemented. And there is a staged  
21 approach to that implementation as it currently stands.  
22 And then we have a staged approach to implementation of  
23 health information exchange on the private sector side  
24 that's currently not in line at all. And so how do we

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 really, you know, really bring those together as opposed  
2 to talking about how we bring them together. Where the  
3 stage is and the releases actually match to each other.  
4 And to be quite honest there needs to be funding for both  
5 sides that's not there.

6 MR. PETRUS: And some of the funding  
7 that's been there in that arena has been silent.

8 MR. CARR: Correct.

9 MR. PETRUS: By different registries or  
10 different initiatives. We just met with them this  
11 morning and talked about that.

12 MR. CARR: Absolutely.

13 MR. PETRUS: How this might be the  
14 leverage for public health, understanding and leveraging  
15 as necessary.

16 MR. CARR: Absolutely.

17 MR. PETRUS: Thank you.

18 MR. MIKE HUDSON: My name is Mike Hudson  
19 and my impression is we've been making progress, although  
20 the gaps that are outlined in today's document I think  
21 are fairly substantial. My background I tended to be  
22 involved in a number of the finance orientated type  
23 discussions. I think the gaps around a sustainable,  
24 financial model are considerable. They're not

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 insurmountable, but they're considerable. And then, you  
2 know, also look at the gap of having a sustainable model  
3 for people -- people meaning all the stakeholders  
4 involved -- appreciate and value what they're getting out  
5 of it and what they have to put in, whether it's in terms  
6 of participation, information, or financial performance.

7 MR. PETRUS: And they go hand in hand.

8 MR. HUDSON: Yes.

9 MR. PETRUS: Absolutely.

10 MS. MARSHA MAINS: I'm Marsha Mains from  
11 the Department of Social Services. I guess what we're  
12 looking to do is be a very collaborative partner with DPH  
13 and work with -- we are certainly going to try and  
14 provide those Medicaid incentive payments to our  
15 providers to work basically with -- to encourage those  
16 smaller providers out there to adopt HR and then work  
17 towards a meaningful use.

18 (Inaudible)

19 MR. RICK BAILEY: I'm Rick Bailey, Deputy  
20 CIO with the Department of Information Technology. And I  
21 concur with Michael. My thought was is that we are here  
22 to support the development of the infrastructure and --  
23 from DOIT's perspective we're here to support this  
24 process and at the domain team level help build the

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 architecture and define what the architecture would be to  
2 secure -- to support the secure exchange of health  
3 information, to meet some of the HIPA requirements, as  
4 well as to insure public confidence and the  
5 confidentiality of the exchange of their data, as well as  
6 the operational procedures.

7 MR. PETRUS: And I would assume that the  
8 internal state DOIT standards that would support common  
9 standards on the presentation application database so  
10 that you'd have interoperability within the state that  
11 then makes it easier for you to have interoperability  
12 within the private sector and providers.

13 MR. BAILEY: Absolutely, yes.

14 MS. MARIANNE HORN: I'm Marianne Horn with  
15 the Department of Public Health and I'm also -- I provide  
16 administrative support to the legal and policy  
17 subcommittees. And we did have a meeting last week and I  
18 had one additional comment on the -- which I forwarded on  
19 to -- (inaudible) -- most of the people around the table  
20 will know about an opportunity through ONC that will be  
21 coming out, more details in May for intrastate  
22 collaboration. So -- in terms of privacy and security  
23 that will be really important as we exchange and we  
24 realize that we're surrounded by opt in states. And our

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 initial recommendation was that perhaps we'd have an opt  
2 out with some qualifications. So -- but there will be an  
3 opportunity to work with those states and not a lot of  
4 funding, but some facilitation of meetings and certainly  
5 access to federal expertise, which will be really  
6 helpful.

7 MR. PETRUS: Thank you.

8 MR. KEN DARDICK: My name is Ken Dardick  
9 and I'm a family physician. I would say there is three  
10 immediate concerns that come to mind, three immediate  
11 impressions about the success of the -- one of them, I  
12 think, right off the top is the concern about the  
13 financial stability of it, making sure that this is  
14 something that's really going to fly. I think buy in is  
15 going to be, to some great degree, contingent upon that.  
16 If people don't feel that it's going to work they're  
17 going to be less eager to buy in. And certainly speaking  
18 as a physician, and from physicians that I've spoken  
19 with, I think that would be a concern.

20 Secondly, I think it's probably the case  
21 that we will be actually seeing more and more physicians  
22 getting EMR's. And to the extent that they do they need  
23 to be really convinced that anything that they do with  
24 their compliant EMR's in their office is going to be

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 transparent and interoperable with this system. They're  
2 not going to have to think twice about it. They're not  
3 going to have to reconfigure it. They're not going to  
4 have to pay somebody to create a new interface for it.  
5 It's simply got to be invisible to them.

6 And the third thing, which relates to some  
7 of the comments that I've heard about potential for  
8 incentives for pay, the doctors that I've spoken to just  
9 don't believe in them. They never materialize. The pay  
10 for performance incentives that are allegedly out there  
11 from the commercial market never seem to take place. The  
12 incentives under Medicare for some of the PQURI  
13 incentives and need prescribing can take a year or two to  
14 actually materialize. And people just don't believe that  
15 they're real and they're not big enough to want to  
16 believe that they're real. So, I think that there is a  
17 real sales job that needs to take place.

18 MR. PETRUS: Thank you.

19 MR. WARREN WOLLSCHLAGER: Warren  
20 Wollschlager with Health. Just quickly, my impressions,  
21 first of all, I think that Gartner has done a good job in  
22 a short period of time, digging pretty deeply into the  
23 HIE community within Connecticut. So, I'm impressed with  
24 that.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 I agree with Michael and some of the other  
2 commenter's, I think the gaps that have been identified  
3 are very wide and very deep. And my final impression is  
4 that the work load of the members of this Advisory  
5 Committee is and is beginning to and will continue to  
6 increase and accelerate as we go through this strategic  
7 planning process. And I want to thank you already for the  
8 work you're already contributing, the time and expertise  
9 that you've given to this process. And I think that's  
10 only going to increase in the short term. And so I thank  
11 you in advance for all of your help.

12 MR. PETRUS: You're actually right. There  
13 is a lot to be done. Thank you.

14 MS. BARBARA PARKS WOLF: Barbara Parks  
15 Wolf, the Office of Policy and Management. It's  
16 reiterating a lot of what people have said, but it seems  
17 to me that the three big challenges here are getting buy  
18 in from consumers on why to use it, security, privacy,  
19 and having providers be confident to buy in to this,  
20 selling it. And sort of fundamental to both of this is  
21 the sustainability issue. And it seems to me that we're  
22 just on the cusp of defining the major pieces of what  
23 we're doing.

24 MR. PETRUS: Thank you.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETER COURTWAY: Peter Courtway, I'm a  
2 CIO and representing the hospitals and health information  
3 exchanges in the state. And I also am pleased, very much,  
4 with the work so far from Gartner in terms of helping to  
5 identify the gaps. I think it helps frame a lot of the  
6 work that needs to be done. I would think, from my  
7 constituents, the -- one of the main challenges that we  
8 have is to integrate the hospital's vision into the state  
9 and the health information exchange where the hospitals,  
10 you know, see the health care as local and central to the  
11 local delivery of care and what their role is in the  
12 broader health information exchange as well as  
13 understanding early on, or as early as possible, where  
14 investments are likely to be needed from a hospital  
15 perspective in their region versus those investments that  
16 they can rely on that may be part of the state, you know,  
17 initiative that -- so it's more of a question for those  
18 that are accelerating -- and there are quite a number of  
19 hospitals that are very -- pushing very hard to get local  
20 connectivity. Some rationalization for the constituents  
21 to say here is where it's probably safe to invest, here  
22 is where your invest might overlap. And also discussions  
23 within the hospitals at the -- that has been facilitated  
24 by the Connecticut Hospital Association and John Lynch is

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 to make sure that we're not overlapping our investments  
2 either. Just to make sure that the precious dollars that  
3 we actually have at the -- at a local level are put to  
4 the best use.

5 COMMISSIONER GALVIN: And let me add on to  
6 you, excuse me, Frank, onto Peter's statement that -- and  
7 several others around the table is, you know, we're at a  
8 relatively early stage in this business and we're looking  
9 for venture capital or to be appropriately capitalized.  
10 And I detect a -- some feelings that somehow these  
11 aliquots of cash and money are going to be injected very  
12 frequently by the federal government. And I don't think  
13 that's the case. I think that we'll -- when some of the  
14 grants -- if everybody gets a grant we'll get a grant, a  
15 proportional grant. Maybe we'll beat out some other  
16 people for them. But we really have to look for can we  
17 create a financially stable structure until sometime in  
18 the future where it starts to accrue users that pay for  
19 it. And the hospitals are the ones who have the money,  
20 the bigger hospitals now, but I think there is another  
21 feeling, well, they'll kind of pay for a lot of it. But  
22 this is going to require a fairly considerable investment  
23 on the part of the state government.

24 MR. PETRUS: Thank you. Those of you on

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 the phone. Mark?

2 MR. MARK MASSELLI: Hi. Mark Masselli,  
3 Federally Qualified Health Centers, can you hear me?

4 MR. PETRUS: Yes, we can.

5 MR. MASSELLI: Okay, great. So, you know,  
6 I like where we are. When I listen to people around the  
7 room clearly there has been -- I think we've got the  
8 right constituent's values. People are talking about  
9 making sure that the process is open. So just in terms of  
10 our position, continue to have that openness. Realizing  
11 that, you know, there will be new people who come in all  
12 the time and that somehow we have to be open to their  
13 ideas. We have to figure out the representative part as  
14 well.

15 There is sort of a sense of a shared value  
16 around, a shared vision around value that people are  
17 going to need to get something out of this process.  
18 There is sort of the pragmatism of that financing is  
19 going to be a critical element in the long run. We may  
20 get some upfront money, but we know that to sustain this  
21 at a level that will be acceptable to everyone will  
22 require us to think about that.

23 And then the issues around confidentiality  
24 of data for both the patient and for the provider making

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 sure that there is a real sense of integrity. You know,  
2 the -- just sort of thinking about, I forget which one of  
3 the providers mentioned it, the -- that there is a focus  
4 now on a lot of smaller providers about, you know,  
5 staying within their own knitting. I am, on paper, I need  
6 to go to electronic health record. We're thinking down  
7 the road on that. And I wonder if it isn't appropriate  
8 for us to reach out to the business community of vendors  
9 because providers like that will turn to a vendor and  
10 say, will my system work or what do you think about that.  
11 So I think we probably need to make sure that we're  
12 encouraging that community of people who are filling the  
13 product and that we're not picking anyone, but all of  
14 them to make sure that they're on the same page with us  
15 around this sort of imitative that we have.

16 And then hopefully the bottom line on this  
17 is sort of the reality that nothing goes well. New  
18 initiatives always take a continued focus that hopefully  
19 there is a sense of realism about the things that we can  
20 do and we can't do. But I think we're well positioned in  
21 such a short time.

22 MR. PETRUS: Thank you. Nancy?

23 MS. NANCY KIM: I share everybody's  
24 concern about the implementation of the vision as well as

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 establishing the vision. And I think we just need to  
2 recognize that although this is the first step, it's the  
3 first step in a long series of steps and that whatever we  
4 create should be nimble and flexible. And we should  
5 remember that we need to build upon this and it will grow  
6 over time. So the buy in has to be continual and we also  
7 have to understand that our priorities may change over  
8 time. So the immediate goal of implementing this in 2010  
9 to 2012 may not be the goal until 2015 to 2020 especially  
10 from a research perspective. As faculty I wanted to make  
11 sure that this is something that we can use not only for  
12 patient care, but we could maximize also for research  
13 purposes to improve health care for our residents.

14 MR. PETRUS: Thank you. Very good points,  
15 the last two points around the concepts of implementation  
16 and realistic implementation and sequencing because we're  
17 not going to have it all at once.

18 MR. THOMAS AGRESTA: Good afternoon.

19 MR. PETRUS: We're just getting some  
20 initial impressions from whatever chance you've had to  
21 review the gap analysis that was sent our or where we are  
22 with the process, or what's come from your committee. So  
23 an impression of where you think we are right now with  
24 regard to this initiative.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. AGRESTA: You know, my impression  
2 about the overall initiative is that, I think, we're  
3 still really doing a lot of learning, and beginning to  
4 understand the questions that we need to answer as a  
5 group and how complex those questions are. And I don't  
6 think that, you know, we should underestimate how complex  
7 some of the questions are and how perhaps not complex  
8 some of the other questions are.

9 And I feel like there is just a -- there  
10 is an awful lot of education that needs to still happen.  
11 And I think what Nancy was mentioning, sort of the  
12 staging of implementation, my concern is that the staging  
13 of education needs to occur even before you implement.  
14 And I think that there is still a long way to go with  
15 regards to that.

16 MR. PETRUS: It is complex in this whole  
17 process of, right now you're somewhere between being  
18 aware of everything that needs to be done and where  
19 you're going, and understanding it.

20 MR. AGRESTA: Right.

21 MR. PETRUS: To get to participating and  
22 actually coming up with a road map there is a lot more  
23 awareness and understanding that needs to happen. I  
24 think is a really good point. Anything else?

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 I'm going to give you a little preview of  
2 some of our findings because I'm glad that you observed  
3 them. It makes everybody's job easier. The Commissioner  
4 identified one of our findings is what's it going to look  
5 like. If there is a profound gap, and we'll get to how  
6 we got to that finding, if there is a profound gap it's  
7 really what is envisioned outside of the principles and  
8 the mission, and the goals, and the imperatives, and the  
9 guidelines, and all that wonderful stuff, but really what  
10 is envisioned for the health information exchange for  
11 Connecticut. And we'll go through some models that are  
12 out there that are options for you. And what's going to  
13 be the best fit here.

14 Another piece that we feel is a major  
15 piece that you folks identified was the concept of  
16 financial sustainability because you're going to be  
17 facing extremely soon the beginning of the phase out of  
18 ONC funding. And it's going to keep stepping down. And  
19 then you have to take a look at how you best phase in.  
20 And some ideas were brought forward in an earlier meeting  
21 that we'll talk about today about maybe there is a core  
22 piece that gets financed one way and there is other  
23 pieces that get financed in other ways. Those two, what  
24 is the scope and focus of your HIE. Part of that scope

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 and focus is also the idea of implementation, and  
2 staging, and nimbleness, and agility, and flexibility  
3 because it's going to evolve because the, as you know,  
4 the feds are still evolving some of their rules and what  
5 they want.

