VERBATIM PROCEEDINGS

DEPARTMENT OF PUBLIC HEALTH

CT HEALTH INFORMATION TECHNOLOGY AND EXCHANGE PUBLIC REVIEW OF PROPOSED HIE PLAN

MEG HOOPER, SPEAKER

AUGUST 26, 2010

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. . .Verbatim proceedings of a meeting in the matter of CT Health Information Technology and Exchange, held at the North Haven Holiday Inn, 201 Washington Avenue, North Haven, Connecticut, on August 26, 2010 at 9:05 a.m. . . .

MS. MEG HOOPER: Good morning, everyone. Thank you so very much for coming and attending this public forum. My name is Meg Hooper, and I'm Chief of Planning at the Department of Public Health.

We very much are looking forward to some comments and discussion about the Draft Health Information Technology and Exchange Plan for the State of Connecticut. We've held two forums. This is our second forum, rather. Last week was at the Legislative Office Building in the Hartford area, and we're hoping to get some of our colleagues and stakeholders in the middle and southern part of the state.

What we're presenting today is the Draft Plan that was prepared by the Department of Public Health with our contractor, Gartner, Inc., and with the advice and input and really direction from our Advisory

Committee.

The Advisory Committee and the Department are both legislatively mandated to develop this plan and to serve as the State's it's called the Regional Health Information Organization, which is essentially a central resource and/or director of some of the Health Information Exchange activities.

Come January, we're successful in our legislative approach to have a new authority established in the State, which is a quasi public. It is not going to be run by a State agency, however, there will be many State agencies as voting members on the new Board of Directors, but it will be a separate entity.

It will serve similar to our resource recovery authority and our --

MS. LYNN TOWNSHEND: CI.

MS. HOOPER: CI, which stands for?

MS. TOWNSHEND: Connecticut Innovations.

MS. HOOPER: I knew that. So it's going to serve multiple purposes, but, right now, the Federal Office of the National Coordinator under the U.S. Department of Health and Human Services has awarded stimulus funds to the State of Connecticut and the Department of Public Health to prepare and implement a

strategic plan to, in fact, improve, govern and monitor Health Information Exchange in the State of Connecticut.

Part of those funds are allocated for planning purposes, and we have contracted with the Gartner, Incorporated Company, and they're not joining us today, but they are available for consult and questions.

They have certainly done a terrific job of helping us with this plan, but the Department takes full responsibility. This is something that we're responsible to do under both State and Federal requirements.

So what we've done is created this document that has to be submitted to the Federal Office of the National Coordinator before September 27th. That's kind of the rush.

We are known for doing a planning process that can take up to a year. We had essentially four months, and we've gathered a lot of input from our Advisory Committee members that represent physicians, hospitals and certainly our community health centers, other providers, consumers and State agencies.

This is what we've done so far. In order to release the other seven million dollars available for Health Information Exchange in the State of Connecticut from stimulus funds, we need to have this plan approved by

the Federal Office of the National Coordinator, so we need to have a viable, real and accepted Health Information Technology and Exchange Plan, however, we recognize, as do the feds., as does our legislature, this is not a set in stone document. This is, in fact, a living, breathing document that's going to change.

We understand the federal and national initiatives, but the federal directives and standards are still not released for every aspect of Health Information Exchange, so we want to express that this is our document to date. This is, with your input, going to be a document submitted for federal approval and the release of additional funds, and this is the document that will serve as a baseline.

Back in 2009, the Department put together a baseline Health Information Technology Plan. This plan takes it to actually setting the strategy and implementation standards.

So Lynn Townshend is going to be doing a presentation overview of what's within the plan, if you haven't taken a look at it. If you don't have time to read 214 pages, we're going to do a brief overview. We encourage everyone to take a look at the plan.

Comments are accepted through August 27th,

and we are happy to accept comments, phone call, e-mail, fax. We're using the Survey Monkey tool, which is an on-line tool that, in fact, you can give your comments. Then it provides a wonderful service of compiling your information.

We also use Survey Monkey to make sure that we've got comments from all sectors that are involved and the stakeholders, so we encourage you to have comments today.

We have a transcriptionst, so that we're recording exactly what's said and what those comments are, so there's no misinterpretation, but, again, please submit any comments at your convenience through whatever media you choose. Again, we are closing the date on August 27th.

MS. TOWNSHEND: Tomorrow.

MS. HOOPER: That's tomorrow.

MS. TOWNSHEND: It is.

MS. HOOPER: What happened to June?

MS. TOWNSHEND: It went away.

MS. HOOPER: Tomorrow at 5:01, or 4:59.

MS. TOWNSHEND: 4:59.

MS. HOOPER: So, please, we encourage your discussion today. I'm going to turn it over to Lynn

Townshend. We believe that the restrooms are that way. They're that way?

MS. TOWNSHEND: They're that way.

MS. HOOPER: You see, don't listen to the State. Erase that from the transcript. Yes, sir?

A MALE VOICE: Are you taking questions at all?

MS. HOOPER: We will. If you'd like to ask a question now?

A MALE VOICE: As part of this process, are you --

MS. HOOPER: Absolutely. Absolutely.

COURT REPORTER: We won't be able to get him on the record.

MS. HOOPER: Correct. What we'll do is, for the transcriptionist and, also, so everyone can hear any questions, again, if it's a short question, I'm happy to repeat it for the record and then give answers, as we would know them, but any comments or questions we would ask that you come to the microphone and make those.

I would ask that, during Lynn's presentation, if you would hold your questions, but, also, if there's something urgent, please don't hesitate. Do you have any questions for me that -- do you have any

questions for me? Well, then, let's get started. Lynn?

MS. TOWNSHEND: Thank you. Thank you very much, Meg. This is definitely your meeting. This is about hearing from you your comments, your feedback, what it is that you hopefully like about this plan, and the constructive criticism that you also have of this plan.

As Meg said, when you do make your comments, if you'd be so kind as to come up to the microphone, state your name, spell your last name for the record, that would be wonderful.

My presentation is very brief, and it's really just an overview of how the plan is set up, so next slide, please?

It is set up as you see before us. It has an Executive Summary, an Introduction and Strategic Plan, the Operational Plan and the Appendices.

The original premise was that the Strategic Plan would go into ONC, we'd get it approved, the Operational Plan would go into ONC, we'd get it approved.

That proved to actually be put into one document, so this is Strategic and Operational Plan together. They'll be considered together by ONC and approved or sent back to us for changes by ONC.

Under the Executive Summary, or under the introduction, we, very clearly, outline the purpose and the audience. The audience is pretty general. We want the consumers and the stakeholders who have any part of this to be part of this very open process.

There is the outline of the Strategic Plan, which you probably had a chance to look at, as we did do a public comment period on that back in June. It changed ever so slightly. We did add in, certainly, the consent model in the Legal and Policy domain.

Then you have the Operational Plan outline and the methodologies employed by both the committee and Gartner to create this plan. Next slide?

The Strategic Plan is set up based on the five domains that ONC has given us, which I'm sure you're very familiar with, Governance, Finance, Technical Infrastructure, Business and Technical Operations and Legal and Policy.

