

VERBATIM PROCEEDINGS

HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

ADVISORY COMMITTEE

APRIL 19, 2010

DEPARTMENT OF INFORMATION AND TECHNOLOGY

101 EAST RIVER ROAD

EAST HARTFORD, CONNECTICUT

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 . . .Verbatim proceedings of the Health
2 Information Technology and Exchange Advisory Committee,
3 held April 19, 2010 at 12:03 p.m. at the Department of
4 Information and Technology, 101 East River Road, East
5 Hartford, Connecticut. . .

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9
10 COMMISSIONER J. ROBERT GALVIN: We'll get
11 the opportunity to approve the meeting our -- the minutes
12 of our last meeting so we will skip directly to item
13 three, Department of Public Health updates and Michael
14 Purcaro.

15 MR. MICHAEL PURCARO: Thank you
16 Commissioner. Good afternoon. About four months ago Dr.
17 Galvin had asked me to work with all of you and the DPH
18 HIE team to accomplish two goals. Secure ONC grant
19 funding and then leverage that grant funding to build the
20 necessary infrastructure to support a sustainable HIE
21 system in Connecticut.

22 As announced at our last meeting we have
23 secured the federal grant funding, which brings us to our
24 second goal of building the infrastructure to support this

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 grant award. Today I present to you our proposed
2 infrastructure plan within the Department of Public
3 Health. This plan is consistent with and 100 percent
4 funded at no cost to our state by our federal ONC grant
5 award. As presented, this plan will allow DPH to meet
6 critical short-term contract deliverables as well as allow
7 them with the long-term support and helpful transition to
8 the current legislative being proposed quasi-governmental
9 regional health information organization.

10 Under the direction and authority of
11 Commissioner Galvin, Ms. Lynn Townshend will be
12 coordinating our HIE activities within the Department
13 within the newly created Health Information Technology and
14 Exchange section. And this section will be strategically
15 placed under our planning branch, which is led by Ms. Meg
16 Hooper and supported in great part by Warren and Marianne
17 in our Office of Research and Development.

18 As part of this section, and as required in
19 the grant award, seven new federally funded positions will
20 be established as follows (SLIDE). As I mentioned, we
21 have the Health Information Technology and the Exchange
22 Advisory Committee. Commissioners of Planning Branch led
23 by Meg Hooper, to be held by chief coordinator, this is
24 where Lynn Townshend will be in an action capacity to

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 coordinate our state's HIE activities moving forward. We
2 have a Public Health Informatics Specialist within the
3 Department, administrative support, support in our
4 administrative branch. We have technical, our technical
5 manager in the Department of Information Technology.
6 Legal support to support Marianne in her efforts, and a
7 grant coordinator, and this position will be filled by our
8 very own Sarju Shah who is our preparatory coordinator for
9 the Commissioner's office and will be reassigned to
10 support 100 percent to this activity.

11 And then the structure our Office of
12 Research and Development Ms. Marianne Horn, Attorney
13 Marianne Horn (indiscernible).

14 Looking at if the current HIE legislation
15 passes as written, this section and it's personnel could
16 be utilized to staff the quasi-governmental RHIO, which
17 would be led by a newly appointed (indiscernible). At
18 this point I will continue to support our state's HIE
19 efforts in my role as administrative chief and as outlined
20 by the Commissioner and turn the implementation of our
21 infrastructure plan, implementation of the plan and this
22 part of the presentation over to Ms. Hooper. Meg?

23 MS. MEG HOOPER: Thank you Michael. Good
24 afternoon.

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 VOICES: Good afternoon.

2 MS. HOOPER: I'm happy to see you all. I'm
3 very optimistic about what we have ahead of us and also
4 what we have behind us. One of the things in the Planning
5 Branch that we're doing in addition to developing the
6 initial HITE plan with the assistance of Dr. Agresta, Mr.
7 Gadea, Mr. Varney, we're also looking forward to doing the
8 strategic and implementation plan. On the agenda today
9 Gartner, Inc. is going to be presenting some of the
10 highlights of the efforts to date. Many of you have been
11 contacted by Gartner for your contributions and
12 interviews.

13 I wanted to start off to say where the
14 Department is going with it's -- not only this new
15 infrastructure, but also our focus. There is not going to
16 be one HIE in the state of Connecticut, there's not going
17 to be a magical orb with lightning as in Dr. Frankenstein
18 that's all going to have all that information in there.
19 We want to recognize that right now there are
20 approximately 80 health information exchanges going on as
21 we speak. We know that today Hartford Hospital, St.
22 Francis is going live with their health information
23 exchange.