6 And the third thing that we identified was  
7 really the hole idea of participation, and  
8 confidentiality, and consumer rights and consumer's buy  
9 in. Those are the three -- I'm giving you the final act  
10 of the play -- is what we came out as if we're going to  
11 address some gaps immediately to move this down to  
12 identify the other gaps as we go through this  
13 presentation I want you to keep in mind, as the decision  
14 makers, as the leaders, as the representative  
15 participatory process here in Connecticut what's it going  
16 to look like, what's going to be the scope, what's going  
17 to be the sustainability. And how do you talk about  
18 consumer participation and rights, the opt in, the opt  
19 out, the confidentiality, securities, some of which is  
20 -- are recommended by the legal and policy committee  
21 about maybe staging that as well.

22 So that's the kind of thing, if you go to  
23 the agenda, to keep in mind as we go forward. I think  
24 your initial impressions is very consistent with the data

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 mining that we have done and the findings that we're  
2 bringing.

3 So, a little introduction about we're  
4 about. I'm going to spend a lot of time on reviewing the  
5 vision objectives. There are take away that we will need  
6 some feedback from you because they're going to be the  
7 preamble to your strategic plan and guide your  
8 operational plan. But today, we really want to take a  
9 look at the current state findings, the gaps, and begin  
10 talking a little bit about some alternatives, test them  
11 out in the short time that we have.

12 MR. ALISTAIR McKINNON: The strategic  
13 vision, the objectives, the principles, and the  
14 imperatives are in this document have been changed based  
15 on the feedback we've got so far. So if you think you've  
16 given me feedback and you can't see it in here, please,  
17 tell me. If you've got more feedback, then, yes, we can  
18 -- so just so you know this is the latest version  
19 including --

20 MR. PETRUS: -- good point, good point.  
21 Okay. Let's move on.

22 Background and objectives, they haven't  
23 changed. Next, basically we're in the week six to eight,  
24 the analysis of the gap for the strategic plan. And I

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 want to talk a little bit about the strategic plan and  
2 the operational plan and where we are in that process.

3 The strategic plan is basically going to  
4 say to ONC here is what we want to do. Here is our  
5 mission. Here is our vision. Here is what we see out  
6 there at different milestones in the life of this process  
7 of what Connecticut is going to do for health information  
8 exchange. That's what we're working on now is the  
9 strategic plan focus.

10 Once we're able to get that, and we can  
11 start parallel working on the operational piece, but the  
12 operational piece is no longer the what we're going to  
13 do, but how we're going to do it. Step one, step two,  
14 step three in each of those domains around governance,  
15 business and technical operation, financing, legal and  
16 policy, and the steps that are necessary to get there.  
17 And, yes, they go hand in glove, but right now we're at  
18 the point of really sculpting what is it you want to do.  
19 How do you want to govern this? How do you want to  
20 finance it? How are you going to operate it? What's the  
21 technical architecture going to look like? And what's the  
22 legal and policy harmonization you're going to do to  
23 insure consumer rights, privacy, security, and the rights  
24 of the patient receiving services regarding the HIE.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   What is that you want to do? That's what  
2 we're focusing on and those are the gaps that we've  
3 identified that we need more from you because this is not  
4 Gartner's plan. And it's not Warren's plan. And it's not  
5 Commissioner Galvin's plan. It's the State of Connecticut  
6 plan. What does the State of Connecticut, represented by  
7 you, want to do with regard to an HIE?

8                   Next, that's the structure. Next, right  
9 now we're at No. 2 in this layer cake. We have done a lot  
10 of reviewing of documents, hundreds and maybe thousands  
11 of pages. I haven't actually counted them, but  
12 Connecticut is really great -- how many pages have we  
13 reviewed? Any idea? We've done a lot of interviews.  
14 And the question has been raised recently should we do  
15 more interviews. I think we really have to talk about  
16 the purpose of all of that because the other side of this  
17 is that once you start locking down the strategic plan  
18 there is another bite at the apple for public comment,  
19 and for many people to have input. And the question is  
20 do we need more input right now or will we need more  
21 input as you start fleshing this out because we have a  
22 lot of ambiguity to deal with and if keep putting  
23 information onto a blank sheet of paper it might make our  
24 job more complex and difficult to get a focus for you.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   So, we are at No. 3. We've done the  
2 domains at our last workshop and we talked about, in our  
3 last workshop, to get input from you regarding the vision  
4 and the goals and imperatives for each of the domains.  
5 And we've done the understanding of the capabilities,  
6 strengths and initiatives. We've done a landscape  
7 analysis. And here we're to talk about the gaps between  
8 your direction for the five domains and your current  
9 capabilities.

10                   Today's workshop, there is three things  
11 that we want to get from you today in the time that we  
12 have together and also that you can give to us after  
13 today. This is not your last opportunity to have input  
14 on this. As we did before, we would -- this is a take  
15 away for you. What you didn't get to say today or  
16 something that you start thinking about when you're  
17 working with your committees you get back to us. We want  
18 to have the level, as we talked about, your awareness and  
19 understanding of what our findings are and either  
20 validation or challenge those findings that we got  
21 something wrong. That could be possible and if we did  
22 it's Alistair's fault.

23                   We want to review the gap assessment. We  
24 did an assessment and we created a very simple -- because

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 we're working in the health care we did a thermometer.  
2 We probably could have done blood pressure, but we  
3 decided we'd do a thermometer -- of where we think you  
4 are from a very deep gap, a mid sized gap, or you're  
5 really almost there. We tried to keep it simple. It's  
6 our subjective assessment based upon what we heard from  
7 you and what we reviewed. We want you to validate or  
8 challenge, either raising or lowering what you think that  
9 gap might be.

10 And lastly, we want to start today,  
11 because we don't get a lot of time together with you, to  
12 start looking at some of the alternatives that we  
13 identified that we think are in the universe of  
14 possibilities for you. As well as we provided, in this  
15 presentation, what we've seen from other states. And  
16 we've even expanded on a couple other states, as you can  
17 see, and the appendix for you to take a look at that we  
18 think might have some validity for you.

19 No. 1 really goes back to what will you  
20 want at the end of the day with regard to the health  
21 information exchange. How well positioned are you to get  
22 there once you're able to define it? And, as I said,  
23 validate, modify, or challenge.

24 Any questions or thoughts about the focus

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 for today's workshop? Okay, let's go.

2 Next, here is what we did in the  
3 resculpturing of a vision statement. And it's important  
4 if we don't lock this down today that you get this back  
5 because it's the first paragraph in your strategic plan.

6 This is your business face. This is what you're saying  
7 to ONC, here is what we want to do. What we heard from  
8 the last semi-workshop that we had together with you, you  
9 had two options. One option was that you could have a  
10 push/pull gateway to share information. Nothing resides.  
11 You're basically providing a utility, a vehicle for the  
12 exchange of health information.

13 We heard that Connecticut wants to  
14 transform its health care system through HIE. That the  
15 HIE will improve in four vital areas, patient access,  
16 continuity and coordination of care, quality and outcome  
17 of care, improved patient experience, and the  
18 effectiveness and efficiency of health care delivery. We  
19 then took that and translated into a vision statement,  
20 which said the vision for Connecticut's health  
21 information exchange is to provide an immediate and  
22 direct link, immediate and direct link between patients  
23 and the patient's entire health record and their  
24 attending providers at the point of care through enabling

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 information exchange across the network, supporting  
2 patients and providers including to improve the  
3 continuity, efficiency, quality, and outcome of health  
4 care in Connecticut.

5 Does that resonate with what we heard from  
6 you a couple of weeks ago?

7 COMMISSIONER GALVIN: This is the time to  
8 speak up, folks.

9 MR. PETRUS: Just a general direction and  
10 if you want to wordsmith do let us know.

11 MR. DANIEL CARMODY: Didn't we talk about  
12 it being a staged approach? I'm not sure if we want to  
13 put that in here, but it wasn't -- when I hear immediate,  
14 direct link, patient's entire health care record I'm  
15 thinking we just, you know, shut the shock -- I do want  
16 to get there, but --

17 MR. PETRUS: -- a vision is the future,  
18 where you want to go in the future. The mechanism might  
19 be a staged approach.

20 MR. MCKINNON: And we do -- there are only  
21 four principles and one of those principles was phased  
22 implementation. So it's quite visible and quite high up  
23 in the --

24 MR. CARMODY: -- so once we get to the

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 objective piece.

2 MR. PETRUS: Yes.

3 MR. CARMODY: We ground ourselves into a  
4 little bit more reality.

5 MR. PETRUS: No, this is Mom, apple pie,  
6 but it is very important because you're saying that  
7 Connecticut is not looking like Arizona did just a  
8 push/pull system.

9 Next.

10 COMMISSIONER GALVIN: Peter, you look like  
11 you had something to say.

12 MR. COURTWAY: It sure is a mouthful. I'm  
13 not sure how I'm going to remember that in the elevator,  
14 you know, for my elevator speech. So in terms of the  
15 vision, at some point, in reality simply characteristics  
16 and vision, but it would be helpful to have it just a  
17 little bit shorter.

18 MR. PETRUS: A catch phrase, send us your  
19 ideas.

20 MR. CARR: The only other thing that I see  
21 that's missing from there, and it brings us back to the  
22 sustainability is the link to health care reform, you  
23 know, either in the top or in the vision. You know, the  
24 concepts of shared risk or shared accountability for

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 patient care, etcetera, somewhere, I think needs to be  
2 there.

3 MR. PETRUS: Good thought. Maybe that's  
4 really what you mean by transform.

5 MR. CARR: Right.

6 MR. PETRUS: And you spell that out more  
7 somewhere.

8 MR. AGRESTA: If we're going to transform  
9 health care one of the ways we have to do it is enable --  
10 making connections to occur not just between --

11 MR. PETRUS: -- a little louder so they  
12 can hear on the phone.

13 MR. AGRESTA: If we're going to transform  
14 health care it's got to be, not just between a physician  
15 and patient it's got to be between all the people the  
16 patient wants to get engaged in their health care  
17 transformation.

18 MR. PETRUS: So you would like the health  
19 information exchange to allow relatives to access the  
20 records of relatives.

21 MR. AGRESTA: Well, if the patient permits  
22 access to their personal health record it might be  
23 possible to do that through that. It may or may not, but  
24 that's at least something to put on the table.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MS. HORN: I just want to make sure that  
2 we have the public health, improving the public health in  
3 this section here.

4 MR. PETRUS: Okay.

5 MS. HORN: That was something we were  
6 hoping for.

7 MR. PETRUS: See now it's getting longer.

8 MS. HORN: I know.

9 MR. AGRESTA: With the vision you might be  
10 able to get -- the statement might be able to get  
11 shorter. The process might be --

12 MS. TOWNSHEND: -- and I know this is for  
13 the network that the REO is setting up or the exchange  
14 that we're setting up. Do we want to also include  
15 anything interstate? Would we want these records to be  
16 available interstate because that is something that ONC  
17 is looking for us to do.

18 MR. PETRUS: If it's not here, it should  
19 be in the objectives and principles, that's for sure.

20 MR. DARDICK: And not to be guilty of --  
21 but it's got to among, not between, because --

22 MR. PETRUS: -- good catch, very good  
23 catch. Let's move on to --

24 COMMISSIONER GALVIN: -- are we all happy

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 with this because this is sort of the beginning.

2 MR. DARDICK: Again, let me just add, has  
3 this acronym, CHIENETS is that established?

4 MS. TOWNSHEND: No. That's just a stop  
5 gap for the moment.

6 MR. DARDICK: Okay.

7 COMMISSIONER GALVIN: But that's a good  
8 question.

9 MS. TOWNSHEND: Absolutely.

10 MR. DARDICK: They take on a life of their  
11 own.

12 MS. TOWNSHEND: We're waiting for the  
13 legislation to come through so we may have an acronym or  
14 a shorter name at that point.

15 MR. PETRUS: Exactly. It's just a -- it's  
16 a placeholder so we don't have to continue to spell out  
17 Connecticut Health Information Exchange Network.

18 The next slide, just some of the goals  
19 that we heard, -- the optimal use of health information  
20 around the continuity both public and private, improved  
21 access to the quality of health care services for  
22 underserved populations. I spoke to that earlier. I  
23 think that is going to be critical as we move to the  
24 Medicaid incentive, Medicare incentive, and then

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 sanctions. Empower consumers and active participation  
2 goes to your point, getting the family, the relative,  
3 other designated care givers involved. Compliant with  
4 all applicable privacy and confidentiality statutes,  
5 current and future so that this is agile, nimble,  
6 flexible, and move forward with current and future  
7 public, private, pharmacy, clinics, etcetera. And as  
8 hospitals are thinking of their investment it has to be  
9 part of the mix of where the future is going to be there  
10 for them as well.

11 Improved public health services was  
12 identified as an important imperative. Also encourage the  
13 adoption of health information technology, which is very  
14 critical for Medicaid and the Medicaid incentive program  
15 for providers, and meaningful use requirements. Provide a  
16 gateway for information across regions, across states  
17 into the national health information network. And to  
18 facilitate public reporting of patient outcomes and  
19 quality measures both in public and private. That really  
20 does hit and support the improvement of health care in  
21 Connecticut.

22 Any thoughts on this is what we heard from  
23 you on these goals? Does that cover the universe? Again,  
24 when we draft the strategic -- obviously, we'll take

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 comments from you after today and when we draft the  
2 strategic plan you'll have opportunity for comment then  
3 as well. We're going to do a workshop around that. But  
4 anything else, any blatant red flags, anything missing?  
5 Because this is what we used to start looking at the  
6 gaps. Okay.

7 MR. COURTWAY: One question I had, I see  
8 here we want a gateway for sharing across the national  
9 level, but there is nothing in here that describes the  
10 role of the HIE in regard to local, regional networks.

11 MR. PETRUS: Yes, we have to get there.  
12 And it's not here because we don't know. Going back to  
13 this with what Dr. Galvin talked about. You have options  
14 on how that's going to happen. Are you going to have a  
15 centralized model? Are you going to have a decentralized  
16 model? How are you going to -- we don't know. So that's  
17 yet -- we know that you want these objectives -- go to  
18 the previous slide.

19 Patient centric, you could have patient  
20 centric care through a distributed system that the HIE  
21 helps tie together or you could have patient centric care  
22 through a centralized system, or you could have patient  
23 centric care where the REO's do X, Y, and Z and the state  
24 centralized do A, B, C pieces of it and then they tie

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 together. But we haven't heard enough from you to  
2 understand how you're going to fill that gap. It's a  
3 good point though. I'm glad you saw that we omitted it.