Another emphasis of the ONC is to coordinate State and Federal programs, which absolutely makes sense, as many Federal programs, the Veteran's programs and the military, are using EMR already in some way, shape, or form.

If you can go back just momentarily, we

started off, of course, with any visions and goals and imperatives that feed into the rest of the sections. Next slide?

The Operational Plan, which was new to you probably as you were opening up this 200-some-odd page document, actually lays out what coordination we are doing or planning on doing with other programs as the Recovery Program and other State and Federal programs.

Again, goes through each of the domains that ONC has outlined for us as being extremely important to include in our plan, and then talks about the evaluation approach, which we've engaged the University of Connecticut to help us with and actually do on our behalf, to make sure that what we're doing is done well and what we can improve on in the future.

And then there is the Operational Plan Master Schedule and Risk analysis. That is on line. It is a lengthy document that tells you, in quite a bit of detail, what the steps are to get to HIE in the State of Connecticut. Next slide, please?

And this is the roadmap for the Strategic Plan. Very detailed, outlined by year, very ambitious. Next slide, please?

The plan is organized into 11 subprojects.

Each of them you will see listed here and, also, the timeline. Again, a very aggressive timeline. As Meg mentioned, this is moving along at a very quick pace. Definitely not a snail's pace. Next slide, please?

This is an overview. There are actually seven steps that we must complete before we get to the first phase of implementation, and these are the program management, which is to make sure that, overall, we have a good CEO on board, that we have bylaws and policies in place, "we" being, I'm saying it in the royal we, the quasi public agency to make certain that this moves forward in a very timely fashion and, of course, a legal and -- a legal fashion. Make sure that we are obeying the statute as it has been written.

There is the development of the authority, itself. The authority stands up finally and officially and legally on January the 1st.

DPH is working very closely within itself to make certain that the transition from DPH being the RHIO or the state-designated entity for Health Information Exchange in Connecticut moves very smoothly, or as smoothly as possible, over to that authority when the authority has the authority starting January 1st of 2011.

There is the Funds Acquisition, and that

goes directly to the issue of sustainability, and we can actually talk a little bit about that a little later on, if you desire. It's something that our Finance Subcommittee, Finance being one of the domains, has engaged Gartner additionally to look at and to have recommendations to see how we can move forward and sustain this in a very solid financial manner.

There is our Solution Architecture, and that is making sure that everything is validated and it's compatible with the standards that are out there, particularly the Federal standards.

Contracting for Systems and Services Vendors, as with anything, any new agency or entity, we need to make sure that we are getting the best value for the taxpayer dollars that are being laid out.

Standards and Adoption, Standards Adoption and Setting, this is to make sure that we are protecting the investment of these taxpayers' dollars and make sure that we're compatible with other HIE efforts both in the state and outside of the State of Connecticut.

And, as I mentioned, this is the last step. That's standing up the HIE, and that is a process, most certainly. We want to make sure does this stable HIE. We want to make sure that the providers who feed into this

HIE can be secure and know that there is a value proposition that they can buy into, so that they can make the best use of the HIE as possible on behalf of their patients.

And then we get to release one, which is the Continuity of Care document and Public Health reporting. That is about improving the continuity of care and Public Health outcomes. We, being Public Health, we like to see that within release one.

Release two is quality reporting. We want to make sure that there is a coordination of care, a quality of care, most certainly.

Release three, Public Health Records, we want to make sure that the patient knows that they had access to their records and they are truly the ones in control of their own health records.

And then there is the relationship of management to customer service. Customer service needs to be a very number one priority, right along with security and privacy. Next slide?

In conclusion, the comment period, as we said earlier, ends at 5:00 p.m. tomorrow afternoon. Anything that’s postmarked the 27th and arrives Monday, Tuesday, Wednesday, even beyond that, anything postmarked

August 27th we will accept via United States Postal Service, but I will be shutting down the Survey Monkey a little bit after 5:00 tomorrow.

We are accepting comment, written comment today. If you can get that to myself, or to Meg, or to Jill Kentfield from our Legislative Office, if you do have it, that would be wonderful, and we're also taking your oral comment very shortly.

The next steps for DPH, as I mentioned, is transitioning to the HITE, the new authority, as it is often referred to.

There are several meetings coming up, and we want to make sure you are aware of them. They are open to the public, and we do take public comment usually at the end of all of our meetings.

There's the September 20th meeting of the Advisory Committee. The Advisory Committee will sunset on December 31st, just about the same time, within minutes, I believe, that the authority will stand up, and we do have the Board that is being constituted right now that will oversee the quasi public.

There is a Legal and Policy Subcommittee meeting. If you have any questions about Legal and Policy issues, we would encourage you to visit that meeting. It

is September 8th from 8:30 to 10:00 a.m. It happens at DOIT, and there is call-in information. We do provide a call-in ability, if you so desire. If you're on the road, or prefer to take it from your office, we can get you that call-in information. It's generally the same for each of our Health Information Exchange meetings.

The Board of the Authority, different in name, it may be similarly constituted. We're still waiting for some of the nominations from the legislators. It's different than the Advisory Committee, and it will oversee the Health Information Exchange of Connecticut, the authorities that stood up in January.

We expect that first meeting to be held in mid October. The plan, links to the plan and further comments may be made at each of the links that are noted there.

At this time, I would welcome you, if you so desire, to either raise your hand with questions or comments, come to the podium, and we will do the best that we can. We'll certainly listen to them. We're here to listen and do the best that we can to answer any of those questions. Who would like to be first?

A MALE VOICE: Is the presentation available?

MS. TOWNSHEND: The presentation is available. It is the same presentation -- this presentation?

A MALE VOICE: Yes.

MS. TOWNSHEND: It's available, and it was given at the LOB. I'll post this one, as well, because it is slightly different, but it is posted on our website, which is CT.gov/DPH, and what you'll need to do is scroll down a little bit, find Health Information Exchange, and it's posted on our -- you think I would know which page it is. I've been working with these pages, but you'll find it.

And, if you need to, I'll get the e-mails from everybody, and I will follow-up and make sure that the presentation goes out to everybody today who has provided an e-mail.

A MALE VOICE: Okay.

MS. TOWNSHEND: Ma'am? Come on up.

MS. MARIE SMITH: Good morning. I see a lot of familiar faces in the room, but, for those who don't know me, I'm Marie Smith. I'm a pharmacist, and I'm at the University of Connecticut School of Pharmacy, however, I have to say I think I'm wearing three hats today when I comment, so I have to disclose all of them.

So that's my first hat. The second hat is, along with Margie Giuliano, who is the Executive Director of the Connecticut Pharmacist Association, she and I were co-PIs, Principal Investigators, on the Medicaid Transformation Grant that we just completed with DSS, and we just reported out yesterday, or two days ago, whatever, so I'm so excited I can actually say something about it in public today, and I think we have some relevant information that would be important.

And Scott, also, Scott Cleary from E-Health Connecticut, is involved in a different aspect of that same Medicaid Transformation Grant. And then, lastly, but certainly, in my mind, not least at all, is Alex Hutchinson in the back of the room and I are co-chairs for the SustiNet HIT Advisory Board, or Advisory Board, the Board's Advisory Committee, I should say, along with Megan Lynn, who are members of that committee, so I guess that tells you that Connecticut is a very small state if there's five or six of us in the room or something.

