

VERBATIM PROCEEDINGS
DEPARTMENT OF PUBLIC HEALTH

PUBLIC FORUM REGARDING HEALTH INFORMATION TECHNOLOGY AND
EXCHANGE STRATEGIC PLAN

MEG HOOPER, CHAIRPERSON

JUNE 23, 2010

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1 . . .Verbatim Proceedings of a public forum
2 before the Department of Public Health to discuss the
3 Health Information Technology and Exchange Strategic Plan
4 held at 5:15 p.m. at the Legislative Office Building, 300
5 Capitol Avenue, Hartford, Connecticut. . .

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CHAIRPERSON MEG HOOPER: I'd like to
10 welcome you all to this public forum hosted by the
11 Connecticut Department of Public Health to discuss our
12 Health Information Technology and Exchange strategic plan.

13 It is a draft document. I'd like to go over it with you,
14 but first some formalities for this forum. This is not a
15 public hearing. We are not expecting testimony. We want
16 to encourage a discussion. If you're interested in asking
17 questions or making comments, please, join us around the
18 table and use the microphones.

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We have a brief presentation on the
overview of our strategic plan and then we will have a
presentation on one of our recommendations from our legal
committee on the consent options and what some of the pros
and cons for the various options that have been reviewed
by the legal committee.

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1 This is being taped by CTN. We do have a
2 transcriptionist, so all comments will be recorded and
3 videotaped. So that might determine who would want to come
4 forward and join us around the table.

5 I'm Meg Hooper, the planning chief for the
6 Department of Public Health. And I'm very grateful that
7 you took the time on this warm evening to join us.

8 I'd like to present to you our draft plan,
9 which is posted on our website. It is available for all
10 public review. And we are utilizing a survey monkey tool
11 for your comments. One of the reasons why we selected this
12 instead of asking you to just submit paragraphs of
13 comments, which we will also welcome, is that with survey
14 monkey we're going to be able to determine who and what
15 type of stakeholders are able to submit comments. So it's
16 something we want to make sure that we are getting
17 comments from the broad spectrum of stakeholders,
18 consumers, users, providers in health information
19 exchange.

20 Just a little bit of background from the
21 Department's perspective, in '07 the General Assembly
22 issued a mandate that DPH write a statewide health
23 information plan. We were not interested in doing this
24 alone certainly. We have a lot of our own investment into

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1 health information exchange from vital records, cancer
2 registries, immunization registries, but we understood
3 that the General Assembly was looking for a broader
4 approach. We created an Advisory Committee, voluntary,
5 and we got a number of providers, users, some legal folks.
6 And we were able to develop an RFP and that went out for
7 bid and JSI was a consultant firm that was selected to
8 write the Connecticut State Health Information Technology
9 plan, which is also posted on the DPH website. And that's
10 listed down under July 2009, where we did issue the plan.

11

12 In between that time the current
13 administration established the American Recovery and
14 Reinvestment Act, which is known as either stimulus or
15 ARRA. And within that is the High Tech Act and I think
16 that most of you are familiar, certainly, with what that
17 Act is about, but we want to stress that the High Tech Act
18 has a number of components that are still being
19 determined. There are a number of regulations that still
20 will be coming out of Washington, but it is the sign of
21 Connecticut being in a good position to begin a dialogue
22 amongst all providers.

23 In June of last year there was legislation
24 that, based on the plan, identified that the Department of

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1 Public Health would be the state's lead health information
2 agency recognizing that our responsibility included not
3 only an Advisory Committee, but, in fact, the
4 responsibility to sign off on any federal funding
5 opportunities directly as a result of ARRA. Again, in
6 July last summer we did publish the technology plan. I'm
7 sorry that I didn't bring a box of it over. It is on our
8 website and I have boxes of the printed plan in my office
9 if you're interested.

10 In October of last year we did establish
11 the Health Information Technology and Exchange Advisory
12 Committee based on the June 2009 legislation. This is an
13 Advisory Committee that includes members that are
14 appointed by legislative appointers, the Governor,
15 leadership in both the House and the Senate. In addition,
16 they are to represent constituencies including consumers,
17 physician groups, other providers, legal advisors, and
18 then also academia.