4 Planning principles.

5 MR. CARMODY: Again, I don't see anything  
6 relative to health plans and the goals as far as by  
7 directional exchange of information. I mean I know -- I  
8 know my organization. I know Aetna has both moved into  
9 sort of a health services model where we're looking to  
10 engage the medical community as they talk about kind of  
11 peer organizations. There is a lot of programs that they  
12 are providing. And that only can be enabled through a  
13 bidirectional exchange of information. I'm not so sure I  
14 see that sort of filtering through here.

15 MR. PETRUS: Okay, good.

16 MR. MCKINNON: I thought we had  
17 incorporated it in the vision.

18 MR. PETRUS: Go back to the vision.

19 MR. CARMODY: That vision statement is  
20 long enough at this point, so if nothing else there  
21 actually is a side of me that says I think that it could  
22 be shortened to make it the elevator speech. I think it  
23 actually is quite lengthy. But not putting it in there  
24 is fine. I just want to --

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: -- what about Goal No. 2? I  
2 mean if we added something about the use of bidirectional  
3 --

4 MR. CARMODY: -- again, in here there is  
5 providers and so, again, part of it might just be the  
6 vernacular. I mean -- again, a health plan isn't  
7 necessarily provider --

8 MR. PETRUS: -- I got you.

9 MR. CARMODY: The intent is not to get in  
10 between patient/provider, it's to enable that ecosystem.

11 MR. PETRUS: Yes, we got it. Good point.  
12 The next slide, we're up to principles, planning  
13 principles, any feedback from what you said earlier,  
14 consumer confidence? And Lynn talked about the  
15 transparent, participatory. Foundation, foundational and  
16 sustainable infrastructure, and, again, we're talking  
17 about something that will be agile, nimble, and an  
18 interoperable platform and direction.

19 Phased implementation, you said it  
20 earlier, we heard that loud and clear that this can't be  
21 a big bang approach. What do you do first? What do you  
22 do second? What do you do third? And, some of you have  
23 already identified in your working committees some  
24 concept of how to phase this in.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 Inclusive and transparent governance and  
2 approach is also we heard and, again, we're going back to  
3 what Lynn said earlier today. Representative, qualified  
4 stable leadership, governance structure on two levels,  
5 the governor structure of the overall direction and  
6 vision for this and the governor structure for whatever  
7 the Connecticut health information exchange is going to  
8 be as a utility, as an operating entity. That it is a  
9 transparent and inclusive process.

10 MR. VARNEY: Just a couple of items, on  
11 the consumer confidence, I think it's important, although  
12 this one -- it doesn't talk to the fact of resiliency or  
13 the liability or the availability of data. Not only does  
14 it have to be secure --

15 MR. PETRUS: -- performance issues.

16 MR. VARNEY: But if it's not available  
17 that's going to run into issues based on some of the  
18 goals -- so I think it'd be important to talk about  
19 resiliency, reliability, availability in that first  
20 principle.

21 And then in the second principle, you even  
22 said it when you described it in the word interoperable  
23 is not in there. And even to the point where we may want  
24 to say that it's standards based interoperable.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: Yes. National standards  
2 based, yes, yes.

3 Let's move on to the domains. You've seen  
4 these before. These are the questions that we use to  
5 guide our assessment. The next one, please. These are  
6 the governances of the domains, the strategic business  
7 imperatives. Go on and let's go to the rating slide.

8 We're now going to go through each one of  
9 the domains back to the imperatives that were set by ONC,  
10 the input that we got from you regarding those  
11 imperatives for Connecticut. And we basically gave them a  
12 three level rating. Target temperature meaning basically  
13 there is minimum gap. You're close to there on what it is  
14 you want to do. Not necessarily the how, remember we're  
15 working now on the strategic plan, what it is you  
16 envision, what it is you want to do, not how you're going  
17 to get there, which in some respects would be the easiest  
18 thing to write what we know where it is you want to go.

19 The second is mid point. There is some  
20 moderate gaps. There is some lifting that needs to be  
21 done. And the third one is there is some significant  
22 gaps and sometimes the gap is ambiguity, or lack of  
23 clarity, or multiple perceptions that need to be  
24 harmonized, that need to come together on what it is that

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 you want for Connecticut. I also want to put a caveat  
2 that these are our subjective assessments based upon our  
3 interviews, based upon what we reviewed in your  
4 documents, based upon the strategic plan that was  
5 published in June of 2009. So there is a lot of input  
6 that we looked and walked away saying, you're at the  
7 target. You're at mid point or you're low. Any questions  
8 about what we're using as an assessment? Trying to keep  
9 it simple.

10 Let's take a look at the governance  
11 domain. The governance domain and this full group is the  
12 group that is responsible for the governance domain for  
13 the Connecticut health information exchange. And you  
14 really have two directions or two points that you're  
15 looking at, maybe points are better than direction.  
16 You're looking at the overall vision, which we just went  
17 through, goals and principles. And you're also looking  
18 at how you insure that the entity that will be  
19 responsible for the management of the utility,  
20 responsible for the availability of the utility, they  
21 will govern the HIE. So you've got two levels of  
22 governance that we're looking at.

23 Strengths, the strengths that we saw is  
24 you have a strong advisory committee that from our

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 experience is fairly representative. And you keep  
2 reaching out to others in your working committees. E-  
3 Health Connecticut provides a vehicle for important  
4 stakeholders participating in this and the collaboration  
5 that's been going on there. There is enthusiasm around  
6 the association, the hospital associations, the medical  
7 society, the working groups that we've talked with, some  
8 of the interviews that we've conducted, some of the  
9 initiatives that the hospitals are already undertaking,  
10 some of the software that's already out there in these  
11 institutions, there seems to be a lot of stuff that's  
12 motivating people to want this to happen to make this  
13 real.

14 The 2009 HIT strategic plan -- I mean  
15 hospital survey that came out and the Danbury health link  
16 really provides a good foundation of the kind of vision  
17 that's been developed and the direction that's been  
18 developed in Connecticut. You're not starting with a  
19 blank sheet of paper. The June 2009 HIT strategic plan  
20 we were very impressed with that plan. It was developed  
21 prior to the ONC guidelines, but we think there was a lot  
22 of work that went into that and the back up that went  
23 into that was extremely helpful. The Lieutenant  
24 Governor's participation in our last meeting, for

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 example, that you have executive leadership support,  
2 maybe soon legislation, in 72 hours, you say.

3 COMMISSIONER GALVIN: We hope.

4 MR. PETRUS: Coordination with Medicaid  
5 and public health have been very forthcoming in working  
6 together. And the certification template developed in the  
7 strategic plan -- so there is a lot of strengths out  
8 there that we think that will support the governance,  
9 the direction, and the vision and how I think we were  
10 able to get the kick start on some of those principles,  
11 objectives, goals, and vision.

12 Any disagreement with the strengths? Any  
13 strength we missed? Any thoughts about these strengths?  
14 Maybe they are liabilities and not strengths.

15 MR. AGRESTA: There is always both sides.

16 MR. PETRUS: I guess they're also our  
17 weaknesses. What is your opinion of how some of these  
18 strengths could be a challenge?

19 MR. AGRESTA: Well, there is lots of  
20 people with -- that have started down the paths that are  
21 parallel and not necessarily connected to each other. And  
22 I think that's a particularly challenging  
23 strength/weakness.

24 MR. PETRUS: I think so. And what we had

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 observed is a lot of stuff has happened prior to the ONC  
2 guidelines, prior to the Medicaid, statewide Medicaid  
3 health information planning requirements, prior to  
4 meaningful use -- being finalized, which they still  
5 haven't been finalized. There is a lot of stuff that has  
6 happened here in Connecticut and now you need to  
7 harmonize it to get back to what will it look like. And  
8 quite frankly, from my experience it's not going to look  
9 like any one of those individual things you already have  
10 out there. And your challenge is how do you bring that  
11 together in a meaningful way to achieve that vision.

12 Let's take a look at the challenges. Some  
13 of the challenges are political. You've got  
14 administrative changes that are going to be coming up in  
15 the near future. And you have a strong reliance on Bill  
16 403 and you're going to have to come up with a Plan B if  
17 that doesn't happen. The whole initiative that has  
18 happened with the Health Connecticut and other pre-  
19 existing HIE's, and what's going in the public health  
20 department with their initiatives to do -- to move away  
21 from silo centricity and the initiative within DSS for  
22 the state Medicaid health information technology plan.  
23 All of those things are moving down the line. And there  
24 are strong thoughts among each of those stakeholders and

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 each of those planners of where they want to go, and how  
2 do you harmonize those.

3 The governance, I think that the overall  
4 governance that you have in place for the vision and the  
5 principles is pretty solid stuff you've got. But what  
6 about the operational -- how do you want, what do you  
7 want, not how. What do you want as a structure for  
8 managing the HIE utility, whatever it's going to be.  
9 That's different than what you're doing.

10 Any additional challenges or challenges to  
11 our challenges?

12 COMMISSIONER GALVIN: This is a good time  
13 for people to speak up if you have ideas about what this  
14 central authority should look like because it's -- as  
15 Frank says there is several different ways you can look  
16 at this. And you've got to start thinking about do you  
17 want have a very strong executive director and an  
18 executive committee called from or drawn from the board  
19 of directors who make decisions about this. You know,  
20 this -- once this is operational you can't just say,  
21 well, we'll meet once a month and talk about stuff. That  
22 ain't going to work. And you're going to need a core of  
23 people from -- and you're going to need a very good  
24 director. And you're going to need a very good computer

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 architect. And it might be the same, might be the same  
2 person, I'm not sure.

3 But we really need your thoughts about --  
4 I'm going to repeat myself, this is just not going to  
5 work if you have an executive director and somebody --  
6 and two or three people in an office and have the board  
7 meet once a month. It's not going to -- it's not going to  
8 satisfy things. You won't hear Ken Dardick's voice about  
9 what's happening out where medicine is practiced. You're  
10 not going to hear Peter's voice about what's the Danbury  
11 model is doing. It's going to be -- you're going to end  
12 up with a small core of people trying to run the thing. I  
13 don't think that's a particularly good way to do it, but  
14 maybe you guys have different ways of thinking about it.

15 MR. PETRUS: Yes, if this is the gap  
16 discussion, we actually think that from the governance  
17 perspective because of how strong this has been put in  
18 place, and the hope of the legislation passing, that  
19 you're really at a mid point. You have some gaps, but we  
20 want to see them in the critical path. I think what we  
21 see as a gap is really the scope of governance, as you  
22 were getting to the broader governance and then the day  
23 to day operation, and how will stakeholders, going  
24 forward with this initiative, influence this idea of

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 transparency and participation.

2           And there is two other pieces that are  
3 really important. One is the reporting. Under the ONC  
4 requirements is all the reporting the you're going to  
5 have to do on metrics and measures to demonstrate the  
6 return on investment of the health information exchange.  
7 And all the ARRA reporting that's going to be required  
8 because of the stimulus money that's going into it, and  
9 the communications that are always going to be in the  
10 education of the community and participation with the  
11 regional extension center.

12           These are less challenging gaps than some  
13 of the other domains that we've seen. This is what we  
14 see as the gaps. Discussion about this?

15           COMMISSIONER GALVIN: Kevin.

16           MR. CARR: Yes, so getting back to your  
17 point, I think outside of that executive oversight and  
18 executive director there is also the fiduciary  
19 responsibility of the health information exchange. It  
20 often gets left out of the governance discussion. And  
21 being able to insure that a 100 percent of hospitals or a  
22 100 percent of providers are participating in a robust  
23 health information exchange, and linking that to the  
24 financial model.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: Yes.

2 MR. CARR: I think it's going to be  
3 critical in this particular domain.

4 MR. PETRUS: Good. Other thoughts about  
5 the gaps? Let's move on to finance.

6 This is all about one word, two words,  
7 sustainability. You've got seed money and not a whole lot  
8 of it from ONC. You've got seed money that's fading out.  
9 No. 1 is how do you finance this moving forward. How do  
10 you make sure that it's available? That it's fulfilling  
11 its service levels? That it's demonstrating return on  
12 investment? That there is a buy in capability here,  
13 there is a value proposition. When we look at the  
14 finance section next we see some strengths. We see that  
15 there has been some identification by the legal policy  
16 committee regarding a staging approach to financing that  
17 we were pretty impressed with. We haven't quite seen  
18 that in other initiatives that we've worked on.

19 And I'm not saying this is a rule that's  
20 coming from the work that you've all done, but this is  
21 something that we see as a strength because there is  
22 people that are supporting you in this initiative that  
23 I've identified that maybe there is two stage, a base  
24 funding for limited functionality that provides the

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 platform. And then transactional funding that continues  
2 to build the infrastructure as you add transactions to  
3 the health information exchange environment. We thought  
4 that was a strength that there was that kind of concept  
5 being floated in Connecticut.

6 There is no funding restrictions in the  
7 legislation so there is no barriers. The hospital  
8 systems, the health systems are encouraging in their  
9 direction. There is a Medicaid transformation grant out  
10 there to pilot something that could really provide a  
11 model. I'm not saying it would be the HIE, but it's  
12 saying can we get people together to share information  
13 around a common population, Medicaid providers and  
14 Medicaid patients. And the ONC cooperative agreement  
15 you've got the award and you've moving forward. We see  
16 those as strengths.

17 Other strengths that we may not have  
18 identified? Warren?

19 MR. WOLLSCHLAGER: (Inaudible)

20 MR. PETRUS: Yes, a good point. And there  
21 is some more 2013 dollars that may be leverable by public  
22 health around the integration of registries. And I know  
23 other states are doing that right now. So, looking at  
24 other potential funds especially for the infrastructure

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 pieces.

2 MR. COURTWAY: Frank, I think another  
3 strength is that there has already been a significant  
4 investment at the local level that could be co-opted.

5 MR. PETRUS: There are investments that  
6 could be leveraged on the HIE like systems that are out  
7 there and would not have to be reinvested if there is a  
8 way of harmonizing that. Good point.

9 COMMISSIONER GALVIN: And I'll just add  
10 one comment, in the health department we see a thing  
11 called the Roman candle effect, and that many of you  
12 probably remember when you were a kid and you had those  
13 Roman candles and you lit them and this bright, very  
14 bright lovely thing popped out and it went about 40/50  
15 feet, and then fizzled. Well, we see that happen all too  
16 often. We get some money from the feds and we go in some  
17 place or get a project and try to get it done, and we're  
18 great for about eighteen months. And, you know, our  
19 projectory is like this and then the federal funds run  
20 out and you don't want this -- this is not something  
21 that's going to go very well if you do it in bits and  
22 starts. And throw eight or nine million in and then  
23 worry about it for another year, and then throw three or  
24 four million. You won't get any place. And we'll end up

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 at that morass that I see as having functional systems  
2 within the hospitals and other organizations, and having  
3 to try to buy some kind of a system for somebody else  
4 with the -- for the consumer. So, I'm very concerned that  
5 we have a plan for sustainable financial.