24 We know particularly from the state

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 departments within Public Health and within my branch, we
2 have an electronic death registry system that's going to
3 go online soon. We have an immunization registry. We
4 have a number of reporting mechanisms that collect
5 information at the local level, from hospitals, from
6 medical examiners, from funeral homes and we translate it
7 for not only state agencies, but then we also exchange
8 that information with federal.

9 We do not want to presume that hospitals --
10 I'm sorry, the speaker is not here, oh, I'm sorry. To let
11 you know Jamie Mooney and Warren Wollschlager are on the
12 phone. Warren is not feeling well and we'd rather he kept
13 his germs away from us. So he is on the phone and most
14 definitely involved. On his sickbed he calls in.

15 What we want to point out is that with all
16 the hospital health information exchanges Mr. Masselli is
17 doing phenomenal with the community health centers, both
18 with their practitioners and with their hospitals. The
19 Department wants to clearly recognize that we're not here
20 to create one HIE, we're here to recognize all of the
21 health information exchange systems that are in place,
22 that are operating, and look at those models. Gartner is
23 doing an excellent job of trying to put together an
24 assessment of the gaps so that we're going to have for the

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 first time an actual identification of the operating
2 health information exchanges in Connecticut, what their
3 models are, what some of their issues are, and where the
4 gaps might be for technology and architecture.

5 Our question to you and to this body is
6 really going to be not only in speaking with Gartner, but
7 at this table, what is the role of the RHIO, regardless --
8 right now DPH is the RHIO, January 2011 it might be a
9 quasi-governmental agency with people like yourselves, if
10 not yourselves on a board of directors. But right now we
11 need your advice in terms of what are the responsibilities
12 that you see for your constituency for a state RHIO. I
13 think that what we're having with our subcommittees we're
14 very pleased, particularly our Business Subcommittee is
15 just cranking and has met a number of times. We're going
16 to hear from all of our subcommittees in a moment.

17 I think that we're moving forward with what
18 has to be done, but I think what might be missing is some
19 kind of an overall goal or a direction. Can we -- what
20 I'm asking for right now is some ideas quickly if we could
21 go around the table. If you could state what your
22 constituency is and what you feel are some of the two or
23 three key issues that a state RHIO has to have as it's
24 responsibility? And I'm going to start actually with Dr.

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 Agresta.

2 COMMISSIONER GALVIN: Let me just interrupt
3 you for a second.

4 MS. HOOPER: Certainly.

5 COMMISSIONER GALVIN: Meg and Michael have
6 outlined pretty clearly what we're going to do between now
7 and the close of this calendar year and I would just like
8 to say I've got a lot of skin in this game guys, I've got
9 some of my finest people detached and working on the
10 program. Lynn Townshend has been serving as my executive
11 assistant, I no longer have an executive assistant because
12 she's full time on the program. Sarju Shah is my grants
13 administrator who's going to be basically full time, so
14 we're committed. I've committed well over \$1,000,000
15 worth of salaries per year to make this thing work. So
16 we're not just sitting around having coffee and kicking it
17 around. We've got the best people we could find,
18 including Ms. Hooper, who is our Director of Planning and
19 also takes care of all our vital statistics. So I've got
20 my A team out there. We're going to make this thing work.

21 MS. HOOPER: I think we already are.

22 Again, thank you so much for coming Peter. You've missed
23 the fun already, but what we're doing right now is --

24 COMMISSIONER GALVIN: You missed the lunch

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 too Peter. Sorry.

2 VOICE: (Indiscernible, too far from mic.)

3 MS. HOOPER: And recognizing actually --
4 I'm sorry, I should preference with there are three goals
5 that the Department is recognizing and with your
6 assistance we can meet them all. First is the Department
7 does need to have a more formal infrastructure to address
8 health information technology and exchange. Mr. Purcaro
9 has presented that in the slide.

10 We also have to meet our ONC requirements.
11 The federal ARA funds have some very specific requirements
12 that have to be met within a certain time frame so we are
13 absolutely monitoring what our requirements are. Ms.
14 Sardru Shaw is going to be our grant coordinator that's
15 actually looking to meet a lot of those deliverables. The
16 key of course is a strategic plan and the implementation
17 plan. We need to finish that during the summer if not
18 sooner and we need your assistance on that.

19 And thirdly, which is why I'd like just a
20 quick discussion today about the RHIO. What is the State
21 of Connecticut's RHIO's responsibilities? Regardless of
22 who's on it, what's in it, but we're not going to create a
23 new system. We're not going to create one HIE. We're not
24 going to create one widget and one software. How do we as

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 a RHIO, the Department of Public Health, how do we
2 actually govern, oversee, monitor, enforce? What are the
3 key activities? So I am putting you on the spot but I
4 really appreciate your input as to what do you see
5 representing your constituency and if you could state
6 such? Dr. Agresta?