And I will submit formal comments to you, as well.

MS. HOOPER: Thank you.

MS. SMITH: But I have four points that I wanted to make as friendly, constructive suggestions,

comments, and I'll just make them in the order that they appeared to me, starting first kind of professionally in my UConn role and then going to the other role.

So the first one I've noticed is one I've noticed in many reports about HIE or HIT. It's not unique to your report at all, but it needs to be clarified as we go forward, and that is this point.

A pharmacist is a health care professional. A pharmacy is not, okay? And I think that's apparent, but it gets mixed up so often, and it will become important as I make some of my other points.

In essence, a pharmacist is a licensed health care professional in the State of Connecticut, they are considered a provider, and we have a public, social responsibility to patients' families and caregivers to assure safe medication use, appropriate, effective and safe medication use.

How does that translate to the report in the finalization of your work? First, I think I would just ask you to go through, kind of in an editorial manner, look at where you use one word, pharmacy versus pharmacist, because I think there's really some -- I'll be happy to help in any way I can, but I believe, as a stakeholder group, there's a listing of pharmacy as an

ancillary service, meaning the business and the data source for information, which is important, but there's no comment, except for one time throughout the report I see mention of the pharmacist as a person to constitute a membership on the Board, so I would just say just be careful on that.

I think both are needed, I guess is my bottom line, is both a pharmacy and a pharmacist perspective or data coming from both sources is important for a really robust HIE.

The second point is that this really relates to the work we just did for the last year and a half with the Medicaid Transformation Grant, which, for those of you who aren't as familiar, was really a piece of that grant was to look at e-prescribing and its impact on Health Information Exchange and what the pharmacist's role in that should be.

So I'll just summarize real quick, but, you know, I was very glad to see that your report really incorporated just the recent final rule or final comment on the meaningful use criteria for HIE.

One of the core set criteria for stage one, which is the one that's the first one to be implemented as of January of '11, is to have an active medication list

for patients, and this was the whole essence of what we were trying to dispel the myth about, I guess, in our work that we just completed, and that is, just by installing, or implementing, or turning the switch on for a very high-level certified EHR in the Rx system will not generate for you a comprehensive active medication list.

Our work, which I'm sure the Commissioner and other people will start to disseminate pretty widely, will I think be good evidence to show where Connecticut can take a kind of a leading role, based on our research, to know the difference and maybe to take learnings out of that and incorporate it into our work here in Connecticut.

What we found in our study, and I appreciate, I think we all in the research group, appreciated that the Camp Project it's called is mentioned in the report, so we appreciate that, what we just found was that 80 percent of the, and this was Medicaid patients, okay, but I think they were, in my mind, from a research standpoint, they are some of the most complex patients, and if we don't have it figured out for them, we certainly aren't going to figure it out for the others, okay?

What we just found in this Medicaid population was that 80 percent of the medication data from

pharmacy claims and from EHRs had discrepancies, were either incomplete or inaccurate.

Not a surprise to us at all, because the data sources are not clinical data sources that a clinician needs through an HIE to make an active clinical decision.

They are more transaction level data, okay, especially the claims data, and it depends on how robust your EHR is, whether you’ve got more than just the name of a drug, but we need a lot more clinically than the name of a drug or the dose of a drug to give us a full picture.

And I do think, you know, you have a nice description in there of value propositions, and I think, anecdotally, I can’t say I’ve done research, but, anecdotally and as a clinician, myself, whenever I needed to work with prescribers on a clinical patient care specific issue, I needed a very full set of data, and that data did not include just the name of the drug or the dose of the drug, okay?

And clinicians, I think, if you ask them, and I don’t know if this came out in any of your work, if you ask them what’s the number one thing you’d love to have, it’s the medication list. Medication list, ED summaries, discharge summaries, okay? So medication list

can be, I think, a very strong value proposition for people to use the HIE.

The third point is I think the information in the report about e-prescribing and its level of adoption is very accurate, however, sometimes, when you look at it at a very high level, it's easy to miss sort of the devil in the details, so there are three components or features or functions to a fully functional ideal e-prescribing system.

One is patient eligibility and formulary checking. Two is medication histories. That includes for multiple prescribers or multiple pharmacies, which an HIE will afford, as opposed to a standalone my docs kind of system.

And the third is electronic routing of a prescription to the pharmacy, and, unfortunately today, the one that really has only been kind of implemented in just about a third of e-prescribers in an office practice setting is they're just using it for the simple rudimentary basic level of routing the prescription.

We don't have formulary checking. In fact, I thought the Commissioner of DSS was going to have another heart attack when I told him on Tuesday that part of our project that digitized the formulary, the preferred

drug list, is digitized. It's available. It's sitting in a database to be kind of, you know, imported into your hand, however, the docs who are serving the Medicaid patients we saw didn't have it available.

Why? Because either, and I don't know all the detail, but either their vendors didn't have it available in an interface to deliver, or they hadn't upgraded to the next version, so I use the example of the cable company.

I have a TV in my house. I have cable coming in through my cable provider. If I don't upgrade to the sport's premium package, I'm not going to look at UConn football on ESPN-U, all right?

If I don't have a TV that is cable ready and I've got an old one with rabbit ears or something, I'm not going to be able to get that nice, you know, premium package, so the Commissioner was very concerned about this.

It's absolutely done. The project is done. It's sitting and waiting in databases, but it doesn't mean that everybody in Connecticut, who has an e-prescribing system, can import that PDL, so there's a lot of that, if you're in the telecom business, it's that last mile, you know, that last mile getting to the house, okay,

so, that exists today and certainly in Connecticut.

And then the last one is I guess wearing my SustiNet HIT Advisory Committee hat. Alex and I are co-chairs on that, and Lynn and Meg have been involved in all of our work to date.

In the final report that we submitted in July, which is posted, and there's a link, I put in the report a link to it on the SustiNet website, we made a number of recommendations about where we thought HIE implications needed to be considered, knowing that this group existed, but we had overlap from the composition of our committee, so there were three things I think we mentioned.

We would make sure that, as the work goes forward to finalize this report, that, whether it's DPH, or staff, or consultant, or whoever else is involved in the Advisory Committee, take a look at that, because there's so many reports floating around we don't always get to look at each other's reports, but there are some recommendations in there about composition of the Board, there are recommendations in there about financing models, so we included those, and we would just ask that they at least be considered, if they haven't been, or maybe they need to be revisited as you finalize your work. Thank you

very much.

MS. HOOPER: Thank you, Marie.

MS. TOWNSHEND: Thank you.

MS. HOOPER: Thank you very much, Marie. And I want to acknowledge both Alex and Marie in their work with the SustiNet HITE subcommittee and their role with the SustiNet Board of Directors.

I think, if you've been paying attention to what's going on with SustiNet, it is a strong body that is making some strong recommendations, and we hope that, as this moves forward, that that information is going to be included.