19 This year in April we -- last December,
20 actually, we had submitted an application to the ARRA. An
21 application opportunity that was hosted by the Office of
22 the National Coordinator, which is out of the United
23 States Department of Health and Human Services. The
24 Office of National Coordinator is ONC. We were successful

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1 in our application and we were awarded 7.29 million to, in
2 fact, plan and create a statewide health information
3 exchange and to be ready for the interstate collaboration,
4 connectivity with other state health information
5 exchanges.

6 In June of this year the legislature
7 discussed how would we best move forward with health
8 information exchange. The Department of Public Health, as
9 named as the state lead health information organization,
10 we recognize that we have certainly an important voice at
11 the table, but there are a number of other folks that are
12 involved and we would like to be an equal partner and not
13 sitting at the decision making power.

14 So we encouraged the legislators and we
15 were appreciative when Governor Rell signed the public act
16 that, in fact, created or creates the Connecticut Health
17 Information Technology and Exchange Authority, which will
18 be effective in January of 2011. This is a quasi-
19 governmental agency that will essentially become the lead
20 health information organization for the State of
21 Connecticut. It will not be ruled by government --
22 rulings for Human Resources, fiscal responsibility, but it
23 is quasi-governmental in that it will have an oversight
24 responsibility. Its members will include state agencies,

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1 private providers, public providers, and others that are
2 there to serve on a Board of Directors. The Board of
3 Directors will direct the authority's activities. The
4 Board of Directors is to be chaired by the Commissioner of
5 the Department of Public Health. There will be 15 members
6 on that new Board of Directors. And the new authority
7 together will be responsible for the implementation of a
8 health information exchange system throughout Connecticut.
9 The Department of Public Health will be sharing the 7.29
10 million dollars with the authority for staffing,
11 communications, and other activities. The Department of
12 Public Health is not keeping that 7.29 million all to plan
13 as we move forward.

14 As we move along in September we are
15 required to submit to the Office of National Coordination
16 our strategic and operational plan that will actually
17 outline what are our missions and our goals. But
18 specifically how will we carry them out to make sure that
19 there is a safe, secure, efficient health information
20 exchange system or combination of systems that will serve
21 our priority group, which is 3.5 million residents in the
22 state and all of our healthcare providers including public
23 health. In January, as I said, the new authority will
24 begin, will be established. The Department of Public

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1 Health, and the current Advisory Committee, and the Board
2 of Directors will be assisting in the actual
3 establishment.

4 This strategic plan, specifically why we're
5 here this evening, the strategic plan is designed to
6 identify not only what the federal agencies want and the
7 Office of National Coordinator, but what Connecticut
8 needs. It is aligned with five domains and we'll discuss
9 briefly those governances. Who is going to make sure that
10 we're doing the right job? Who is going to make sure that,
11 in fact, the public/private partnerships are going to
12 serve the needs of the community and the providers.
13 Finance, how, of course, will we be able to pay for it.
14 The actual infrastructure, business and tech operations,
15 and tonight we'll be exploring more of the legal and
16 policy issues.

17 Obviously, the strategic plan is doing
18 what's called an environmental scan. It's also known as a
19 gap analysis. What is going on in the State of
20 Connecticut? I'm very happy to announce there are up to
21 80 existing health information exchanges between
22 healthcare providers, between public health agencies and
23 private healthcare providers, within institutions, and
24 across institutions. Are they all in the same

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1 conductivity? Are they all even in Word or in Mac? Nope.
2 So one of the things we want to do is not rebuild from
3 zero, we want to take what we have and see how we can take
4 those successes and create more. The assessment has to
5 identify not only what is available and what our capacity
6 is for interaction, integration, but, of course, what are
7 the challenges.

8 Our process, both at the request and the
9 demand of the Commissioner of the Department of Public
10 Health, J. Robert Galvin, and the ONC, this is an open
11 process. DPH nor the Advisory Committee that's in place
12 now has a set design on where we're going. We need to make
13 this work for the State of Connecticut. 7.29 million
14 dollars is not something to just let sit according to one
15 or two opinions. We have an approval for 700,000 dollars
16 for planning funds. ONC will not release the rest of that
17 7.29 million if we don't submit a real, viable, signed off
18 on comprehensive plan.