6 MR. PETRUS: And I think if you don't it  
7 feeds into the skepticism that you've never going to do  
8 it and people will go out and do their own thing.

9 COMMISSIONER GALVIN: Do their own, yes.

10 MR. PETRUS: Good point. Let's take a  
11 look at the challenges. The number one challenge is not  
12 how are you going to do it, but what is it that you want  
13 to do in developing a short, medium, and long term  
14 business model. And it may go back to that two stage  
15 approach that the finance work group had already  
16 identified. And what are the other sources of revenue  
17 that Warren identified and you might also be able to  
18 identify that could be harmonized into a solution.

19 You have to come up with a commitment for  
20 the matched dollars as the ONC money phases out. 90  
21 percent and I think 70/30 or whatever it continues to  
22 drop down. Where is your guarantee of that matched  
23 money? You're not going to have an HIE up and running  
24 that's going to be transactional next year. Where do you

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 get that matched money and how do you secure that  
2 politically within your tight budget times? That's going  
3 to be really critical.

4 How do you leverage federal financial  
5 participation either through grants or other  
6 opportunities that you might have in working with  
7 partnership with state agencies that may have FFP that  
8 could be appropriately used?

9 Thoughts on the finance challenges? Did  
10 we miss any?

11 MR. AGRESTA: I think you -- careful  
12 thinking about transaction based, you know, type of fees  
13 as well as to who gets actually hit by the fees because  
14 when you go to the places where the most transactions  
15 take place they may actually be the places least able to  
16 actually provide any transaction, you know. So as you  
17 develop these models it really needs to be a very careful  
18 impact analysis on what is it going to mean and will it  
19 actually be sustainable when you try to implement it.

20 MR. PETRUS: And in a strategic plan  
21 you've got to do some ready -- in about what is it that  
22 you want to do having some analysis that you will do  
23 through your operational plan. And it is key and ONC  
24 talks about that no undue burden on payers, providers,

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 patients, etcetera.

2 MR. CARR: You mentioned it in your  
3 statements on this slide, but it's not really jumping out  
4 to me from the text on the slide around the importance of  
5 the matched funding. Whereas many states have, you know,  
6 existing e-health funds that have ten million bucks  
7 sitting in them and then they know they can go ahead and  
8 go forth with the planning and say, okay, -- the next  
9 year out, etcetera. And then they can use some of that  
10 ten million to fund innovation.

11 MR. PETRUS: Exactly.

12 MR. CARR: So just that really needs to be  
13 --

14 MR. PETRUS: -- is there appropriations in  
15 403?

16 COMMISSIONER GALVIN: No.

17 MR. AGRESTA: No. I would put that as a  
18 need or challenges in the finances.

19 MR. PETRUS: Okay, I would too.

20 MR. CARR: Because you said it and that's  
21 really -- it needs to jump out at us.

22 MR. PETRUS: Yes, other states have  
23 matching funds, as you said, anywhere from a couple of  
24 million to 15 million in one state that are used

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 basically to match and do some of the seeding necessary  
2 until they get to the transactional point of funding the  
3 HIE.

4 MR. COURTWAY: (Inaudible) so inside of  
5 the standard number of initiatives, the sustentative  
6 initiatives, the SS initiatives, and let's say, for  
7 example, that there is a question of whether or not the  
8 HIE's should house an electronic health record. That is  
9 some model charged back.

10 MR. PETRUS: Yes.

11 MR. COURTWAY: And you know the  
12 development of that business model say, you know, it's at  
13 a sustainable business model is that in -- coming to the  
14 finance committee domain? Is that operations domain?  
15 Where do we cross these different aspects to say we can  
16 create a sustainable model from the finance committee  
17 with this set of three out of ten products that are part  
18 of a robust exchange?

19 MR. PETRUS: Yes.

20 MR. COURTWAY: Where does that get --

21 MR. PETRUS: -- I think it is in  
22 governance. I think it's in technical architecture and  
23 it's in finance.

24 MR. COURTWAY: Now, there is not supposed

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 to be anything in technical architecture, I'm sure of  
2 that.

3 MR. MCKINNON: That's exactly where we've  
4 got the gap --

5 MR. PETRUS: -- that's exactly where we do  
6 have the gap too.

7 MR. MCKINNON: It's funny you should ask.

8 MR. JOHN GADEA: This is John Gadea. I  
9 just have a question, we're talking about transactional  
10 fees. That sounds like a real, kind of a dirty word. I  
11 mean is it 10 dollars a transaction fee? Is it a half a  
12 cent? I mean what exactly are we looking at here?

13 MR. PETRUS: It depends on the  
14 transaction.

15 MR. GADEA: Fair enough. So it could  
16 potentially be anything.

17 MR. CARMODY: I think part of it goes back  
18 to what are we trying to build. I mean it goes back  
19 through -- you know, you don't know what -- you want to  
20 ask somebody how much are you going to pay for something  
21 it's like, well, how much are you asking for or, again,  
22 it goes back to what are we trying -- once we go through  
23 this from a financing perspective is it a little or is it  
24 a lot? I mean, again, are we billing out to the empth

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 degree or is it just pieces? I mean then you can come  
2 back and understand what you're talking about relative to  
3 how much money you're trying to cover.

4 MR. PETRUS: There you go. And that's the  
5 biggest gap we see. It's hard to come up with costs  
6 implications when we're not sure what it is you want.  
7 And it goes to the other side in what's going to be in  
8 the product service portfolio. Going back to what you  
9 were saying. I don't know. You have not provided us  
10 enough information for us to say what that transactional  
11 key is going to look like or what that platform is going  
12 to look like and should you use state seed money to build  
13 X, Y, Z, or do you use Medicaid money, or a public health  
14 information network or a public health information  
15 technology architecture dollars to build a certain piece  
16 because we don't know what the Connecticut HIE is going  
17 to be. Is it going to be the HR bank? Or is it going to  
18 be a centralized entity? Or is it going to tie together  
19 REO's? Or is it going to be both that the REO's will do  
20 X, Y, Z and the HIE for the state will do A, B, C? And  
21 you might also have an EHR -- you haven't gotten there  
22 yet. You haven't been able to articulate what it is that  
23 you want for us to help you come up with the financial  
24 cost and what might be the best sustainable plan for you.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1

2

MR. HUDSON: That sounds like a pretty significant gap.

3

4

MR. PETRUS: That is a very significant gap.

5

6

MR. HUDSON: We're in a sort of circular process of questions that can't be answered because you can't answer the questions before that.

7

8

9

MR. PETRUS: And that's one of our three major gaps.

10

11

MR. HUDSON: Right.

12

MR. PETRUS: This is a critical one because this one -- governance we can go forward because we come up with pretty words and we can help you --

13

14

15

MR. HUDSON: -- right.

16

MR. PETRUS: With organizational charts and if you have to modify them later it's a cooperative agreement unless you need legislation. But this one you can't do it with pretty words. And it's tied into another one that we'll get to.

17

18

19

20

21

COMMISSIONER GALVIN: Frank, would you -- and group, would you want to do something -- I mean everybody and his brother is trying to sell you cable stuff and this and that and the other. Would you want to

22

23

24

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 market it as we'll put in our -- we'll put our product in  
2 your office and then we'll charge you so many cents per  
3 minute of use. And if you go in there one day and the  
4 machine says, sorry, Dr. Agresta, I don't feel like  
5 working today, we'll fix it for you and we'll give you  
6 updates. And we own the hardware and at some point maybe  
7 you offer somebody a deal and say, you can buy the  
8 hardware or amortize the hardware. Would you want to do  
9 it that way and get rid of that sting of having to put  
10 equipment into your office which may not be viable 18  
11 months after you put it in there?

12 MR. PETRUS: We'll get to options, that's  
13 for sure.

14 MR. AGRESTA: I don't think we're talking  
15 about any equipment.

16 MR. PETRUS: No.

17 MR. AGRESTA: Which would sit in offices.

18 MR. PETRUS: We're talking about a model  
19 right now.

20 MR. AGRESTA: Right. But I think that, you  
21 know, your question of whether the service that's  
22 provided is a service that's paid for at the level of  
23 whoever is providing care I think is going to be quite  
24 challenging. I think we've got to recognize we're also in

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 a time frame where we're trying to get electronic medical  
2 records out there at a pace that is probably not  
3 sustainable, and not achievable either. And everybody is  
4 doing their own stuff anyway. And so we're in this sort  
5 of -- it would have been great if we could have done this  
6 before everyone was doing their own stuff so it could be  
7 harmonized before hand. We're not there. That's not  
8 where our reality is. And so we have to figure out how  
9 we're going to do this in the context of everybody trying  
10 to do their own stuff at the same time.

11 MR. PETRUS: We do have certification and  
12 compliant requirements that vendors and health systems  
13 and hospitals and providers get there. But, yes, we're  
14 not down to -- how are you going to do this? We're still  
15 at what is it that you want to do.

16 MR. CARMODY: Again, we all go back to the  
17 point that you made before that there are a couple of  
18 folks that are all sort of in that same circle again,  
19 what is the Department of Social Services doing on the  
20 Medicaid front? I mean we may also -- I think one of the  
21 things we probably should do sooner rather than later is  
22 get some of those folks together, whether it be with the  
23 executive committee or just bring them in, because then  
24 they get -- you can start to talk about, okay, so what

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 part of the landscape are you covering and what are you  
2 handling? Because then you can start to say, again, if  
3 we're going to be an enabler and they are putting money  
4 in other places to do certain things, then we can make  
5 sure that we're complementing one another in that  
6 enablement part of that ecosystem as opposed to just  
7 going off and doing our own thing.

8 MR. PETRUS: Absolutely because if you do  
9 the latter it's going to cost you more and it's going to  
10 be very difficult to have the metrics and measures  
11 necessary to be in compliance, and it will not fulfill  
12 your vision. We're going to get to some options and  
13 alternatives in a minute and we've got half an hour left.  
14 So I'm going to recommend we just go onto the next domain  
15 so we can --

16 MS. HORN: -- we've got till 4:00.

17 MR. PETRUS: We've got till 4:00?

18 MS. HORN: Yes.

19 MR. JEFF PERKINS: One more comment is the  
20 concept of a sustainability can also evolve over time.  
21 It doesn't have to be on day one what it might look like  
22 in year two or year three or etcetera down the road. So,  
23 just as you're evolving the capabilities of HIE you want  
24 to kind of match the financing aspect to allow that

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 evolve as well at the time.

2 MR. PETRUS: Good point. Let's take a  
3 quick break so you can have a little bio-break and  
4 stretch. Let's take a five minute break. I know you'll  
5 take ten, but and we'll come back and finish up the  
6 domains and then talk about alternatives.

7 (Off the record)

8 MR. PETRUS: Any thoughts?

9 COMMISSIONER GALVIN: Is anybody out  
10 there?

11 MS. BOYLE: Yes, I'm here.

12 COMMISSIONER GALVIN: Okay.

13 MS. BOYLE: But I don't have any other  
14 additional comments.

15 MR. PETRUS: All right. Onto the technical  
16 infrastructure, and this is the nuts and bolts. And,  
17 again, it's hard to talk about the nuts and bolts until  
18 we have blueprints of what it is you want to build. So,  
19 if we take a look at strengths though there are some, I  
20 think, demonstrative strengths in Connecticut. The  
21 conceptual architecture that was drafted in June of 2009  
22 is viable. It's -- it makes sense and could be a  
23 hypothesis or a baseline for you to move forward.

24 Also, the legal policy group talked about

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 a definition of data categories when you start thinking  
2 of how you build the architecture consistent with how you  
3 could then respond to consumer and provider's needs,  
4 which then ties in, I think, to what was identified by  
5 the finance group. And we think there is some harmonizing  
6 that could happen between the vision that was identified  
7 by finance and the vision that was now identified by  
8 legal. Patient care and services within the first year,  
9 public health with various types of public health data,  
10 vital statistics, immunization, registries, quality  
11 reporting, research and market analysis, and, I think,  
12 prevention and wellness and analytics, and then legal  
13 investigation or inquiry. You got some interesting way of  
14 thinking of building the architecture to provide support.  
15 Again, we were impressed with that and impressed with the  
16 finance approach that's starting to come together and it  
17 needs to be tested out.

18 Substantial from what we saw in the data  
19 that we reviewed and the individual we talked about. The  
20 health systems and hospitals are moving. There are 80  
21 some odd health information exchange like systems out  
22 there in Connecticut. There is a wide adoption of EHR.  
23 And there is the commitment by the State Department of  
24 Social Services to move forward with the Medicaid health

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 information technology planning process for EHR adoption.

2 So, there is a lot going on including the  
3 pilot for DSS and E-Health Connecticut and the Danbury  
4 health link. There is a lot going on that is providing  
5 knowledge, lessons learned to Connecticut regarding  
6 technical infrastructure.

7 Anything we missed regarding strengths?

8 MR. COURTWAY: The second page.

9 MR. PETRUS: Let's go to the second page.  
10 More strengths, we talked about the DSS pilot and that  
11 there is already a decision, an open -- that's out there  
12 with the MAS platform, which is the Misist Open Source  
13 platform. There is a variety of systems, the Connecticut  
14 Health Information network we talked about, KEMNET and  
15 DOIT infrastructure and staffing, a lot of stuff going  
16 on.

17 But, as we talked about before, there is a  
18 lot of stuff going on that are great strengths, but  
19 they're right now in silos and often in separate tracts.

20 Next, challenges, you kicked it off,  
21 Doctor, by saying what would it look like. The No. 1  
22 challenge, what is the operational scope and what is the  
23 level of centralization for the Connecticut health  
24 information exchange, a big area of ambiguity for us. We

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 need more information around the agenda for state  
2 agencies and health information requirements. We're  
3 learning about the Medicaid incentive program. We learned  
4 about public health, but you have other agencies out  
5 there that are also providing services that would have an  
6 impact on the health information exchange.

7           Quality reporting, what are the metrics  
8 and measures that are going to be set. Broadband mapping  
9 and access to the 1.8 million dollars regarding is there  
10 gaps in that last mile regarding broadband capabilities?  
11 And the dependencies and constraints that need to be  
12 tested.