I believe that we did. I will verify, Marie, definitely on the financing models the Board recommendations. We can talk with the legislature and encourage that you, also, and Representative Ritter is here today.

The Board members for the Board of Directors starting January 1st, named before October 1st, are legislatively appointed. There are some State agencies named to the Board of Directors, as is the case with the current Advisory Committee.

We encourage anyone that has -- actually, we encourage everyone. If you know someone that should be

serving on the Board of Directors and you feel that strongly, contact the legislators. It's all the leadership from both sides of the aisle, Democratic and Republican leadership in both the House and the Senate, in addition to the Governor.

So I think there are opportunities, especially for recommendations, and we do hope that people that do come forward that the legislators will listen to them.

We do have, I think, three that have been appointed to date and will move forward. Thank you so much for the comment on pharmacist and pharmacy.

MS. TOWNSHEND: Good point.

MS. HOOPER: Yeah. I really appreciate that. And your point about the medication list, I love the cable analogy, because, in fact, that is what the situation is.

And I think that the reality is that we're all looking at is that that kind of an issue, the availability of an existing piece of important information, is not able to be uploaded in some of the physician's practices.

So the simplicity of that problem, now multiply that, that, in fact, we want a Health Information

Exchange of valuable data, full sets of data that is fully protected from abuse, fraud, or viewing, in fact, for over 6,000 providers in the State of Connecticut, so, again, we appreciate the complexity, and we also appreciate that as each step moves forward, we find some things to take care of.

The Department also believes in the full set of data. Obviously, we're all concerned about the privacy and security. The full set of data will assure, in our minds, a much better health outcome.

I think that those of us that have been in the field for awhile it was actually from the pharmacies, that the pharmacists were saying I can't prescribe or assure that to a customer that I'm not mixing their medications if I don't have a full set of information about their current medications.

I appreciate those comments. Marie will send those in electronically. Any other comments or questions that would like to come forward now? Mr. Mitchell, will you step forward, please?

MR. BOB MITCHELL: I'm Bob Mitchell, independent consultant these days. I just wanted to make an observation on I think it was the first diagram in the report that depicts the organizations in boxes in kind of

a balance of the, I'll say, outside of government and then the quasi pub in the center and all that kind of stuff.

The observation I would make is that I noticed you have the State HIE, whatever that is, within the diagram and within the box associated with the quasi pub.

As I would interpret that, that describes or implies that the State and its agencies would be an enterprise, as we had talked many times about that being a so-called edge system, or an edge HIE, would be incorporated within the overall statewide global infrastructure within the State, and I think that makes a lot of sense.

I hadn't seen that before, and I think that, on reflection, makes a lot of sense to me. I would suggest that perhaps in the report you describe that to the degree necessary, so that the readers of this and the observers, like me, that look for things like that would, in fact, see that right away and recognize what's going on and how this is going to fit.

The example comes to mind to me here was not only what Marie was saying, but when I started thinking about Al Gore, who we know invented the internet many years ago and has gone off to other things, he was an

1 originator of the internet, because he was involved with
2 taking the federal agencies and putting them into an open
3 forum, into the internet and presenting content throughout
4 the United States, as well as around the world.
5 In this state, we had a project, again,
6 ancient history, but I think relevant to this, was to
7 assemble all of the municipalities and bring them into the
8 fold with the state agencies, and when the state had its
9 presence known on the internet, we had taken the same kind
10 of content to approach to bring in all the state agencies,
11 bring in the municipalities and create an overall view of
12 the state and the governance and, hopefully, in many
13 cases, made it transparent for people to say, well, where
14 is that data?
15 I don’t know where that data is and the
16 system that was established to allow you to just go find
17 it without necessarily knowing that. So I think it’s
18 consistent with that theme, which we know was a workable
19 model, and the project that I was involved with went on to
20 get an award from Al Gore, which I still have and wear
21 proudly every night when I go to bed.
22 But I think it’s a good example of the HIE
23 approach that you’re taking, and I applaud that, but,
24 again, I would emphasize that perhaps you describe that a

little more, so that people can see that and understand that.

I also think, as you were describing how Public Health, with being one of the initial priorities, this will be advantageous to Public Health, also, being the first, so to speak, but certainly when DSS and other State agencies become part of this, because there are at least 14 or 15 state agencies that have a health care component within their programs.

This offers the advantages of having all that consistent and in a formatted way and delivered in a consistent way and meeting the quality standards of all the other agencies, so you don't have big discrepancies. I'll get off my platform. Thank you.

MS. TOWNSHEND: Bob, thank you.

MS. HOOPER: Thank you, Bob. I want to acknowledge Mr. Mitchell was a member of our Advisory Committee back in 2007, between those two years, again, for legislature.

The Department was charged with developing the first HIT plan, and there was no Advisory Committee in legislature, but DPH certainly recognized that we were not in this alone, and we did not have that expertise, and we invited Mr. Mitchell, so thank you very much, Bob, and we

will add that clarification.

Questions or comments from others? Yes, sir?

MR. JIM ALBERT: I'm Jim Albert. I'm currently the CIO at Charlotte Hungerford Hospital, so I'm a techie by background. I've been a CIO private sector, as well as for 20 years in the Air Force, for the last 32 years, so counting the number of gray hairs, I blame my daughters for all of that.

But, anyway, I just wanted to throw out some comments about areas and some recommendations about areas to consider. We are building out a Health Information Exchange at Charlotte Hungerford Hospital, as well. Numbers of hospitals are doing the same in their market sector. We're up in the northwest hills, pretty much the only game in town, relatively small population base, spread out somewhat rural.

Anyway, so, we're using it as, to some degree, a collection of the community, as well as, of course, I'm not totally unmercenary, but it's a marketing pitch, as well, to make life as easy as possible to do business with us, so that, essentially, we generate more activity to the hospital as a means of integrating the community, improving patient care, etcetera, so there's

kind of a yin and a yang to the HIE that's being built, and I know there's others, Danbury Hospital, Hartford Hospital is building out theirs, Yale is building out theirs, and there's a lot of different models that you could use.

The joke in the HIE business is, when you've seen one HIE, you've seen one HIE, because, unfortunately or fortunately, they all come from it at a different angle, and they all end up with a different solution set, but we're all trying to get there eventually.

So one of the things that I would say from the state HIE perspective, of course, I'm looking kind of up at the state, going what do I really need or want from a state HIE, and, frankly, you know, I don't necessarily want the State HIE to be worrying about my catch basin, but there are certain hospitals, and we've had this rolling debate at CHA, Connecticut Hospital Association, amongst the CIOs.

We meet every month, and we spend about three hours going over all of this, and I tend to Chair most of the meetings, but there is no consensus.

Some of the hospitals want to build out their own HIE with electronic medical record systems and

all of the rest, and others say we just don't have the resources, or the time, or the energy to do it, so a good half of the group is hoping that the State comes to the rescue, and the other half is saying the FEMA bus is not coming, let's not wait. Let's do our own thing, and then, you know, eventually, we'll get there.