19 The vision of the plan and the vision as
20 defined by the Advisory Committee, which serves to advise
21 the Commissioner is to very simply facilitate the secure
22 health information exchange system. We go on to explain
23 across the care continuum we're not looking for just
24 primary care. We're not looking for just what might happen

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1 between a community health center and an emergency
2 department. We're talking about the continuum of care
3 that, in fact, supports patient's health needs both at the
4 point of treatment and also linking for further diagnosis
5 assistance, further treatment, completing health records,
6 and, of course, making sure that the attending providers
7 are aware of everything that's going on.

8 In addition, we'll see that our other goals
9 include a more efficient healthcare system. There is so
10 much information that's out there now we'd like for the
11 healthcare system to have a break in how much money has to
12 be spent into an infrastructure of sharing both printed
13 and electronic information.

14 Let's talk about the finance. I just want
15 to go over some of the key points on the resource sheet
16 that is available. And also if you'd be interested in
17 signing in to let us know, if you haven't already, I just
18 want an idea of who is here so I can, again, get an idea
19 of the folks that are contributing to the discussion. The
20 resource sheet that we prepared includes our website and
21 where you can find the strategic plan in detail, also, the
22 link to the survey monkey for your comments. We are more
23 than happy -- my name and contact information is on the
24 resource sheet. I'm more than happy to take a comment, a

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1 phone call, a ten-page paper, your comments matter.

2 I wanted, though, to just talk about some
3 of the key points. From the finance realm the discussion
4 about value proposition we can talk about this for a while
5 and I have a feeling that this is the choir. So I don't
6 need to go into too much detail, but, in fact, the value
7 of health information technology, electronic health
8 records, electronic medical records is accepted by many.
9 We don't know that it's accepted by all and at what cost.
10 What value proposition states, it's a new -- not a new
11 term, but it's a term that's being adopted across the
12 country and used by the federal agencies that basically
13 says you have to make a product that's not only efficient,
14 desirable and affordable, but it has to be worth it to the
15 consumer. This isn't just about one group or another. So
16 we have two key considerations to make.

17 Financial management and reporting, the
18 reporting requirements about the 7.29 million dollars and
19 in the future of health information technology and
20 exchange is going to be full accountability. There is --
21 this is public funds. ARRA requires very strict reporting
22 on funding not only allocations, but also how much
23 information on who is getting what money and at what cost.

24

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1 There is also the issue with when we do
2 provide funds to the authority, the Department of Public
3 Health will contract with the Connecticut Health
4 Information Authority those funds will have to be
5 accounted for. We also strongly urge that any funds that
6 are going into financing health information exchange
7 systems will also be very -- an open and transparent
8 process with full reporting.

9 Technical, we cannot use one architecture
10 for every one of the 30 acute care hospitals, the 41 full
11 time health departments in the State of Connecticut, the
12 450 skilled nursing facilities, the 15 community health
13 centers and their 80 satellites, and let's see 8 to 10,000
14 private physicians. There is not going to be one
15 architecture, but we will look to have an enterprise
16 architecture that can be embraced by all. We will acquire
17 -- what we're looking for is a service orientated
18 architecture.

19 We will be looking to that all technology,
20 architecture, products and services will, in fact, be
21 outlined in three releases. I want to just point these
22 out again. Continuity of care documents is a term that
23 many of you already are using and certainly in the
24 Department of Public Health we use right now. It is

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1 essentially how we report aggregate information about
2 what's going on for vital records again, and some of those
3 others that I mentioned. This provides not only the base
4 line for as we move forward, but it also provides the
5 immediate reporting information from local to state to
6 federal.

7 Release II is essentially about the quality
8 of care and reporting. If you all remember the health
9 information exchange issue came up to try and improve the
10 quality of care. There were folks that were allergic to
11 certain medications and in the emergency department, if
12 they were in a state that they could not speak for
13 themselves, they were given medications that were counter
14 to their positive outcome. That was one of the earliest
15 discussions. How do I make sure that when I go to an ED
16 they're going to know that I'm allergic to penicillin.
17 The quality in the gaps in care is one of the -- is our
18 second release, is what we're calling it. We're actually
19 looking at quality reporting and that we are looking to
20 the integration of data from a variety of systems so that
21 whether or not I go to a community health center, an
22 emergency department, a surgery center, possibly even a
23 dentist, a behavioral health, and my primary care doc that
24 everyone is going to know at least what I'm allergic to

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1 and possibly what some of my diagnostic and radiologic
2 history is.