13           MR. COURTWAY: Is Gartner collecting the  
14 information on those other information systems in other  
15 state agencies? I mean is that an active --

16           MR. PETRUS: -- yes.

17           MR. COURTWAY: Piece so that we can  
18 rationalize, okay, is that something that stays there. Is  
19 that now a function of the --

20           MR. PETRUS: -- yes, good point. It's  
21 actually a good point as we talked with the Medicaid  
22 people to say, do you see yourself building a separate  
23 health information exchange that would integrate with the  
24 state health information exchange or will the state

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 health information exchange be the exchange that you will  
2 use.

3 MR. COURTWAY: Does that extend out to  
4 things like immunization registries?

5 MR. PETRUS: Yes.

6 MR. COURTWAY: The state should have a  
7 separate immunization registry database as opposed to  
8 using a core HIE database as a registry.

9 MR. PETRUS: Or do they use the health  
10 information exchange for the push/pull to populate or to  
11 transmit? So as you do data reported repository and  
12 reporting out do you do that in a separate registry? Do  
13 you do that through the push and pull of the health  
14 information exchange or a combination? We have ambiguity  
15 about what you want to do.

16 MR. COURTWAY: But you're collecting the  
17 opportunities?

18 MR. PETRUS: Yes. Other challenges?  
19 Temperature, we had this at the mid point because there  
20 is a lot. The challenge is not the technology. There is a  
21 whole lot of stuff going out there it's how do you want  
22 to put it together. And the number one gap is to conform  
23 the scope of core versus shared services provided by the  
24 Connecticut health information exchange.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   What is the business information and  
2                   technology and solution architecture that the HIE for  
3                   Connecticut will encompass and how will you promote the  
4                   adoption for the HR/EMR in the community. We view this as  
5                   a real core and we want to talk -- this is the other  
6                   major gap that we see. So we saw finance and we see this  
7                   as the -- so you start defining this and starting  
8                   defining how you're going to handle the sustainability,  
9                   there is no there therefore.

10                   MR. AGRESTA: I'm not sure we've -- that  
11                   we don't have a bigger gap or concern with technical  
12                   infrastructure. I mean there is an awful lot of legacy  
13                   systems out there. There is an awful lot of, you know,  
14                   built one time type things. I think the technical gaps  
15                   are bigger perhaps than might be recognized. You know, I  
16                   mean I'm quite certain that most of the hospitals  
17                   connected to an HIE are going to be going through an  
18                   enormous amount of work to get their system to conform to  
19                   that transfer of data. And because they're in legacy  
20                   systems, etcetera, I think it's bigger than we might -- I  
21                   mean designing a system is different than implementing  
22                   and building it, and actually having the finances to move  
23                   in that direction and the skilled personnel, etcetera.

24                   MR. PETRUS: So let me push just a little

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 bit. So you're saying there is a lot of legacy systems  
2 out there that may not be compatible, or interoperability  
3 would be challenged, or they're going to have to be  
4 ripped and replaced.

5 MR. AGRESTA: They don't have the  
6 semantics, the ontology setup, the -- I mean all the  
7 things that are going to be important for  
8 interoperability. I think those are bigger challenges  
9 than perhaps --

10 MR. PETRUS: -- then on the other side  
11 what we saw is the tremendous movement that hospitals and  
12 health systems, the DSS pilot with E-Health Connecticut,  
13 Danbury that there is just a lot of lessons learned and  
14 models out there, and architecture out there that could  
15 be leveraged.

16 MR. AGRESTA: I agree, but I think that,  
17 you know, it's all -- right now there is a lot of one off  
18 type --

19 MR. PETRUS: -- okay, that's fair.

20 COMMISSIONER GALVIN: Yes, I think you're  
21 right, Tom. I know when Lawrence Memorial went to  
22 electronic health records they thought it was going to  
23 cost them 10 or 12 million dollars. It ended up costing  
24 them, I think, more than 20 million and it's a new

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 system. And it was pretty much designed for them. It  
2 probably connects with Yale since they have a working  
3 relationship. But if that system had significant  
4 difficulty connecting with other systems I don't know  
5 where they'd find another seven or eight million bucks to  
6 fix it. I think they'd be very -- so it may be a bigger  
7 -- you're right.

8 MR. COURTWAY: Tom, I would agree. I think  
9 the technical challenge in getting everybody to ride the  
10 exchange are going to be immense, but I think in setting  
11 up the technical architecture and the design of the  
12 exchange it's going to be pretty prescribed in regard to  
13 which standards, what formats you need in order to be  
14 able to play it in the exchange. I do believe that if we  
15 draft from the standards based approach that builds over  
16 time and start getting into a, well, you know, your  
17 system is not able to communicate at the right standard  
18 level, you're not certified, but yet you want to play,  
19 and if we start building that in we will have an  
20 unsustainable investment. And it would not be affordable  
21 for anybody. So, I think it's going to be a balance  
22 between the two, but the challenges of getting everybody  
23 to see where their investments can come in and how those  
24 investments will benefit them is going to be key in

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 getting people to make their local investments into the  
2 electronic health record.

3 MR. PETRUS: Anything else? So, you would  
4 lower this from mid to low?

5 MR. AGRESTA: I don't know if I'd lower  
6 it. I'd just make sure that --

7 MR. PETRUS: -- it's articulated.

8 MR. AGRESTA: That it's articulated and  
9 it's recognized because there is implications for  
10 financing too.

11 MR. CARMODY: And the other thing I want  
12 to raise it up, I'm not quite sure if it's a challenge or  
13 a strength or where you even put it, but, again, some of  
14 the things that we've talked about over the last few  
15 meetings is making sure that we're not reinventing the  
16 wheel. So as you think about administrative  
17 simplification and how information exchange is exchanged  
18 between many players in the marketplace today how can you  
19 leverage that in the beginning of, you know, you have a  
20 Hepa 5010 implementation so you -- then you have new  
21 administrative pieces. You know NAFC's, certain -- even  
22 competitors leverage, you know, certain administrative  
23 ways in order to exchange information, I think that there  
24 is already a beginning, when you start going into the

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 clinical piece that's where you start -- I'd get  
2 concerned because then you have the ontology that you  
3 talked about of going from system to system that could be  
4 divergent. But you already -- if there is someplace in  
5 here we could capture that there are some standards that  
6 are being exchanged today I think that that could be  
7 helpful.

8 MR. PETRUS: Yes, this whole -- what  
9 mechanisms are you going to put in place to leverage  
10 those standards that have been adopted and then how do  
11 you adopt emerging standards. And some of those emerging  
12 standards have not been defined yet.

13 Let's move on to business and technical  
14 operations, and this is all about the operations, the day  
15 to day operations, the utility, what you define the  
16 utility is going to be. And all the requirements  
17 necessary to make sure that it's available, that it's  
18 affordable, it's adaptable, it's flexible, it's  
19 responsive. And all of the business side, the fiduciary  
20 responsibilities are met, and all the reporting that is  
21 necessary to demonstrate that it is a compliant utility  
22 focusing on the vision and goals that you've established  
23 for it. And it's managing the service levels, it's  
24 managing the operations of the organization. Strong

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 leadership, strong capability, whether that is an  
2 operation that you outside, you still have to manage it,  
3 or if you're going to do it in house somewhere.

4 Strengths, we felt that there was  
5 sufficient information regarding the readiness to move  
6 forward, that the current planning process is an open and  
7 transparent process. Your state procurement process, if  
8 you wanted to leverage it, includes the availability of  
9 contracts that can provide support. Licensing agreements  
10 that could support -- and that there is vendors available  
11 to provide software as the service capabilities, to  
12 manage this on your behalf, and they have DOIT's  
13 standards and best practices around architecture,  
14 application, development, service level management that  
15 provides an infrastructure and support for the business  
16 and technical operations.

17 We also see that there is experience from  
18 working with HIE's elsewhere that you can leverage. There  
19 is lessons learned from the pilot that is going to be  
20 developed soon of what's working and then sharing and  
21 reliability, the availability of the pilot. And then you  
22 have other agencies like you moved with consumer affairs,  
23 I think around the licensing --

24 MS. TOWNSHEND: -- Consumer Protection.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: Consumer Protection around an  
2 enterprise approach to licensing that -- so we thought  
3 that there are those kinds of strengths regarding  
4 business and technical operations.

5 Any strengths we missed?

6 COMMISSIONER GALVIN: I'm going to  
7 interrupt you for just a second.

8 MR. PETRUS: Yes.

9 COMMISSIONER GALVIN: When you talked  
10 about outsourcing we see a fair amount of that with water  
11 companies and at one time -- UCONN does its own water,  
12 but there was several discussions around why don't you  
13 just outsource it to one of the big water companies. And  
14 those are -- there are pros and cons involved with that.  
15 I mean MDC doesn't outsource water to people like -- but  
16 that's a whole different organization than if you just  
17 have a committee which outsources the administration,  
18 this program. And I -- when you outsource you lose a lot  
19 of the headaches. If you got back flow, cross  
20 connections that don't work, it's not your problem, it's  
21 the so and so water company, on the one hand. On the  
22 other hand, you don't have to kind of control and you  
23 don't have the ability to make the organization reflect  
24 the personality of the State of Connecticut. I think

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 that's a very crucial juncture about, you know, are we  
2 just going to broker this out or are we going to do it  
3 all ourselves?

4 MR. PETRUS: The gaps are challenges that  
5 we see. It goes back again to the need for clarity. The  
6 ambiguity about the business plan, the operation plan,  
7 what are you going to do? The priorities for  
8 implementing services, the analysis of the customer base,  
9 developing an effective communication plan, how are you  
10 going to put this infrastructure together because the  
11 legislation provides an authority, provides a governing  
12 body, but what about the day to day business and  
13 technical operations. And how do you work with and  
14 develop a relationship with the customers because the day  
15 to day business operations means that you're responding  
16 to the needs and the expectations of your customers to  
17 deliver something at the end of the day. You haven't  
18 defined what you're going to deliver outside of a vision.

19 Plus it's hard to define who your customers are, and  
20 it's hard to have a business plan on how you reach out to  
21 your customers with your business plan to demonstrate  
22 your value proposition and what you're going to manage on  
23 their behalf, and what service levels you're going to be  
24 there to maintain.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   And other challenges? The whole idea of  
2                   how do you develop authentication and security. How do  
3                   you develop the performance metrics and processes? What  
4                   are you going to do in that arena? And then what's your  
5                   staffing plan. All of this, to us at this point, is  
6                   pretty ambiguous and not clear. I mean part of that is  
7                   because you haven't defined what the health information  
8                   exchange is going to be. So how am I going to manage  
9                   something if I'm not sure what it's going to be.

10                   Further challenges is the ARA requirements  
11                   and the linkages with other initiatives that are out  
12                   there including the regional extension center and also  
13                   with public health and the Department of Social Services  
14                   with their pilot and that there is a real question of how  
15                   that -- how that pilot is going to feed, support, be a  
16                   part of -- and integrate because you think of the  
17                   millions of dollars that go into Medicaid and that's  
18                   going to be a critical piece of this. And going back to  
19                   what you talked about earlier is how do you leverage the  
20                   investments of hospitals and work with hospitals and  
21                   health systems that have already put systems in place and  
22                   how do those plans come into work with your ability to  
23                   manage the utility to provide the service level in  
24                   meeting the expectations of your customers.

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   And so when we get to the target  
2           temperature we see it low. We see some major gaps and  
3           it's not necessarily major gaps because the business and  
4           technical operations is such a challenge, it's hard to  
5           build business and technical operations when your vision  
6           for what the HIE is going to be, is it going to be a  
7           Kool-Aid stand or is it going to be a Starbucks, which  
8           there aren't many in Harford for some reason. So not  
9           defined the operational business plan; not in place,  
10          marketing communication plan; not defined, performance  
11          measures; and the approach and strategy for hosting,  
12          and/or sourcing, and/or delivery the infrastructure as --  
13          if you haven't said what you want to do in any of those  
14          areas yet. So -- and we're very disappointed that the  
15          working committee hasn't brought back a definition for  
16          business and technical operations. You're supposed to  
17          intuit.

18                                   Any disagreements? Okay.

19                                   MR. AGRESTA: It's a huge challenge. I  
20          think it's -- I think it gets back to, you know, defining  
21          what we want to do and until we do that, you know, a lot  
22          of these things can start to fall into place once we  
23          decide what we want to do. But the challenge is this is a  
24          huge, huge to do list. And you can't even get to the --

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 to it until we figure out what it is we want to do.

2 MR. PETRUS: And quite frankly it's not  
3 going -- it will come together a lot easier when you  
4 decide what it is --

5 MR. AGRESTA: -- yes, you can then even  
6 figure out what can feasibly be done. You have to get  
7 into phasing stuff because you know what's capable of  
8 being phased first.

9 MR. PETRUS: Because you're going to need  
10 different business and technical operations capability  
11 for the design, development, implementation then you're  
12 going to need for the first phase, whether it's this --  
13 and then when it gets to about this big, you're going to  
14 need something else.

15 Legal and policy, and this is the  
16 challenge of how you harmonize all of the federal and  
17 state laws and regulations regarding patient right,  
18 consumer rights, confidentiality, special populations,  
19 across state jurisdictions, assuring that you're  
20 protecting the security and confidentiality and the  
21 rights of patients and consumers as well as providers.  
22 How does that all fit together?

23 Strengths, we felt that there has been a  
24 lot of work done by the legal policy committee and you

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 still haven't shared that 800 page document with me.

2 MS. HORN: Would you like me to send it to  
3 you?

4 MR. PETRUS: Yes, some day --

5 MS. HORN: -- just don't hit print.

6 MR. PETRUS: So, I think that there has  
7 been a lot of work so that once you establish the  
8 direction that you want to go and you start putting your  
9 roadmap together I think that the legal and policy is  
10 probably where it needs to be for your first and maybe  
11 second phase of developing and implementation. There is  
12 not as much ambiguity here. There is a hybrid model that  
13 has been promoted, or thought about, or has been working  
14 regarding patient consent. Progress has been made on  
15 data sharing agreement, consent policy forms through the  
16 DSS pilot that can be leveraged. There have been lessons  
17 learned from that. And there is lessons learned from the  
18 Danbury Health Link approach. So there is a lot that you  
19 can built on from what has happened in your community and  
20 what has happened in this group and it's working  
21 committee.