So, unfortunately or fortunately for you, you have a wide stakeholder constituency, right, that has very wide needs. Some are screaming help me, help me, help me, and others are saying stay out of my business, so good luck with that. (Laughter)

But, anyway, so I would assume that the State would have to, of course, accept all children to the table and try to meet all of the needs, the problem being is to meet all of the needs is technologically an extremely complex puzzle.

If you look at the hospital HIE scenario, let's say Hartford Hospital, or Yale, for example, they have decided early on in their development process to standardize on one or two products and said, you know, you can have any EHR you want, as long as it's Allscripts, you know, the old Henry Ford method, right?

With Yale, it would be you could have anything you want, as long as it's epic. With Charlotte

Hungerford, you could probably have an EHR within a list that we're going to provide you, because the trick to all of this is the interfaces.

Technology is not mature. We are in a situation, where the marketplace is not at the level we need it to be, because they have not, as I joked earlier, under a free market capitalist democracy, God love us.

We have worked really hard over the last 20, 30, 40 years in technology to differentiate ourselves in the market and capture market share, not to standardize and make ourselves Lego blocks that can be easily interchanged.

So the marketplace is not built. The software is Legacy, it's relatively old in design in most cases, and for the State to say we want all children to be able to participate, that leaves you open to an awful lot of interface requirements.

And when you talk about interfaces, and I have a graph that I show, but I won't show it here, but you have to remember that every system has a send interface and a receive interface, and every system they send to must also be able to receive, translate, perform a function and send back, so there's a lot of moving parts, and, of course, each one of those has a bill attached to

it.

The vendors have rapidly discovered that this is a full-time retirement plan for them, so where you used to pay $4,000 or $5,000 for an interface, this week it's 10, next week it will be 15, and, oh, by the way, if you wait long enough, we probably won't get to you until 2013 anyway, because the vendors have run out of Indians to do this, so they're struggling.

In fact, from the hospital's perspective, we use Meditech, is our hospital information system. For me to get to meaningful use, Meditech is going to have to give us new software, the certified software, right, for electronic health records.

They are now quoting 2013 as the first available date that they could get it to you. Fortunately, we were in the cue a little earlier, and I stamped my shoe on the table loud enough that we got into the cue, but at least half of Meditech's clients will not be able to receive meaningful use certified software before the window of stimulus funding has closed.

Okay, so, Meditech and all vendors have made Sophie's choice, which children live, which children die, based on their resource allocations, so it's tough.

I don't want to go off too far into the

weeds here, but I think the State needs to make a real decision somewhere in the mix, as to what do you want to be when you grow up, or when you build up? Do you want to be bridge to connect HIEs at a local level, or do you want to be the HIE, like in Maine, for example?

You have a lot of models to choose from, and, along with that, you have to decide do you want to be, as Bob alluded to, the edge federated model, or do you want to have a repository, where you're actually collecting data?

My assumption is that the State will use the HIE as a means of collecting data. We are hoping that we can start reporting our data to the State via the HIE mechanism. Right now, it's a catch-as-catch-can. A lot of it is a PDF file on a fax, or a fax kind of a thing, so we're hoping that improves. That's one of the requirements we would add to the table.

We also want to know, of course, if one of our patients got health care, health care services from Backus in Norwich, or Hartford, or St. Francis, or ECHN, or one of those, so we're really looking for the HIE at the State level to be the bridge to connect our HIE with Charlie Covin at ECHN, so that we could find out, you know, Mrs. Smith had her hip fracture taken care of in

Manchester instead of in Torrington, those types of things.

COURT REPORTER: One moment, please.

MR. ALBERT: Anyway, it's funny, actually. You mentioned, Bob, the Al Gore thing. I worked, one of my last jobs in the Air Force was the Technology Advisor to Mr. Clinton, Bill Clinton, so I did defense planes, trains and automobiles for a couple of years to the White House when Al Gore actually said, you know, he invented the internet.

And the DARPA, the Defense Advanced Research Project Agency, worked for my office at the time, so I had to put out the press release to explain that the vice president what he really meant to say was he's a supporter of the internet, and he would love to fund us to grow it in a different direction.

I had flashback visions when you mentioned that. It was like, oh, my God. I also joke. My office was one floor above the press room where Monica Lewinski and Linda Tripp worked, so I --

MS. HOOPER: Do you want that on the transcript?

MS. TOWNSHEND: It is now.

MR. ALBERT: But, anyway, so it was kind of

an interesting time in the ‘90s, but thank you for bringing that flashback back to me.

Anyway, so, I think one of the things is you have to decide, you know, who are you going to serve and in what function, because that is all good projects, large projects especially. You start with acquirement.

Now, if you look on the federal website, there are 19 use cases that the federal government has and the industry has identified, and it includes everything from referring a patient from a specialist to a hospital, sending a summary record back from the hospital to the specialist. There’s a lab, ordering a lab, receiving a result. All of those things are all outlined.

And, if you go down that list, as I would recommend, you know, you kind of like decide we will support this one, we won’t support this one, and there’s a lot of quality measure and data repository type of things, as well.

In my mind, I think the State really functions in that capacity. There’s other things the State really does well, and that is managing centralized consents. One of the things we cannot function in the industry right now is if the consents for the patients are decentralized.

I do not know whether or not Mrs. Smith has opted in or out if she's not in my catch basin, but I would love to be able to look at the State and say all or nothing, too. It can't be I'll allow this data, but not that data. It's technologically infeasible for us to pick and choose what part of the electronic medical record is accessible to people.

It can be done, but you've now added an awful lot of cost, and you've added a lot of risk. In a project this size, you know, building the Brooklyn Bridge all over again is a matter of risk versus cost.

There's a big debate in our group, as well, as to the build or buy option, okay, and it boils down to open source, which is a build, you know, where the stuff doesn't exist, and you decide you're going to build it on the fly, versus a commercially available Health Information Exchange product suite.

I assume the State will go out with an RFP somehow or another, and they will receive inputs from the industry, and you'll receive the 25 companies, you know, sending in their -- we know pretty much all of them, because they go to every state, and they submit to every state.

The last big group was West Virginia, so

everybody is kind of coming off of the West Virginia effort, and the Carolinas had one and all that stuff.

So we have to decide, and that's a raging debate in the hospital IT world. Hartford is pushing the open source option, because that's what they chose. Others are saying there's a lot of risk to that.

Open source means you're not paying for a software license, because you've got some guy named Tony in the back room that's building it, the problem being there's a lot of risk to the fact that there's no one to support this software, other than the person who wrote it.

So rather than paying a license fee, you're actually paying more on the maintenance side. One way or another, there's no free lunch. I tend to be risk averse, and I think the State is also in the business of being somewhat risk averse.

When you're looking at a complex problem like this project, risk is a huge effort and a huge endeavor to take care of and the cost, and the State has to realize we have a problem, too.

I know we've talked about this with Scott and myself and others, Doug. What's the sustainability model? Who is going to pay for what, and how long will they pay for it, and what's the value they're going to get

out of it in the consultant world, what's the value prop, and who is going to pay for it?

So I think the State really needs to be conscious of, if you choose a certain style that you say my HIE will do all to all, be all for all, you've just exponentially increased your risk and your cost, and you need to figure out who is going to cover all of that, and do you really have the expertise to tie all components together and keep it that way?