3 Release III is when we really move into the
4 personal health records where, in fact, all of my
5 information can be on an electronic record that I can
6 manage, that I can control, and that my providers that I
7 select will be able to review. In the business plan we
8 have a deployment strategy. We're going to go with an
9 incremental approach not because it's just a good idea,
10 but that really is the only way that we're going to be
11 able to do this. We want to recognize what is in place and
12 what is successful.

13 We also have a communication strategy.
14 We're going to be working with the other state agencies
15 and statewide health information exchanges that includes
16 E-Health Connecticut, Pro-Health Connecticut. There are a
17 number of hospitals that have some wonderful measures
18 under way to exchange information, electronic health
19 records. We all want to work together on a communication
20 strategy, again, going back to the value proposition that
21 this is valuable information and we all need to agree on
22 not only the purpose being for quality of care, improved
23 health outcomes, and of course the efficiency of the
24 healthcare system.

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1 Legal and policies, we're going to be
2 speaking to -- Attorney Boyle will be presenting on the
3 consent options. We do consider that the privacy and
4 security of any health information exchange is the highest
5 possible concern. As the State of Connecticut, as an
6 executive agency, along with our partners in the
7 Department of Social Services we are charged with the
8 assurance that we will not be sharing your information.
9 The privacy and security issues are being addressed by a
10 legal and policy subcommittee that, as I mentioned, will
11 be presented forthwith. The privacy and security framework
12 at the national level is certainly going to direct a lot
13 of our activities. We will tailor what is appropriate for
14 Connecticut.

15 I wanted to throw this in. It's very
16 difficult, of course, on a large slide like this, but, in
17 fact, whether you can read the words or not that is how
18 complicated as it's going to be. What I just wanted to
19 point out is on the left are essentially the state agency
20 health information system today. Around the edges are the
21 local health information exchanges in existence. We have,
22 of course, the hospitals. We have all the different
23 providers. Don't forget pharmacies, laboratories, our
24 payer system, which includes healthcare providers and

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1 payers, our consumers. What the job, we believe, for the
2 state health information exchange and the new authority
3 and its governing Board of Directors is to make sure that
4 this picture is always considered in any decision. There
5 is not going to be one decision that does not affect all
6 of the partners involved.

7 I will be happy to enter comments, but I
8 would really like to ask Attorney Boyle to do a
9 presentation. She does have another appointment that she
10 needs to get to and then we'll take all questions after.
11 If that's acceptable, thank you very much.

12 I'm sorry. I'm obviously mistaken and
13 Attorney Boyle is not present yet, but I just named the
14 woman who was at our Advisory Committee meeting the other
15 day that she now is, but she is in fact not. It was a test
16 to see if you were -- and you have passed successfully. So
17 I will humbly ask that we wait a moment for Attorney Boyle
18 and actually entertain comments and/or questions at this
19 time about the strategic plan so far from either what
20 you've seen in this presentation or what you've been able
21 to look at. What I would ask is that you use the
22 microphone at that -- the table there and press the red
23 button so that we can record your comments for not only
24 CTN, but also for the transcriptionist.

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1 Would anyone like to address any questions
2 or concerns that we are very happy to hear at this forum?
3 Well, then Marianne. Attorney Boyle is being superseded
4 by Attorney Marianne Horn, who works with the Department
5 of Public Health, who will be presenting on the consent
6 option recommendation.

7 MS. MARIANNE HORN: Okay, thank you and
8 thank you all for coming out tonight. I'm happy to stand
9 in the very worthy shoes of Lisa Boyle. And I do want to
10 thank the members of our committee, the subcommittee, who
11 have met. If I could have the next slide it has, I think,
12 the names of all the subcommittee members. As Meg
13 mentioned we have numerous people on the subcommittee. We
14 realized Lisa Boyle is the Governor's appointee to the
15 Advisory Committee. She is an attorney at Robinson and
16 Cole and specializes in health law. But we realized that
17 we needed to have more expertise at the table and these
18 are the committee members, I am one of them, who have
19 worked very long and hard to provide what is really still
20 a very high level overview of where we're headed with this
21 consent model and I'm eager to hear your feedback.