22 Challenges, there is still some areas that  
23 need to be addressed, principles for data ownership by  
24 type of data. Who owns the data, the whole issues of

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 stewardship right are really important aligned with  
2 privacy and security. The HIE policy framework, that  
3 policies that need -- as you talk to ONC about this what  
4 do you want to do, not how you're going to do it, to  
5 develop a policy framework for the health information  
6 exchange through these different phases, the finance  
7 committee saw some phases, the legal saw some phases for  
8 the development.

9 And then a big one is to determine the  
10 Connecticut patient consent policy that balances the  
11 needs and rights of participants and stakeholders, but  
12 also -- for improving health care. And all the education  
13 that needs to go around that for providers, and patients,  
14 and their families to understand the benefits of health  
15 information exchange as well as their rights and  
16 responsibilities. So, you've got the broader pieces that  
17 are in place regarding the strengths here, but the real  
18 key area is determining the consent policy, opt in, opt  
19 out. It's one of the big three, financial statements,  
20 sustainability, what's going to be the scope and focus of  
21 the Connecticut HIE, and what are we going to do about  
22 patient consent, participant consent.

23 MS. BOYLE: I have a question, this is  
24 Lisa Boyle.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: Go.

2 MS. BOYLE: Would you -- are you expecting  
3 -- we've been working on all of these issues. When you  
4 say determine consent, I mean we're working right now on  
5 sort of a recommendation which we're going to discuss at  
6 our next meeting, which would include, you know, an --  
7 probably look like an opt out subject to, you know, the  
8 special confidentiality areas with like break down by  
9 data size in terms of, you know, what a phased in  
10 approach and maybe some discussion of what happens with  
11 those individuals -- is that what you're looking for from  
12 us a recommendation?

13 MR. PETRUS: Yes.

14 MS. BOYLE: I recognize at some point  
15 there will be a consent form that you'll probably want us  
16 to develop. But are you looking right now for a  
17 recommendation from that committee?

18 MR. PETRUS: Yes, for the strategic plan  
19 you would be bringing back to this group, which is the  
20 broader governance group for the Connecticut HIE, you'd  
21 be bringing back a recommendation that would go into the  
22 strategic plan this is what Connecticut is going to do  
23 regarding patient consent and participation in the HIE.  
24 Then when you get to the operational plan this is how

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 we're going to do that. Here is the consent form. Here  
2 is the policy structure we're putting in place.

3 MR. PERKINS: Frank, one thing I might add  
4 to that is in addition to the recommendation is just the  
5 rationale. You know there might be several different ways  
6 of doing, you know, certain things. You make a  
7 recommendation, why is that the right way for  
8 Connecticut. I think that will be helpful to communicate  
9 in the strategic plan.

10 MR. COURTWAY: Lisa, this is Peter. Is the  
11 group also considering the advice and guidance on  
12 consents for those, you know, systems that may span a  
13 border to another state that has a different consent rate  
14 or a different consent format?

15 MS. BOYLE: Not yet. I think we haven't  
16 evolved to that yet. I think at this point we're still  
17 trying to work through kind of a model for Connecticut in  
18 terms of what we -- you know, I can -- I'm not really  
19 sure whether we're kind of stepping on other toes in  
20 terms of what we're doing, but we've been focusing in on  
21 kind of the structure, the model for whether it's opt in,  
22 opt out, how -- whether it's a centralized data base, and  
23 I think that's actually what we -- and that's actually  
24 what we're working on writing something up right now in

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 the next -- we have a meeting in another week or two  
2 where we're going to be considering -- like discussing  
3 actually something drafted. We've also been kind of just  
4 looking at sort of types of data. You know what the time  
5 frame is for getting the HIE to like accept that data or  
6 deal with that data by use. So we really haven't looked  
7 at like, at this point, and then, you know, also we're  
8 trying to work on the -- analysis. We really haven't  
9 looked at kind of, you know, state to state transfers of  
10 data and that level of detail. My sense is unless someone  
11 tells us that we need to accelerate that I don't think  
12 we'll be ready for that for a little bit. Like I think  
13 we think we have to work through the Connecticut stuff  
14 first.

15 MR. COURTWAY: Well, I think the challenge  
16 I would -- you put out whether or not it makes it to the  
17 Gartner list is -- and if I heard you say correctly that  
18 you're going to have -- the committee is going to  
19 recommend an opt out, but you're explicitly leaving out  
20 the other protected information whether or not it's HIV  
21 or behavioral. I think that everybody is going to need  
22 some clarification of what behavioral means so that  
23 they're clear that a depression or other psychotropic  
24 drug that's being prescribed by a primary care provider

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 or other non-licensed behavioral professional is not  
2 protected information and will be in the exchange. So,  
3 there is some nuisances there that people will need some  
4 guidance on.

5 MS. BOYLE: We have been talking about  
6 that, not at the granular level, but we have been kind of  
7 talking about that and recognizing a whole bunch of  
8 issues like that where we're going to have to get on. I  
9 think it might be helpful for everyone to kind of know  
10 where the subcommittees is going. I think -- it appears  
11 to be coming out of the group is that it looks like it's  
12 going to be something like the Maryland model. So if you  
13 go -- I mean that's in terms of the recommendation, what  
14 it might look like. If you look at the health and human  
15 services website there is a state by state analysis and  
16 they -- there is a description of Maryland which seems to  
17 be, at least right now, where our subcommittee looks like  
18 it it's going.

19 COMMISSIONER GALVIN: Let me ask a very  
20 elemental and perhaps dumb question, but if I'm one of  
21 Tom Agresta's patients and I tell him I don't want -- I  
22 don't want electronic medical records. Does that mean  
23 that Tom has to create a paper record? I mean I can say,  
24 yes, but if you get that stuff on the computer about me

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 one of your office staff can look it up or you might make  
2 a mistake and send it someplace. So I don't want to be on  
3 your computers at all. You're going to have to do a paper  
4 record for me.

5 MS. BOYLE: I've actually had clients that  
6 have had to deal with that, you know, providers who had  
7 nearly VIP's don't want to have an EHR. And in those  
8 cases I think the physicians have erred on the side of  
9 creating, as much as it is a challenge for them, creating  
10 a paper record for that patient. But it's obviously not  
11 ideal.

12 MR. AGRESTA: Also there is two points  
13 here, one is the opt in that I -- it's not about  
14 electronic health record as much, I don't want my  
15 information to go through the health information  
16 exchange. So there is another level of it's okay for you  
17 to have electronic health record on me, but I don't you  
18 to exchange it with anybody unless I give you specific  
19 consent each time you want to share it, which places me  
20 in a challenge when I get in the emergency room and I  
21 can't talk. They can't have access to my medical record.

22 The other is what you're bringing up is I  
23 don't want electronic health records period and some  
24 physicians may accommodate that, but other physicians

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 will not provide services to that consumer.

2 MS. BOYLE: Right.

3 MR. COURTWAY: One other question for you,  
4 Lisa, in terms of the challenges from the legal domain  
5 point of view, you know, in reading the Bill No. 403, you  
6 know, as a not for profit I see all the different  
7 exemptions, but since the 403 would conceptually be  
8 receiving Schedule CMS funding does that make it a  
9 Medicare provider and if so is it subject to Stark and  
10 all of the other issues that that brings along, or is  
11 that not really considered CMS funding or DSS funding?  
12 Just a challenge for you to think about.

13 MS. BOYLE: I'm thinking it through. I'm  
14 trying to think of whether I had that issue yet. I think  
15 -- I mean we tend to think of it in terms of  
16 reimbursement. Participation is a -- pursuant to a  
17 provider agreement, but that's a good question. I'll put  
18 that on our list of things to look at.

19 MR. COURTWAY: And I think it comes down  
20 to the definition of provider, is the HITE utility a  
21 provider like the phone company or the fax company, the  
22 phone company that you send faxes are they considered a  
23 provider.

24 MR. PETRUS: As we looked at the gap for

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 legal and policy we saw at a mid point and that we think  
2 there are gaps but we think that the group is on the  
3 right track and if there are gaps it's going to be around  
4 further defining data ownership and policy and management  
5 records and consent. And the other thing is the whole  
6 question of, and this is important in the strategic and  
7 operational plan, is how do you enforce -- how do you  
8 make sure that those that are participating and are  
9 customers of, and using the utility are complying with  
10 policies regarding patient consent, security, and  
11 confidentiality.

12 MS. BOYLE: We actually have started to  
13 talk about that. I mean one of the things we talked  
14 about is, you know, on the optimal side, you know,  
15 getting legislative changes that would support a strong  
16 enforcement methodology, probably tied to this authority,  
17 and maybe the AG's office.

18 MR. PETRUS: Anything else on legal and  
19 policy before we start looking at the gaps and some  
20 possible alternatives for your consideration?

21 MR. GADEA: Why do you need patient buy  
22 in?

23 MR. PETRUS: Why do you need patient buy  
24 in?

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   MR. GADEA: Yes. I mean that's the system  
2 that's in place. That's the system you're going to,  
3 that's the way it is. What is -- what problems does that  
4 present because if you have a doctor, take Dr. Agresta's  
5 office, and you say, I have patients who come in all the  
6 time and I enter this record for this one, this record  
7 for this group, this record for this group, it becomes  
8 virtually impossible.

9                   CMS came up with tamper resistant  
10 prescriptions. They're only for Medicaid patients.  
11 There is not one office out there that the physician  
12 carries one type of prescription in one pocket for the  
13 Medicaid patients and another group or another type of  
14 prescriptions for his non Medicaid. Most offices, that  
15 I'm aware of, they just use them on everybody because you  
16 just -- you know, you're taking away from the focus of  
17 what you're supposed to be doing, which is treating your  
18 patients, and now you're categorizing them for all these  
19 different things.

20                   So I'm just curious --

21                   MS. BOYLE: -- I'm having a hard time  
22 hearing that questions so could they, please, speak  
23 louder.

24                   MR. GADEA: Okay.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: The question that's being  
2 raised is why do you need patient buy in and it's just  
3 the way it is and if you start segmenting the patient  
4 population it will make it more complex and probably have  
5 a negative impact on the provision of health care.

6 MR. AGRESTA: I'll add to that. In the  
7 midst of actually writing a note on an electronic medical  
8 record I'm taking care of the whole patient. I don't  
9 segment the data about that patient. If they have HIV,  
10 and depression, and diabetes, etcetera, I'm taking care  
11 of that whole patient, and so does the consultant, and so  
12 does the other folks. And those data elements are not  
13 separated currently in any electronic medical record  
14 system that I'm aware of to the degree that one could  
15 separate out those data elements from a note. I mean  
16 they might be able to hold the problem list and, you  
17 know, not push through the HIV problem, for example, or  
18 not push through the HIV medications, or you might be  
19 able to filter stuff like that in an HIE. But I think  
20 that to think about an opt out system where the data  
21 isn't available, but where you even give the message that  
22 you can easily segment out portions of the data from a  
23 health information record perhaps gives the wrong message  
24 and sets us up for the risk of failing to be able to

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 actually implement it.

2 MR. PETRUS: The -- is how do you work  
3 with patients to help them understand how all of this is  
4 in their best interest.

5 MR. AGRESTA: Well, I mean it's a  
6 different thing if they go to a mental health provider or  
7 substance abuse provider who only does that type of care.

8 MR. PETRUS: Right.

9 MR. AGRESTA: And that entire note can be  
10 segmented off and not sent through as opposed to trying  
11 to filter out the notes that contain, you know, any kind  
12 of mental health data because that's also the note where  
13 you change their medications for a good reason outside of  
14 their mental health thing and now there is a missing  
15 piece of data that's really important to their care.

16 MR. COURTWAY: I think the only other gap  
17 though I see here is that I don't see sanctions. I don't  
18 see anything talking about unifying the sanctions.

19 MR. PETRUS: Yes, enforcement and  
20 sanctions, okay.

21 MR. AGRESTA: We're indemnifying from a  
22 malpractice standpoint. The HIE, the providers that  
23 provide care through it, etcetera. So those are big  
24 issues that are gaps, I think, as well.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   MR. PETRUS: Okay. You got it. Let's move  
2 on to some of the gap analysis that we did. Go to the  
3 next slide. What we did is we took those categories -- we  
4 categorized the gaps that we identified and then tried to  
5 rank them based upon the importance to the strategic plan  
6 and the degree of difficulty. And this is based upon an  
7 approach that we use for the analysis of information  
8 technology. And we really came up with the definition of  
9 the health information exchange, the sustainability  
10 model, and the consent policy management out of which you  
11 just started to discuss. And how do you come up with  
12 consent policy that makes sense, provide for the  
13 confidentiality, security and responsibility of the  
14 patient, but can be managed.

15                   And the rest addressed out in different  
16 points. So, as we went forward with today's discussion  
17 saying if we're going to help you write the strategic  
18 plan we need to know these -- to these three things.

19                   Next slide, so we've clustered these and  
20 basically for your working groups finance, technical --  
21 and they're interrelated, by the way, technical  
22 infrastructure, what's the scope, distributed,  
23 centralized, type of service and support from the state  
24 HIE, and consent policy and management were the ones that

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 jumped out. This is our assessment of the gaps that we  
2 think right now are in the critical path and provides a  
3 certain level of paralysis to be able to write the  
4 strategic plan.

5 Your thoughts, agreement, disagreement.

6 COMMISSIONER GALVIN: Well, I hear you  
7 saying that you can't write a coherent plan until these  
8 are resolved.

9 MR. PETRUS: Until we know this, what you  
10 want, how you're going to sustain it, how you're going to  
11 insure consumer rights and responsibilities.

12 COMMISSIONER GALVIN: A friend of mine  
13 once said if you don't know which way you're going it  
14 doesn't make any difference which route you take.

15 MR. PETRUS: Right, exactly.

16 COMMISSIONER GALVIN: We've got a bit of  
17 work to do.

18 MR. PETRUS: And we're going to try to do  
19 some of it right now. Here is what we see as potential  
20 alternatives for discussion today in the half hour that  
21 we have left, and we're going to give you some examples  
22 of each of these. Regarding the scope, basically there is  
23 three major models. Model No. 1 it's a centralized  
24 model. And a centralized model defines basically if there

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 is not a real health information exchanges that are  
2 payers, providers, labs, pharmacies, the whole universe  
3 of providers, that -- and there is not a lot of  
4 operating HIE's. Typically a centralized model the state  
5 investing their dollars and building the health  
6 information exchange, it supports all the health  
7 information exchange like systems that are out there,  
8 makes the best system.