Health Information Systems break on a routine basis, mostly based on interfaces. Whenever you touch one of the components of the interface, the whole system breaks like a house of cards, and you end up back rewriting your code and retesting every possible use case across every possible system.

The other issue you'll get into if you be all to all is how do you prioritize who gets the first sandwich, and who waits four years to get into the HIE? So I think, basically, we recommend, or I would recommend, I don't want to speak for the Health Care IT community, just for myself, but of course you have to base yourself on standards, right?

And most of the standards are done, but there's still a few. John Halamka, Dr. Halamka in Boston

is in charge of setting the standards for the industry. He's very, very good at it. I trust him implicitly, but -- so we will work ourselves around the standards as much as possible, right?

And you basically leave it open, and my recommendation is you let the vendor be responsible for insuring that they can connect to the State HIE rather than the State, but you've got a whole bunch of people that are going to be involved in the testing, and this is where you have to start worrying about whether or not DOIT or whoever is going to be responsible, Diane Lawless and crew, or whoever, do they have the resources to do this?

This is an enormously expensive proposition, interface management, and these are not the low-end people of the IT business. These are the extremely high-end people. These are the $100,000, $200,000 a year people, and when you need 50 of them, it starts to get a little pricy, and it's very risky.

So it's a challenge for the State, obviously, to come up with the stakeholder needs, right, and I know you've gone through this.

The other thing is you need to phase it. You need to figure out what you're going to do first. Are you going to go big bang, stake goes up, all functions are

supported, or are we going to do this in a phased approach?

I don't see where big bang could be possible, so it's going to have to be staged in some way or another, and maybe it starts with labs or CCD. Continuity of Care document might be a good place to start, because that helps, that covers a lot of ground on data collection, and then, of course, who is managing it and that kind of thing.

I think that's pretty much it. One of the things we're also waiting on or hoping that the State will work on for us is the whole master patient index record locator.

Now the national government, federal government is doing this, as well, NHIN Connect and NHIN Direct, and, Doug, you're on that committee, I believe, so there's some activity going on to create the master patient index scenario for the country, but I have heard over the last week that the government does not really intend to have a huge dictionary in the sky.

There isn't going to be a phone book in the sky that says Mrs. Smith's social security number, X, Y, Z, date of birth, age, sex, all of those things, is the same Mrs. Smith in Tulsa, Oklahoma, you know, all of

those, so I was hoping that would be the case, because it would make life a little simpler, but it's not, so I think somewhere in the state I would recommend that we look at creating a master patient index, so that I know that the record at Backus Hospital for Marian Smith is the same record for M. Smith at Torrington, which is the same record for Mary Smith in St. Raphael's, and probably somebody named Teresa, because there is a misspelling, in Danbury.

You have to be able to pull all that together and try to do our best, so the whole MPI record locator is a big issue I think the State needs to address. Thank you.

MS. TOWNSHEND: Thank you.

MS. HOOPER: Thank you. Okay, now I'm depressed. No. Thank you very much for all the questions. I think that what Mr. Arnold has raised for us is something that we're all aware of.

MR. DOUG ARNOLD: That wasn't Mr. Arnold.

MS. HOOPER: Oh, I'm sorry.

MS. TOWNSHEND: That's Jim Albert.

MS. HOOPER: Right. Sorry. Are you Mr. Arnold?

MR. ARNOLD: I am Mr. Arnold.

MS. HOOPER: Well, psychically, what Mr. Albert -- I'm sorry. What we're looking at really is, again, that complexity. I think, to answer some of your questions, what the State is looking at is realistically embracing the hybrid model of recognizing the various Health Information Exchanges that are in place, a phased in approach of how do we make sure that there is interface among those, that there is standards being met, how does the State and the new authority enforce those standards?

We're at a crossroads here with DPH moving out of the realm of enforcement and/or direction and being a contributor to how the new authority is going to take place. All of these issues are going to be coming up. I think that your point about the hospitals is well taken, then multiply that times the 60,000 licensed physicians, APRNs, pharmacies and pharmacists, and our health care providers, including skilled nursing facilities, acute care hospitals, specialty hospitals, substance abuse centers and the like, so it is a complex issue, and we do very much support the phased in approach.

If the legislature could come up with, I don't know, four or five million a year, then we could do with -- how about six or seven?

A FEMALE VOICE: All those numbers sound

easy.

MS. HOOPER: Don't they? Okay. We've got it on the record.

A FEMALE VOICE: That was sarcastic.

MS. HOOPER: Let's clarify that for the record, also. What we are looking at is a limited amount of funds from the feds certainly for the development of and implementation of. We are looking for that reimbursement from CMS over time to certainly be a support to the providers.

Our concern is, in fact, we could have the funds to build a Health Information Exchange system for the State of Connecticut. I don't think that there's enough money for Connecticut to be able to do that. Maine is able to, because they have a centralized health care system. Delaware has a centralized health care system.

You've just heard that we have, again, among the hospitals, of course there's not going to be consensus. Again, the vendors, the industry, the government, we have a lot of work to do, so I very much appreciate your comments, also.

Mr. Arnold, that I knew, you had your hand up?

MR. ARNOLD: Yeah. I'd just like to --

MS. HOOPER: Please.

MR. ARNOLD: I'm Doug Arnold, and I am the Executive Director of MPS, Medical Professional Services, which is a network of about 400 physicians in Connecticut, and, like other speakers here, I have to confess I also wear a number of hats.

I am a founding member of the Board of Directors of E-Health Connecticut, of which Scott is closely associated, and I think there's some other people. We're all fellow travelers in this HIT world.

I have a couple of comments about some things that have been discussed, the excellent comments that have been presented this morning so far, extremely excellent, and I also want to make sure that everybody in this room and the State is aware of some of the other federal activity, specifically, NHIN Direct, that may be able to substantially offer an early onramp for a lot of small practices into the State, which would eventually may become the State HIE and/or a quick and easy, hopefully quick and fairly easy onramp to local HIEs that are being built now.

MS. HOOPER: We are hoping so.

MR. ARNOLD: So I wanted to talk a little bit about that. A couple of things that I'm hoping that

we can see. I'm not sure if -- Lynn? Where is Lynn?

MS. TOWNSHEND: I'm right behind you.

MR. ARNOLD: Oh, here you are. No wonder. I didn't have my eyes in the back of my head on. Is the budget for Gartner Group published on the State website?

MS. HOOPER: I think it's in our budget application to the ONC, but we'd be happy to break that down.

MR. ARNOLD: All right. The other thing that I'd like to comment on is, in the plan that was put together, the draft plan, there's the timeline for when the State HIE is going to be up, like we've talked about what other people had, it's going to be beyond the time when the docs are going to be able to qualify for the meaningful use incentives.

So anybody who is trying to help physicians take advantage of those meaningful use incentives that are being offered by the feds for Medicare or Medicaid needs to have an alternative solution, even if it's a temporary one, because all the docs can have EHRs and have all the data and everything, but if they can't exchange, the whole purpose is exchange, so that's got to be -- and there are potential ways for exchange to happen, which are going to not be incredibly costly and complicated.