22 But I really want to thank the members of
23 the committee. I took a quick count before I came over
24 here and we have met nine times since February 2. These

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1 are volunteers donating their time to this effort. And
2 that's in addition to other full committee members or
3 committee meetings that they have attended. So they're
4 really doing tremendous work on this. And forgive me, this
5 is not my PowerPoint, but I will do my best.

6 So this is what really informed our
7 decisions and what we kept in mind as we went through
8 developing the consent model recommendation. We had no
9 particular model in mind as we started out. We identified
10 that, obviously, privacy concerns are of great concern to
11 consumers, to patients, to providers, and have kept that
12 in mind as we've developed this policy.

13 Usefulness to providers, how is this
14 information going to be of most use to providers, and
15 looking at the improvement and quality and efficiency of
16 healthcare, trying to get a system that flows and quickly,
17 in real time, gets records out to patients and to the
18 providers who need them. And finally we have to look at
19 the HIE as a business. Our Commissioner is very much out
20 there beating the drum of this is going to fail unless we
21 are able to maintain this health information exchange as a
22 business. We need to make it sustainable. We need to make
23 it useful. We need to make it so that it is -- has
24 information there that is useful to people that they will

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1 pay for.

2 We did give -- we didn't do a lot of review
3 before we started. There is some very good materials that
4 have been worked on for many years in this area and
5 actually reading some of them today as I pulled them out
6 for one of my interns I realized that there has been,
7 there has been some excellent work done here in
8 Connecticut identifying the barriers to health information
9 exchange. And very recently the Office of the National
10 Coordinator developed a white paper and went over all the
11 different models that there are. And those are contained -
12 - there is a handout that is available going through all
13 of the different models from no consent to opted out to
14 opted out with exceptions to opt in and opt in with
15 restrictions. We looked at all of these approaches. We
16 looked at approaches taken by various states and began to
17 look at the type of model that we wanted to develop.

18 We actually decided to do a model that is -
19 - we're not labeling it, opt in, opt out or anything. It's
20 -- those labels can get very confusing because there are
21 different stages in the transit of the information and I
22 think it can get confusing to people if we label it one
23 opt in or opt out.

24 In developing our consent model, again,

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1 these are some of the values and concepts that we looked
2 at that, again, we really want to improve the quality and
3 efficiency of healthcare services by providing information
4 on a real time basis. If that information is -- it's a
5 lengthy time before the doctor can access that information
6 it really may not provide the benefit to the patient who
7 is, as Meg mentioned, perhaps in the emergency room
8 needing to have that information very quickly. Then we
9 aren't improving on paper records. We really need to have
10 this information flow. We need to be able to rely on it.
11 It needs to be quality information and it needs to flow
12 efficiently.

13 So, one of the key decisions or our
14 concepts behind our model is that it should maximize the
15 amount of the information collected by the HIE. So we are
16 looking toward a model that will have information in there
17 that is going to be useful and that is not obstructed in
18 its flow.

19 And finally we looked at the existing laws
20 and -- federal and state laws, and wanted to come up with
21 a model that disrupts that system as little as possible.
22 We -- so that's really where we have gone with this is
23 that we have developed a model that follows federal and
24 state laws. It adds an HIE. This model is going to

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1 require a lot of education on all fronts. I think that
2 the move to electronic health records will require a lot
3 of education of the providers. The providers who are going
4 to be dealing with their consumers, their patients, and
5 really reassuring them that there will be privacy and
6 security processes. That the technology will make sure
7 that the information that flows is -- does so in a secure
8 manner. And I think once people understand the model that
9 they will be reassured there.

10 And I think that's the next slide. Thank
11 you. So, as I mentioned, we really look at existing -- we
12 looked at the existing confidentiality laws and under
13 HIPAA, the Health Information Portability and
14 Accountability Act, Health Insurance, I'm sorry, it allows
15 the use of and disclosure of personal or protected health
16 information for treatment, payment, and health operations
17 right now. And so we are building on that model. Specific
18 federal and state laws that require a heightened
19 confidentiality, which we call sensitive protective health
20 information, such as HIV records, alcohol and substance
21 abuse, mental health, abortion, other prior additional
22 attention.