9 MR. MCKINNON: Smaller --

10 MR. PETRUS: -- smaller states too.

11 MR. MCKINNON: Low populations.

12 MR. PETRUS: Low populations, Vermont, for  
13 example. Regional health organization approach, a  
14 distributed model, is you've got a lot of health  
15 information exchange, robust exchanges, out there.  
16 California is a great example of that. Where the state's  
17 job is how do we tie them together and become a gateway.  
18 An emerging model is health records -- basically it's a  
19 repository. It's a data warehouse. I hate to use the term  
20 warehouse, but it's infrastructure capability where  
21 electronic health records can reside with the appropriate  
22 security and privacy and can be drawn on as necessary by  
23 the training partners within the health information  
24 exchange. We're going to talk in detail about these.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 Revenue, sustainability model, there is  
2 four kind of alternatives to start thinking about. One  
3 is the subscription fees. There is action fees. Claim  
4 based payer assessment, performance based incentives,  
5 which there is a lot of skepticism about, or a  
6 combination.

7 In the consent policy and management model  
8 is the -- (inaudible) -- and what we're trying to do with  
9 this, we have an alternatives analysis workshop coming up  
10 for you, which will be a similar format to this, is try  
11 to start you thinking about these alternatives now and  
12 they're interrelationship.

13 Let's take a look at a centralized  
14 provider service alternative. And this is a centralized  
15 technical infrastructure that would be developed and  
16 maintained. And there is a regional health information is  
17 the entity that brings things together and then there is  
18 the health record bank. In the first one, the  
19 centralized -- Vermont, Delaware, Rhode Island, Maine,  
20 and Utah, we've provided more information for you on  
21 Rhode Island and Maine in the appendix.

22 MR. MCKINNON: It's corrected on this  
23 slide. It's Appendix C in a different document. It's a  
24 document called trends and market --

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: -- that's right.

2 MR. CARMODY: Can I ask a question?

3 MR. PETRUS: Yes.

4 MR. CARMODY: I guess this is two things,  
5 one of the things, as far as like trying to close the  
6 gaps that he's -- that -- during the course of the  
7 conversation the fact that we need to tie off with other  
8 folks and I, again, I just sort of scanned the rest of  
9 the presentation, I didn't see us coming back to that  
10 other conversation of before we get into the three that  
11 you identified, it still comes back to me that we want to  
12 go back and have a conversation of what are we within  
13 this sort of this conversation.

14 MR. PETRUS: Yes. So -- and I guess what I  
15 would do is use these three as a lens to have those  
16 conversations.

17 MR. CARMODY: Okay, well, then I guess  
18 then as we continue to go through the dialogue then I'd  
19 like to see us -- how do we plan on getting to having  
20 that dialogue with those other players to figure out what  
21 is the Connecticut HIE relationship to what they're  
22 doing. And I also would have thought that during the  
23 dialogue, and especially when I look at the three that  
24 you punched out as gaps and I tie that back to the goals

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 piece, what's a way and an order to enable these goals  
2 that's going to be able to then have a conversation --  
3 now, again, I'll draw on what we've talked about both the  
4 legal team talked about as well as what the finance team  
5 talked about which was, you know, should we be enabling  
6 certain key pieces of information -- you know, and,  
7 again, in this phased approach, to say that we want to  
8 get to, again, lab and pharmacy and continuity of care or  
9 some types of gaps across that emergency room type of  
10 concept. Again, trying to get back to something more  
11 tangible so that when we look at these three gaps that we  
12 can start to understanding maybe how do we prioritize the  
13 phases so that when we look at these we can put them in  
14 some type of context. I just -- I see these. I've looked  
15 at these. A lot of these models aren't sustainable. I  
16 mean CaliReo, not sustainable. Tennessee, Dudley --

17 MR. CARR: -- they're having some  
18 difficulties with it now.

19 MR. CARMODY: I mean it's those things  
20 that I get concerned with. What are we going to -- what  
21 does that business model, that business model that we  
22 then can say, I want to fund it. I can tie the goals to  
23 it and then we can actually get to what we need to  
24 achieve.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   MR. PETRUS: And my sense is that's what  
2 this group is about to do because the two points you  
3 raised, the actions best align with your vision and goals  
4 and the actions best align with the Connecticut  
5 experience because I agree with you. You can't take a  
6 Tennessee model and make it work here or a California  
7 distributed model and make it work here, it may not even  
8 work there. But I don't know. By the way, I think all  
9 these options are aligned with your vision. I mean they  
10 call could be. The real question is what's going to be  
11 the best option for Connecticut.

12                   MR. CARR: As I went through the documents  
13 some of these slides may be crying and some of them may  
14 be happy. And so 35 was actually one of them that made  
15 me happy and the reason it made me happy is because it  
16 ties back to your statement around this structure where  
17 we'd have patient -- and these are really closely --  
18 they're aligned with -- and so kind of back to your point  
19 can we use those to frame out the discussions, okay,  
20 within -- so now we're assuming, if we thought this was a  
21 strength in your framing that these would be supported in  
22 some way by the health information exchange, and that's a  
23 big assumption, but if we use that as an assumption they  
24 would just start saying what types of -- we could make

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 the decision say what's types of services are under basic  
2 care. Or what types of use cases are supported under  
3 basic care. And then just kind of build out that list so  
4 those are our major categories of types of services and  
5 then underneath we have more detail. And we could work  
6 that way because this made me really happy, this slide. I  
7 don't know if it made everybody else happy.

8 MR. PETRUS: 35 made you happy, which one  
9 made you cry?

10 MR. CARR: A lot of them. One of the  
11 reasons it made me happy though is if you look at the  
12 purposes of even -- it is okay to transmit data for the  
13 purposes of public health reporting and -- without  
14 reaching consent, but then you can deliver that  
15 information to the point of care with -- so they all kind  
16 of start getting bundled together at that point --

17 MR. PETRUS: -- yes, and it was  
18 interesting that that came -- that technical architecture  
19 phase approach came from the legal and policy side.

20 MR. CARR: Right.

21 MR. PETRUS: How else would you want to  
22 have this dialogue? I guess I'm -- I'm actually  
23 confused. I'm uncertain that -- Gartner can have this  
24 dialogue with itself, and we probably will tonight, but

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 this is the place for this kind of dialogue. When you  
2 start thinking of the experiences out there with what the  
3 hospitals have done, with -- is it a vision for the pilot  
4 with E-Health Connecticut, the kind of HIE types of  
5 things out there, and I keep saying HIE like because I  
6 don't see the full HIE robust capability out there. I see  
7 pieces of it within a health system that looks and feels  
8 like a health information exchange. So -- and I see this  
9 I've got to say, how do you want to --

10 MR. CARMODY: -- I would have said that I  
11 thought the way that you could help us with those other  
12 folks, you know, those other constituents that we've  
13 talked about several times, you know, how would we go  
14 about engaging them? How would we go about having a  
15 structured conversation with them? How can we then talk  
16 about it in terms of if we did engage them how would we  
17 stake out what we should be in relationship to them.  
18 We'll create a dialogue and facilitate our way through it  
19 because that -- I'm looking for how you could help us get  
20 to some of those answers. We actually ultimately have to  
21 do that.

22 MR. PETRUS: Well, quite frankly we've had  
23 some of those discussions with some of the stakeholders  
24 and some of the stakeholders, well, you should do it my

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 way.

2 MR. CARMODY: Oh, if you reach out to them  
3 and they'll say, do it my way.

4 MR. PETRUS: Yes. So we've had those  
5 conversations and now we're bringing these options here  
6 because I see the big dilemma here in Connecticut for  
7 you, and I think you're getting to the -- of it, the big  
8 -- here is does the state need a centralized approach to  
9 an HIE? First, that's yes or no. If it's yes, it's a  
10 centralized HIE for what? Everything or what pieces.  
11 That's area No. 1.

12 Area No. 2 is, no, the state is not going  
13 to build a statewide HIE. The state is going to build a  
14 gateway or an infrastructure to support the health  
15 information exchange that may or may not exist in  
16 Connecticut, develop a roadmap for that. And where there  
17 isn't the capabilities in these HIE like entities over  
18 there, the state is going to take the responsibility to  
19 do them, which is a little different flavor of this.

20 So, to me, and the third one is the health  
21 records bank, and -- which is a new concept where the  
22 state will assume the responsibility to build a health  
23 records bank that would be an edge of the health  
24 information exchange that would be a repository for

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 electronic health records.

2 MR. CARMODY: So maybe it's in a dialogue  
3 with how to prepare for that other conversation with  
4 those other groups. If you interacted with them how  
5 could we best prepare if we were going to meet with them  
6 so that when we build out an HIE it's one that is  
7 complementary to one another.

8 MR. PETRUS: Part of the challenge that  
9 we're having working with you all is that the role of  
10 this group, when we work with other states it's the role  
11 of this group to do that. And we have full day workshops  
12 with that kind of dialogue to do exactly that. We're  
13 kind of compressed in how we're doing this. So, if this  
14 group doesn't represent all that is out there and it  
15 doesn't represent the Connecticut experience regarding  
16 HIE life then we're challenged to work with you to help  
17 get to the next phase, which is the alternative health  
18 systems.

19 MR. CARMODY: I mean I think we do  
20 represent a good portion of the cross constituents. I  
21 think there is a recognition on behalf of the group, and  
22 other people can chime in, is the fact that we know we're  
23 not the only cross functional group that's out there and  
24 there is other folks that have money, that have a charter

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 of what they think they want to do, and how do we bring  
2 them together. So I don't think it's that fact that you  
3 don't have enough representation, it's how do you make  
4 sure that we don't, again, create a microcosm onto itself  
5 which doesn't enable that whole piece.

6 MR. CARR: It feels like we have to create  
7 a framework and a model and then go out --

8 MR. CARMODY: -- right.

9 MR. CARR: To validate it and then shape  
10 it from that point forward. So, I think -- I hear what  
11 you're saying because I hear the same thing. We all hear  
12 the same things. We probably said the same things to you.  
13 But, at some point we have to create a model and then  
14 start working it through the process to get a buy in and  
15 then change it whenever somebody comes up with a really  
16 good idea that needs to be changed, but we have to start  
17 somewhere and I think that that's where we're kind of  
18 churning here.

19 MR. PETRUS: And that's where the  
20 strategic plan comes in.

21 MR. CARR: Absolutely.

22 MR. PETRUS: Here is what we want to do,  
23 then you've got the strategic plan.

24 MR. GADEA: But you said there is 85 of

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 these subgroups around the state.

2 MR. PETRUS: The last I heard it was 80,  
3 but we don't have a definitive number.

4 MR. GADEA: Let's say it's 50.

5 MR. PETRUS: But there are HIE like  
6 systems out there and they may be a pharmacy system, or a  
7 lab system, or a system within a house system, or -- I  
8 mean a hospital.

9 MR. GADEA: Or a Yale system or a Hartford  
10 Hospital system.

11 MR. PETRUS: Yes, exactly.

12 MR. AGRESTA: Yes, I can't --

13 MR. GADEA: -- they want to see this thing  
14 go because there is nobody here from that group other  
15 than Peter. How do they, as the people that are way  
16 ahead of the curve in implementing this, how do they want  
17 to see it go? We could sit here and try and figure out  
18 what they want, but I think it's irrelevant. What do  
19 they want? Now, that may be doable, it may not be  
20 doable, but what do they want? What does UCONN want?  
21 What does UCONN tied to Hartford want?

22 MR. AGRESTA: I can tell you that it's a -  
23 - that is the big -- the huge elephant in the room is all  
24 these systems want something different because they've

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 invested time, money, and thought in this. And I would  
2 argue that there is not 80 HIE like type things out  
3 there, there may be five or seven viable ones. And there  
4 are a lot of little mini data exchanges and that's  
5 nothing, you know, and that's not going to be  
6 sustainable, and that can't -- you know, and that's  
7 probably got a figure of kind of, you know, going away.

8 I agree with you we need to bring  
9 stakeholders together in a room. I also see the value in  
10 what Kevin is saying is create a model that we think  
11 actually does what I do think we have enough knowledge  
12 around the table to think -- to think with perhaps a  
13 little reaching out to kind of figure out, you know, what  
14 would be a model that might work across multiple  
15 organizations. And then I think you throw them in a room  
16 for a day and say, you've got to walk out with a plan  
17 that people can agree on on some level because everybody  
18 is in trouble if we don't come up with a plan that suits  
19 the needs of the majority. And maybe you figure out in  
20 that plan, you know, who might be disadvantaged by moving  
21 in that realm because they've already taken the first  
22 movement in a path that isn't going to be completely  
23 aligned with that. And you figure out how to help them  
24 and that's part of your plan is to figure out how to make

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 that whole or make it better.

2 COMMISSIONER GALVIN: Well, there are very  
3 some big stakeholders out there and the hospitals have  
4 the money and, the larger ones, and the more successful  
5 ones, and they developed systems. So they're in --  
6 they're way ahead. And the big medical groups, not to  
7 single out anybody, like ProHealth, is way ahead. And so  
8 I think part of our experience is at least saying what do  
9 we do here? I mean we're sitting here talking about  
10 systems that we're trying to develop and they're already  
11 developed in some ways and we're talking about putting  
12 electronic records in all doctor's offices, they're in  
13 every -- that's part of being in ProHealth, you get  
14 electronic medical records.

15 So, do we need -- what kind of a dialogue  
16 -- I think we need to decide what kind of dialogue we  
17 need in order to take advantage of what Yale has done,  
18 what ProHealth has done, and that's the kind of  
19 fundamental thing of our existence.

20 MR. AGRESTA: And if they have  
21 diametrically opposed visions about how to move forward  
22 because of the architecture and the knowledge they've put  
23 in, we need a process by which we move forward anyway.  
24 You know, and --

MEETING RE: DOIT/HITE  
MAY 3, 2010

1                   COMMISSIONER GALVIN:  -- we can't have two  
2                   or three different systems, we can't have a ProHealth  
3                   system, a Yale system, and a St. Francis Hartford system,  
4                   and our system because it just ain't going work.

5                   MR. AGRESTA:  Well, you could if you had  
6                   regional -- with a state to tie it together, but I'm not  
7                   sure that that's -- I'm not sure that that's actually the  
8                   best system.

9                   COMMISSIONER GALVIN:  That's a decision  
10                  and I come back to we've had our own public health  
11                  foundation for almost, over six years and we get some  
12                  money in a grant and we do okay, we get a million bucks,  
13                  we're fine.  We're out of money, we lay everybody off,  
14                  etcetera, etcetera.  So, somehow it always goes forward  
15                  we need to be talking to elected representatives and  
16                  saying, we need sustenance, sustainable funds, or we  
17                  can't do any of this stuff.  And that was my plan a long  
18                  time ago is what the hospitals will say, well, gee, I'm  
19                  really sorry you don't have enough funds to sustain you  
20                  that's tough.  And Pro Health will go along and some of  
21                  the other big groups and we'll be nowhere.