And I urge you, again, to echo the comments that Jim said. This is really complicated business. I can't ever get a straight number of how many docs there are in Connecticut, but 10,000, plus or minus five.

MS. HOOPER: Okay. That's good.

MR. ARNOLD: Okay? All of those physicians I can guarantee you do not have and cannot afford in this era of health plans cutting physician reimbursements their own HIT staff, so we've got to make this simpler and doable for physicians, so we can use the internet, we can use readily available applications to exchange, so I want to make a couple of comments on that NHIN Direct, if you wouldn't mind.

I am, in addition to some of the other things I said, I am participating on the NHIN Direct, a couple of committees on the NHIN Direct.

NHIN Direct is the Nationwide Health Information Network, and there are a number of layers, if you can think of it, and a lot of the National Health Information Network work has been done on the protocols for exchange of huge amounts of data, from VA, to social security, to the DOD, to big health systems, whatever, and all that is extremely important, however, none of that is going to affect hundreds of thousands of physicians who

practice in small practices, essentially small businesses in America, which is where the majority, especially the primary care, in this country is delivered.

So the ONC saw that there was a need to have some kind of a national policy basically for the rest of us, those that represent all those docs in small practice, and that's how the NHIN Direct Project came about, and it's been going on for about six months now.

The NHIN Direct is the goal is to create a set of protocols for secure exchange of information from end point to end point between health care providers, or pharmacists, or laboratories, or hospitals, or other health care providers in support of meaningful use, and, so, at the very lowest level, what can happen is basically how can we just get up from all the information that's being exchanged by fax now, take it to at least to e-mail? That's the lowest common denominator.

So if all of your doctors in Connecticut and everybody over here has a real nice EHR that their hospital paid for, or somebody else, and these guys have nothing, and these guys have, you know, some little small little brand, whatever, and nobody has got -- anything has been certified yet, because the whole certification process is up in the air, so this is Wild West health care

IT (laughter) I hope everybody appreciates that.

So the goal of NHIN Direct is to try to be able to come up with some really simple ways, where all of you that have Allscripts, or NextGen, or DocSite, or nothing, or, if you just have e-mail, can share clinical data. They're working on a lot of the privacy and security stuff, too.

So the first main goal of NHIN Direct is to enable small practices at various stages of EHR to implementation to be able to demonstrate exchange, and those are crucial core, exchanging health information or the capability of, is one of the core meaningful use criteria for section one, so that's what NHIN Direct is trying to solve.

NHIN Direct can also enable the exchange of information and the demonstration that this information be exchanged can really help the Regional Extension Center's efforts to assist providers, because, again, if you're just a small practice and you bring up an EHR, all is wonderful, but it's not, because you can't exchange anything, so we're going to give the means, the most simple means to exchange, and then, if that exchange can later on be subsumed or connected to, and I'm not a techie here, so I apologize for my lack of specificity in

terminology, but we can take advantage of the vat that's spilled by the State.

And that's one of the main, another main, well, the benefits of NHIN, is that it provides a baseline for exchange that the states can build on as they bring out HIEs.

And, so, I would urge everyone in this room and at the State to very much not view NHIN Direct as a competitor to the HIE, but as an enabler and a way to really create the low cost means for a lot of small physicians in small practices to be able to get on this, get in this game, and, if we don't do that, we're not going to -- we're going to miss the boat, because we have to remember that, I don't know what exactly the percentages are, but a high, high percentage of the physicians in Connecticut are in groups of five or less.

MS. HOOPER: Right.

MR. ARNOLD: I mean it's like 75 percent, or something like that, but it's a whole bunch of them, and that's who we need to make sure we're getting. By saying that, I work for docs, and I don't mean to minimize the importance of connecting the school health clinics and federally qualified health centers and everybody else who provides, you know, real important care, but those are

organizations.

I mean all the hospitals are -- there's only 37 hospitals in the state, and they've all got IT departments. They've got really smart guys, like Jim, working for them, you know?

I wish I had 1,000 of him to work for docs, but we don't, so we've got to make due with what we got. Okay. That's enough for me. Thank you.

MS. HOOPER: Thank you very much, Mr. Arnold, and my apologizes, Jim, but, you know, you two are so easily mixed up. (Laughter) I want to thank you very much. I think what I'm hearing is that the desire for a statewide Health Information Exchange I don't know, frankly, whether it will be one system that can be operating statewide, I think realizing that, in fact, the hospitals, many of the provider groups that are larger with 100 plus physicians.

Certainly, our community health centers have electronic health records, also. They actually received some stimulus funding to advance some of their efforts. I think that we need to embrace what does exist. How do we assure some continuity and consistency among them?

Again, depending on our work with the

legislature, with the feds, how much money will it take to build one Health Information Exchange System? I don't know if that is unrealistic.

As the Department and the Advisory Committee and our colleagues and stakeholders were seeing the need for that, and I appreciate that NHIN Direct and what's the other, NHIN Express?

MR. ARNOLD: NHIN Exchange.

MS. HOOPER: Exchange. NHIN Direct.

MS. TOWNSHEND: Direct, NHIN Connect.

MS. HOOPER: Connect. That there are, at the federal level, some efforts to try to introduce these options for others. One thing that we strongly believe, and it's in the plan, that the new authority has to address is what can be done within the State of Connecticut. We are also advocating with the feds on the unreasonableness of the time line for meaningful use requirements.

2011 is three months away, and we've already heard your own experiences, reading through the plan, reading through the newspaper.

The meaningful use requirements, just to clarify, that DPH has its current role, the new authority will have its role, and DPH will continue to be an

advocate for Public Health, our reporting information, our databases, including vital records, certainly, and next to the pharmacy information and pharmacist recommendations and documentation, we think immunization could be second, because instead of doing your little blue piece of paper every time your children go to school at the start of every year, if you had an immunization record electronically, then you could find out who has been immunized.

Possibly, when we get into the now we're facing H-3 and 2, possibly, for the influenza outbreaks, having that information, about who has been vaccinated, could be helpful.

MR. ARNOLD: Better have lab data, too.

MS. HOOPER: The thing is, with the meaningful use, as almost all of you, if not, all of you know, is really based on three requirements, lab information and certainly the continuing care and -- I'm sorry? And the medications.

And, again, as we get into the continuity of care, what are the variables that would be included in that? So I appreciate your comments very much. We do not have an easy time of it. We need to be very realistic.

Who is going to get the sandwich first? I

really like that. Are we going to go for the individual docs that need a lot more assistance, in terms of providing resources, and encouraging them that the value base proposition is, in fact, applicable?

MR. ARNOLD: But that's what the -- the State of Connecticut also got 5.7 million dollars for the Regional Extension Centers.

MS. HOOPER: Correct.

MR. ARNOLD: And, so, let's make sure that we pony up and work together. Whenever the ONC gets going, and Scott is shaking his head back there, I mean whenever we get the final budget and the document signed, we're ready to rock and roll.

MS. HOOPER: Right.

MR. ARNOLD: And, so, there should be very close collaboration, I think.