23 So we looked at this consent model in two
24 ways. One is the collection of the protected health

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1 information into the HIE. And at this point the
2 participation in the HIE is optional for providers. There
3 are certainly a lot of incentives out there that are going
4 to encourage beyond improving patient care, but financial
5 incentives that are going to encourage providers to
6 participate in the HIE and they can't retrieve PIH from
7 the HIE unless they participate. Our model is a
8 presumptive inclusion. The protected health information
9 flows from the participating provider for all of the
10 provider's patients in the electronic health record into
11 the health information exchange with no exception.

12 The -- there is a business associate
13 agreement as there is under existing law. It will meet the
14 HIPAA requirements and this also serves as a participation
15 agreement with terms and conditions for participating in
16 the HIE.

17 And this next point here is a really key
18 point. There is a master patient index where each patient
19 will be uniquely identified and there is a patient
20 registry showing the master patient index and the
21 locations where the data is stored. These are maintained
22 on separate servers. There is no linkage of the protected
23 health information and the patient identifier in one place
24 and there has to be authentication. So, as I mentioned,

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1 even though this is a very high level presentation I think
2 that when members of our group understood that this is
3 what we were proposing they were reassured that this
4 information is going to be, even though it's all flowing
5 in, it is essentially not identifiable. And the patient
6 registries uses the master patient index to identify where
7 the personal or the protected health information is
8 located.

9 The second step is the disclosure, the
10 flowing out of the information from the health information
11 exchange. And, again, I remind you that under existing
12 law HIPAA allows the use and disclosure for treatment,
13 payment, and health care operations except for sensitive
14 protected health information or when there is a
15 restriction that has been granted and accepted by the
16 provider. And the provider transferring the health
17 information -- to the health information is responsible
18 for identifying that sensitive protected health
19 information and any restriction granted. So when it goes
20 into the health information exchange the physician has to
21 identify that there is sensitive PHI in this and that
22 before it's released it would need to have a particular
23 consent to flow out of the HIE. This will require a
24 uniform policy on restrictions to be adopted across HIE's.

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1 So our committee has a lot of work yet to go ahead of us.

2 Again, the disclosure of health information
3 from the HIE is -- it will be disclosed for treatment
4 payment and healthcare operations as permitted under HIPAA
5 unless it's sensitive protected health information, or
6 there is a restriction imposed by the patient, or the
7 patient elects not to participate in the HIE they can opt
8 out for all purposes. And then disclosure for TPO of sort
9 a generic protected health information is determined
10 according to existing state and federal laws. So we're
11 staying very close to the model that already exists. As I
12 mentioned it just -- there now is a health information
13 exchange that allows this information to flow much more
14 fluidly.

15 This was mentioned earlier that if they --
16 the patient says I don't want to have my information flow
17 out of the HIE then that is applicable for all providers.
18 There is no disclosure from the health information
19 exchange. And it is not disclosed to any party by the
20 health information exchange except if there is a
21 requirement such as there is certain public health
22 reporting requirements and then it would flow out. But
23 that is something that, again, if somebody is not
24 interested in having their records shared in this manner

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1 then they can opt out. And there was a concern that it
2 might be confusing about which election form that's signed
3 by the patient, it's the latest selection form by the
4 patient that controls, that can change it at any time.

5 As we mentioned, again, the disclosure of
6 the health information from the HIE is determined
7 according to existing federal and state laws using a
8 standard form. We're doing -- my intern, Kate Gedney here,
9 is doing wonderful work with Lisa Boyle over at Robinson,
10 Cole and they are updating the HIPAA pre-emption documents
11 looking at state laws and determining where they are more
12 stringent than HIPAA. And the sensitive protected health
13 information will be disclosed by the HIE only if proper
14 authorization is on file at the HIE.