22                  MR. AGRESTA:  I'm not sure that it's not  
23                  in their best interest to have something cohesive too.

24                  MR. MCKINNON:  All these stakeholder

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 groups --

2 MR. AGRESTA: -- can you repeat the  
3 question?

4 MR. MCKINNON: And all these different  
5 hospital groups have their HIE -- they've actually made  
6 investments and done some stuff -- they've done planning,  
7 they've done thinking to pull some ideas together amongst  
8 them and want the state to create a centralized approach.

9  
10 MR. PETRUS: Maybe another way to phase  
11 that or would trust that the state could pull it off?

12 MR. AGRESTA: I think there is concern  
13 about that, but I also think that if the state had a  
14 cohesive way of pulling together centralized approach  
15 that they could leverage their own experiences and their  
16 dollars, etcetera, I think they'd be willing to kind of  
17 move in that direction if there is good leadership to  
18 kind of pull them together and kind of move them in that  
19 direction. I don't think they're going to trust it to  
20 begin with. I think there is a bit of work to do there.  
21 That's probably why we probably need to get them all in  
22 the same room and say, here is where is everything lines  
23 up and here is where --

24 MR. CARMODY: -- some of the common

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 denominators. I mean, again, it goes back to are you  
2 trying to make this big overarching piece or -- even  
3 though you have systems that are out there you come up  
4 with some common denominators and say, look at it, is  
5 there something lacking across those ecosystems or the --

6 MS. BOYLE: -- I can't hear anyone  
7 anymore.

8 MR. CARMODY: Is there something that's  
9 across those ecosystems that are the common denominators  
10 that we need to try to sort of link together. And, again,  
11 is that the enabling piece that allows us to say, look  
12 it, we're going to play in these gray areas and those  
13 gray areas are what allows us to link between you. We're  
14 not trying to replace whatever those other people are,  
15 but we're actually trying to complement or enhance them.

16 COMMISSIONER GALVIN: Well, I think what I  
17 see, and this is a personal opinion, is that there is  
18 more motivation on the part of the big players to try to  
19 do something that's compatible with what the state is  
20 doing so that they don't, big quotation marks, they don't  
21 get in trouble. Or some people will tell them that their  
22 system is not the way the State of Connecticut likes and  
23 they'll be stuck with trying to exchange information. So  
24 I think there is more of a negative feedback on that then

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 a positive. I think that ProHealth doesn't want to get  
2 into problems with exchange their data. I think that they  
3 don't want to get involved in being anti competitive  
4 because all their physicians are being equipped. So what  
5 I hear from the people who made the big strides is how  
6 can we stay close enough to you that we don't go down the  
7 wrong part of the highway.

8 MR. PETRUS: And I think what we see in  
9 the distributive model, which is probably more in line  
10 with the Connecticut experience is that the distributive  
11 model really has a common set of statewide policies and  
12 standards and protocols managed by some kind of authority  
13 so that going back to what legal and policies is trying  
14 to put together, finance and sustainability and that  
15 there be statewide interoperability that ties those five  
16 or six real and others will use the full -- but there  
17 would be centralized components like a master patient  
18 index that would be absolutely important. There would be  
19 a record locator capability and messaging protocol that  
20 would be absolutely appropriate along with security  
21 authentication. And maybe predictive analysis and data  
22 business intelligence and -- so this model that we see in  
23 Michigan and in New York might be the one that's best  
24 aligned and a centralized model at least from what we've

MEETING RE: DOIT/HITE  
MAY 3, 2010

1       been hearing and wanted to have that kind of discussion.

2                       And the last model in this -- is the  
3       direct patient control of health record banks. This  
4       becomes, from legal and policy issue, a little bit  
5       different in that this is really patient control and  
6       we're seeing this whole idea that if a record -- if a  
7       health record bank would be this model that consumers  
8       would chose to have you access to their health records  
9       once it's completed so wherever they may be at any time,  
10      and some have laminated cards so if they are in an  
11      emergency room and can't talk they know they can access  
12      their pin number or whatever to have access to their  
13      record. And they're also -- it allows for the outcome.  
14      This is a model that is not widely in place, but another  
15      emerging model.

16                      Understanding, by the way, as all of you  
17      know, but sometimes we have to be the professor of the  
18      obvious, this is new stuff. So talking about  
19      sustainability, talking about the creation of a statewide  
20      health information exchange, and an active health  
21      information network and how that's all going to fit  
22      together and whether it's going to work or not there is  
23      a lot of unknowns out there. And why it's important for  
24      you to definitely tailor it to your needs not necessarily

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 the needs to one or two of your stakeholders, but how do  
2 you harmonize all your stakeholders, the dialogue that  
3 you're talking about. And to be able to have a strategic  
4 plan that can be submitted to ONC by the end of June.  
5 That wasn't my timeline, by the way, it's a reality which  
6 you're faced with. And then going back to what you may  
7 want to do the best you can as this governing body to  
8 come up with a direction or a model to do some talking  
9 out there in the community that can then be vetted for --  
10 you're still going to get another bite of the apple when  
11 you do the operational plan.

12 MR. HUDSON: So it strikes me that there  
13 is clearly not an intuitively obvious answer to this  
14 question otherwise we would have -- sitting with that as  
15 a critical gap on this. So how then do we have a  
16 discussion that provides maybe more flesh to the bone on  
17 this that says, you know, here are some ideas that the  
18 model, here are the attributes. Here is what we thinks  
19 fits well in your environment, and here are some areas  
20 that don't fit well. But how do we look at this because  
21 we don't have any straw models to go out and talk to  
22 anyone about let alone the issue of let me go talk to  
23 some of these other people and they'll tell you their way  
24 is the better way. Just give it to us and we'll do it for

MEETING RE: DOIT/HITE  
MAY 3, 2010

1       you. That's where I see the challenge.

2                   MR. PETRUS: Part of our approach will be  
3       an alternatives analysis. This is not the alternative  
4       analysis. This is a trailer for the -- a preview for the  
5       movie yet to come. We are going to do some of that work  
6       and we're going to do a straw man alternative analysis  
7       with pros and cons and pluses and negatives and so forth  
8       in the next workshop that we have like this. But we  
9       thought it was imperative, because there is so much  
10      ambiguity, and we're scratching our heads to think this  
11      is a tough one.

12                   We've worked in other states where one  
13      person had already come up with the answer and he knew  
14      what he wanted for the statewide HIE. Unfortunately, he  
15      didn't have a lot of respect for the stakeholders so --  
16      and so therefore -- there was no ambiguity about what he  
17      wanted. Our challenge was to help him understand there  
18      might be other people who have ideas and that's a long  
19      story that I'll tell you over a beer sometime.

20                   Here, we're just in the opposite that  
21      you're all very polite and gentle people and trying hard  
22      to listen to each other. And in the course of this it's  
23      a little like eating -- with a fork, you're trying to --  
24      well, what do they really want.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. AGRESTA: Well, why don't I make the  
2 obvious statement that a health record bank in  
3 Connecticut is probably the furthest one for us to  
4 achieve. It's really out there and far away from where  
5 we are and what's actually happening. And in some ways,  
6 it might be an easy one to rule out. How is that?

7 MR. COURTWAY: Or the easiest one to rule  
8 in.

9 MR. AGRESTA: You know, maybe --

10 MR. PETRUS: -- because nobody has got it.  
11 You're not competing with anybody. From a legal and  
12 policy it provides a lot of consumer rights and  
13 responsibilities.

14 MR. AGRESTA: But I think you -- but  
15 you've got to look at the states that it happened in and  
16 what their background is that they have -- like a Pfizer  
17 up there and others who basically had a whole host of  
18 data they just dropped in for them. We don't have that  
19 here. We're not going to have that.

20 MR. PETRUS: And there has been recent  
21 breaches into the bank too that if you read the media.

22 MR. AGRESTA: Oh, yeah.

23 MR. PETRUS: Just for the few minutes,  
24 let's go to the next, revenue and sustainability model.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 This is another one, two stage funding considerations  
2 that we think folks need to start talking about, and how  
3 you're going to go forward. Absolutely you've got to  
4 look at what are you going to do for the dollars, the  
5 matched dollars, in the cooperative agreement. You said,  
6 you're going to get a 100 percent money till the end of  
7 this year and then next year you want to draw down the  
8 other money and they're going to say, yes, you can draw  
9 it down, but you've got to show us that you got the 10  
10 percent committed. So you've got to have that 10 percent  
11 committed. So that's going to -- that's not just  
12 sustainability, that's really in the near term you've got  
13 to have it. And so there is going to be a bake sale at  
14 our next workshop.

15 And then you have the subscription fees,  
16 transaction based and performance based things to  
17 consider as you move. Pros and cons, we've started this  
18 and, again we're going to be going through more of this  
19 in the alternative analysis, but we wanted to give you  
20 some sense of -- and then the consent one, we'll move  
21 quickly to the consent. The legal working group  
22 subcommittee has proposed a hybrid model that you've  
23 discussed some of the challenges around that model.  
24 There is some other alternatives that could be considered

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 as you move forward. And we did some pros and cons on  
2 that as well. We're giving you some examples.

3 Next steps, we want your input. As we did  
4 last time, input and then that will come to us. So go  
5 through this with yourself, with your colleagues, with  
6 your committee. Give us feedback. Let us know where --  
7 if you can give us general feedback, but you would also  
8 give us feedback on specific pieces of the presentation  
9 because what happens is that the last presentation that  
10 we did and this presentation starts to distill the  
11 narrative for the strategic plan. So if you've got  
12 thoughts about elevator vision statement, got to love it.  
13 We'd love to have that. This is the story we're going to  
14 be telling to ONC in the strategic plan that you'll get  
15 to vent as well before it gets submitted. But that's  
16 what we need from you, we need those comments.

17 MS. MAINS: Is there a deadline?

18 MR. PETRUS: There is a deadline.

19 Alistair, the deadline is when?

20 MR. MCKINNON: Yesterday. The end of the  
21 Friday.

22 MR. PETRUS: How many of you are going to  
23 have committee meetings in the next week or so?

24 MS. HORN: Finance is meeting tomorrow.

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 MR. PETRUS: Tomorrow.

2 MS. BOYLE: Legal is on the 19th.

3 MR. PETRUS: Okay. Why don't we say the  
4 close of business on Monday, Alistair? The close of  
5 business Monday the --

6 MS. TOWNSHEND: -- the 10th.

7 MR. PETRUS: May 10th. So we need your  
8 confirmation on the gaps and the priorities, any thoughts  
9 that you have regarding next steps. We will be moving  
10 forward with the alternatives and the alternative  
11 analysis workshop we will go through each one of these  
12 domains. We will identify all -- we'll identify all pros  
13 and cons. And it's our goal to walk out of that workshop,  
14 and it will be the same kind of format, the three hour  
15 format --

16 MR. McKINNON: -- actually that's  
17 something to look to agree to because we're meeting on  
18 May -- the next meeting on May the 17th. Can we schedule  
19 -- it starts at -- and finishes at 2:00, so it's a  
20 regularly monthly -- we need more time. So do we make it  
21 1:00 to 3:00 again, 1:00 to 4:00?

22 MR. PETRUS: It is important that we have  
23 your time to do this. And if you have -- if we have to  
24 schedule another time than your regularly scheduled

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 meeting to do that talk with Dr. Galvin and Lynn and let  
2 us know your preferences. But typically we do this in  
3 sometimes full day workshops or half day workshops with  
4 stakeholders. We have compressed this significantly to  
5 do this.

6 MS. TOWNSHEND: Can we throw out the  
7 question at this point, did you want to do regular  
8 committee business at your regular monthly meeting or  
9 would you prefer to have that meeting on the 17th be  
10 towards the alternative analysis and make it three hours?  
11 Or do we want to look for another date for the  
12 alternative analysis?

13 COMMISSIONER GALVIN: We need to do the  
14 alternative analysis. The other stuff will --

15 MS. TOWNSHEND: -- on the 17th?

16 COMMISSIONER GALVIN: On the 17th. The  
17 other stuff will get sometime.

18 MS. TOWNSHEND: So can we -- now, I guess  
19 I'm asking for the permission of the group to expand that  
20 to 4:00, which would be an extension of one hour. So it  
21 would be 12:00 to 3:00. 12:00 to 4:00 everyone? Lisa,  
22 did you hear that?

23 MS. BOYLE: Yes.

24 MS. TOWNSHEND: Okay. I'll send out an

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 announcement.

2 MR. PETRUS: Thank you for your time, your  
3 patience, your good humor.

4 MS. TOWNSHEND: And just very quickly, the  
5 business and technical meeting for tomorrow at 5:00 will  
6 be rescheduled. The finance committee meeting will take  
7 place at 11:30 tomorrow.

8 MR. AGRESTA: We thought that we might try  
9 to do just a small core group of people.

10 MS. TOWNSHEND: A small core group of  
11 people?

12 MR. AGRESTA: Yes. We'll invite whoever  
13 is capable of coming on the phone or here, but not make  
14 it a formal meeting. But I think we need to digest what  
15 it is we need to do from this, and develop a pathway  
16 forward as opposed to sort of --

17 MS. TOWNSHEND: -- so you still need a  
18 second meeting of that full committee.

19 MR. AGRESTA: It's just there is a lot to  
20 accomplish, but we need a strategy.

21 MS. TOWNSHEND: Okay.

22 COMMISSIONER GALVIN: In the meantime,  
23 there is probably only ten big -- five or as you said,  
24 Tom, major systems that we need to talk to and

MEETING RE: DOIT/HITE  
MAY 3, 2010

1 Connecticut Hospital Association is one of them. But  
2 maybe in the meantime we should be asking these people  
3 what do you want.

4 MR. COURTWAY: So we need an executive  
5 committee meeting to try to bring the chairs of the  
6 different groups together to talk about this path  
7 forward? I mean I'm not sure that we're going -- that  
8 we're moving at a speed that's going to get us to where  
9 we need to get to. So I don't know if there is any  
10 benefits in that.

11 MS. HORN: Are you scheduling an executive  
12 meeting?

13 MS. TOWNSHEND: If that's the will of the  
14 committee then we can certainly do that.

15 MR. AGRESTA: I think you're right, but  
16 it's going to be a challenge as to when.

17 COMMISSIONER GALVIN: Are we set? Do we  
18 have any public comment? There you go. Thank you. We're  
19 adjourned.

20 (Whereupon, the meeting was adjourned at  
21 4:03 p.m.)