MS. HOOPER: And, right now, there is. Thank you very much. I wanted to lead to that, that with the meaningful use reimbursement, DSS is the agency managing that for the Medicaid providers. The Medicare providers are being directly reimbursed through CMS.

Within that, DSS has this word for both planning and for the implementation certainly in the not so much the pass through, but the administration of the

reimbursement rates for Medicaid.

In addition, there are three awardees under the stimulus funds. E-Health Connecticut received the 5.75, because we had the wrong number, so we're correcting that, million for the Regional Extension Center, and it's a kudos and a congratulations, because we weren't sure if Massachusetts was going to get it and have to train our docs and to work with them to meet meaningful use requirements.

E-Health Connecticut and the Regional Extension Center have the responsibility and will do a great job of training a portion of those Medicaid providers. We want to take those models and apply them across the entire spectrum of health care providers.

Right now, the responsibilities are to the Medicaid providers and a portion of them. We really need to see how this is going to stretch out to a number of the providers. There's a lot of work to be done. Yes, sir?

MR. ARNOLD: The Regional Extension Centers brought this focus on priority primary care providers, but it's not exclusively on providers that are treating Medicaid. It's all primary care providers.

MS. HOOPER: In the concept, and I believe that the goal is the 1,372?

A MALE VOICE: 1308.

MS. HOOPER: 1308, 1,308 primary care providers being the focus there.

MS. TOWNSHEND: And that's the first year.

MS. HOOPER: And that's in the first year.

MS. TOWNSHEND: First two years.

MS. HOOPER: Two years. There are a number of efforts going on, very much appreciating the coordination we currently do with DSS and with Scott and Ms. Petrillo.

Have a once-a-month meeting, if not, more frequently, on how are we combining our efforts. We are looking at the cross-coordination and responsibility for -- communications is already established with Lynn, as the DPH representative, working with Scott on the September 29th forum that's coming up, working with DSS on putting forward its efforts for the meaningful use, making sure that that information is getting out.

We're also talking about how do we combine those resources to be more effective, because we can take certain amount of monies, and, as we've seen in the past, they end up staying in a pot in a silo. How do we take advantage of this, because the amount of funds coming through are not going to be plentiful?

Are there other comments? Questions? Yes, sir? How are you?

MS. TOWNSHEND: Come on up.

MS. HOOPER: Come on up. I'm trying to think. I know who you are.

MAJOR BARRY GREEN: It's Major Barry Green, Chief Executive Officer, Libertas, in Norwalk, Connecticut. I'm here wearing a couple of different hats today, as a number of us are.

First off, my company and I have been participants in the E-Health Connecticut projects since 2007 at the request of the Lieutenant Governor. We are also involved in this NHIN Direct project here in Connecticut, and we're also bringing into Connecticut the Department of Defense's HIE and EHR system that has held, depending on which defense contractor is bragging at that moment, anywhere between three million and nine million individual patient records in a single dataset.

The reason that I bring this part up is that, for nine years, my company has done direct implementations at the small practice level. At the end of the day, we are the small practice advocate, because our bosses, so to speak, as a company are the doctors, themselves, in the small practices.

I would urge everybody here, because there are a number of stakeholders in the room, that, frankly, we stop inventing and start delivering.

What's going on right now is that, if you go into the Department of Motor Vehicles to renew your license, if they had to send somebody downstairs to the basement to pull a paper file with your driving record, you'd be furious at the amount of time and inefficiency it took, and most of us would not consider DMV the pinnacle of technological success, and, yet, relative to where we are in the health care industry, it is.

We've been bragging since I was a little kid, that we have the best and most technically proficient health care system in the world, and the fact of the matter is that the paper records still pile up around the doctors' offices, and nobody likes seeing them.

What we're approaching the NHIN Direct project with, as well as other things that our company is doing right now, is simply saying, look, there is technology that exists.

The big EHR vendors are not incented to make HIE work, because, for the next three to five years, they want market share, because then they can force any state in the country to adopt their standards, because

they have 2,000 physicians here, 5,000 physicians here using a particular product, but I don't think there's a single technical person in this room or non-technical that does not know how to send a text message or an e-mail, and that is a communicative structure that is part of our society, and, yet, the health care industry hasn't adopted it.

We're going to be looking over the next few months in the NHIN Direct project and other things that we're doing to use technology that exists, that is stable, that is well supported, that doesn't rely, Jim, on Tony in the back and just his direct knowledge of the one open source system, but simple, stable stuff, and I wanted to invite members of the Commission, DPH.

I know we're going to be acknowledged in some way in the overall State plan as one of the startup HIEs, but the other thing is I'm going to look to our leadership in the NHIN Direct to see how much information we can share as we go, and should you folks be participating in, because our goal is to get some ARRA money back into the doctors' pockets, and that can only happen, at least at the top level of the money, over the next two to three years.

So we're going to put our heads down and

concentrate on that, and then we invite the participation and the comments.

MS. HOOPER: Thank you very much, Major.

MS. TOWNSHEND: Thank you.

MS. HOOPER: Thank you very much, Major. Any other comments or questions? Again, please take advantage of -- we really are interested in not only your thoughts and concerns, but any comments that you'd like to make about Health Information Exchange, whether it's related to the plan or not, we want to take into consideration.

All comments will be reviewed and considered for inclusion in the final draft plan submitted to the Office of National Coordinator, but please know that all comments and all of the transcriptions are going to be shared certainly with the new Board of Directors and, also, with the new authority as it moves forward.

We're not done with the discussion, and your comments, whether they're included in the final plan or not, are not going to be tossed away.

MS. TOWNSHEND: And I know that the legislators, Senator Harris, had requested a copy of the comments, as well.

MS. HOOPER: Absolutely.

MS. TOWNSHEND: I just want to remind people -- I'm sorry to interrupt.

MS. HOOPER: Please.

MS. TOWNSHEND: That if you've not had an opportunity to sign in, we would love to get your e-mail address. Just two days ago, I put together an all stakeholders' e-mail address that was so large that Outlook told me I had too many, so I'm going to have two lists.

If you'd like to be added to that and get regular information about when meetings are being held, about the September 29th event, about how the Board is progressing, please make sure that you do sign in, and that sign-in sheet is out in the foyer way on the table with the lamp. Thank you.

MS. HOOPER: Thank you, all, very much for coming, and be sure to have some breakfast now, because we paid for it. (Laughter) And that's it. Thank you.

(Off the record)

MS. JAN DOMBEK: Can I speak now? Hello. My name is Jan Dombek. I live at 23 Judge Lane in Newington, Connecticut, and I have been in health care for more than 25 years, and I have worked in Medical Records/Health Information Management departments.

I've worked in a number of capacities, and, currently, I'm a director. My comments are more on the consumer and public side. I'm very, very concerned about the paradigm shift.

In my position as Director of Health Information Management, I have been obliged to protect patients' confidentiality through access authorization. Health Information Exchange highways have me concerned.

I would have many issues on how we could protect patients' confidentiality, and I am very, very concerned that there is not a really easy opt out process. Thank you for the time to make these comments, and I look forward to making more in the future.

(Whereupon, the meeting adjourned at 10:35 a.m.)

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