15 This is, again, our overview. We realize
16 that there are many, many details that need to be worked
17 out, but this is the model we feel will work for
18 Connecticut. The provider elects to participate or not.
19 If they do then all of the PHI of participating providers
20 is collected and -- into the HIE. And then in terms of
21 the disclosure it is disclosed for TPO unless it's
22 sensitive PHI then you need a specific authorization or
23 consent, or if there is a restriction, or if the patient
24 has elected not to participate in the HIE. So just as with

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1 paper records this information would not then flow out of
2 the disclosure or would not be disclosed from the HIE
3 without additional consent.

4 This is a review of some of the core
5 consent options that were in other papers. And we're not
6 going to spend a lot of time on that. I mean they're very
7 interesting and so, again, we elected not to label ours
8 because I think that gets very confusing about where
9 you're opting in and where you're opting out. Presumptive
10 inclusion and then you can restrict the disclosure as
11 provided in existing law.

12 And this is a quote, I'm not quite sure
13 where it's from, from the Office of the National
14 Coordinator, "in practice there is many choices model
15 permeations as entities that participate in electronic
16 exchange, each entity regardless of scale encounters who,
17 what, why, and when decisions and results and based on its
18 own unique set of legal, cultural, political, and other
19 contextual circumstances." And I think that that is
20 definitely -- this is Connecticut's model that we are
21 recommending. We're very interested in hearing feedback on
22 it and I guess we can open it up for comments. Thank you.

23
24 And I would like to mention that our chair

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1 of the subcommittee, Lisa Boyle, has joined us and I'd be
2 happy to have her come up to the table and assist with
3 questions. Thanks.

4 CHAIRPERSON HOOPER: Thank you very much,
5 Marianne. And, okay, this is the real Lisa Boyle. Sir.

6 MR. RICH KUBICA: Hi, I'm Rich Kubica of
7 Pharmal, Hartford Hospital, and HIMS. I just look over the
8 TPO issues because with High Tech they have become more
9 stringent so the committee that reviewed the TPO for HIPAA
10 should go back and look at it in light of High Tech
11 because I know that is a tight restriction.

12 MS. LISA BOYLE: What we're doing actually
13 right now is we're doing a full blown look at all of the
14 laws related to confidentiality. We started with a
15 preemption analysis that was done when HIPAA was enacted
16 and we're bringing it totally forward.

17 MR. KUBICA: All right, good.

18 MS. BOYLE: Of state and federal.

19 MR. KUBICA: Okay. Thanks.

20 CHAIRPERSON HOOPER: Thank you, Lisa. Any
21 other questions? Oh, thank you, sir, but you're more than
22 welcome to add more comments. We'd also entertain, of
23 course, a discussion, but if there are questions or
24 comments that you would like to add for the record we

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1 would be very happy to receive them. Again, please, make
2 sure that there is -- if you have any comments at all
3 there are a variety of methods to let us know what you're
4 thinking and how you feel not only about the legal and
5 consent model, but also about the strategic plan, the
6 process, the legislation that is going to create the new
7 authority, and any other concerns you may have.

8 Would you like a recess and then come back
9 or -- no, if there are no other comments we will close the
10 forum, but I do not want to do so until everyone is
11 comfortable with that. So, we'll just sit for a minute
12 and encourage comments positive or negative. Anything
13 that would like to be submitted -- was that the gentleman
14 that was coming back? Thank you very much, Ralph. Any
15 comments, we won't call this formal testimony, we do not
16 have a bill before us, but any comments at all, please,
17 the resource sheet, again, has my contact information. You
18 do not have to use survey monkey. Any comments, concerns,
19 papers, other reports, other analysis that you'd like us
20 to refer to in any of the areas of governance, finance,
21 business, architecture, technical architecture, business
22 operations, and certainly the legal and policy issues we
23 have quite a resource library now, but we're always happy
24 to learn more.

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1 Also to let you know that we're going to be
2 sharing all this information with our other key
3 stakeholders as I'm looking at E-Health Connecticut and
4 with Pro-Health being for large parts of the state. Again,
5 we have other partners that are serving large portions of
6 the state also and, certainly, our partner agency DSS.
7 This will not be an exclusive process.

8 There being no comments, I encourage
9 everyone to have a safe ride home and enjoy air
10 conditioning. Thank you all very much for coming.

11 (Whereupon, the public forum adjourned at
12 5:55 p.m.)