7 DR. THOMAS AGRESTA: Well, I guess the
8 official constituency I'm representing is medical research
9 organizations.

10 MS. HOOPER: Okay.

11 DR. AGRESTA: But I'm also a primary care
12 clinician, so I can't take that away --

13 MS. HOOPER: Right.

14 DR. AGRESTA: -- and I will never take that
15 away of what I do.

16 MS. HOOPER: Thank you.

17 DR. AGRESTA: I think that the -- some of
18 the key things that need to happen at the state level as
19 opposed to at the level of what I'd really say are the
20 regional, you know, HIEs is that the state level needs to
21 help coordinate what happens between those regional HIEs
22 so that data can transfer and travel between them, around
23 patient care, around quality measures, around outcomes so
24 that we can actually try to improve both quality,

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 outcomes, efficiency for all providers -- for all patients
2 rather. And then we need to maintain some information
3 about that so that it's transparent to everybody that
4 we're making progress and moving forward.

5 From a representing sort of academic
6 research organizations I think one of the key things is to
7 try to allow the exchange and the infrastructure and the
8 rules around that to be developed in such a way that we
9 can actually improve care so that we can measure stuff,
10 that we can, you know, get data that is appropriate to do
11 research on in order to improve care.

12 MS. HOOPER: Thank you very much Dr.
13 Agresta. Marcia?

14 MS. MARCIA MAINS: I'm Marcia Mains, I'm
15 from the Department of Social Services. I represent the
16 Medicaid population, both of our -- both our clients and
17 our Medicaid providers throughout the state of
18 Connecticut. I think DSS's role is to assist our Medicaid
19 provider community in moving forward with implementing
20 certified EHR technology through the Medicaid Incentive
21 Program, which is something that CMS has tasked Medicaid
22 departments to do. So in doing that we would further
23 support the exchange of electronic health information,
24 better service to our clients. We have a very transient,

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 there are pockets of our population that move about a lot
2 so for providers to have access to a client's medical
3 records would be a tremendous benefit to our population.

4 MS. HOOPER: I think we're going to hear
5 this all around, but we do have one universal cause around
6 this table and that is to improve health outcomes and with
7 an efficient healthcare system.

8 MS. MAINS: Yep.

9 MS. HOOPER: Barbara?

10 MS. BARBARA PARKS-WOLF: Barbara Parks-
11 Wolf, I'm with the Office of Policy and Management. In
12 more broad brush I see the RHIO as providing the
13 overarching structure, it's the liaison between the
14 federal and the state and the local. It establishes
15 standards on which all the different projects can feed and
16 get technical assistance from. It protects the consumer.
17 You've got -- you've got assurances that there are
18 privacy, security and consumer protections in place and
19 provides the place where stakeholders are represented and
20 the best interest of the state is represented and that we
21 have a system that is sustainable and it provides the
22 basis to get a consensus about that in the state.

23 MS. HOOPER: Thank you Barbara. Mr.
24 Varney?

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. MICHEL VARNEY: Mike Varney from the
2 Connecticut Department of Information Technology. Our
3 perspective on the RHIO and our role within it our
4 constituency really are the state agencies. We're here
5 just from a technical perspective and from a procedural
6 process perspective just to make sure what is generated
7 and created as a secure, efficient, reliable standards-
8 based exchange to enable all of the things that
9 everybody's already talked about.

10 In the future if we just do those four,
11 they sound simple things, although they're not, we'll have
12 accomplished our mission.

13 MS. HOOPER: Do you see -- what do you see
14 as the state RHIO? For DOIT what's the role of a state
15 RHIO from your perspective do you think?

16 MR. VARNEY: I think that's the
17 coordination body to bring everybody together that we can
18 lend our assistance with and that creates that exchange of
19 the different constituencies and perspectives. That's
20 what we see the RHIO performing.

21 MS. HOOPER: Because sometimes the
22 healthcare industry doesn't recognize state agencies as in
23 fact viable and very important members of health
24 information exchange. Mr. Gadea?

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. JOHN GADEA: John Gadea, Director of
2 State Drug Control. Our constituency is primarily the
3 patient, the consumer, the physician, the pharmacies, the
4 hospitals, the drug companies and the wholesalers, okay?
5 That have to do with the drugs. We currently have a
6 database in the state that is operated by one individual.
7 It basically contains all controlled substance
8 prescriptions written in the state of Connecticut for the
9 past right now two years. That data is shared with every
10 physician who would like to be registered in the system
11 free of charge 24/7. They're able to review their own
12 patients for better care and monitor their patients.

13 The E.R.s are using it a lot, methadone
14 clinics are using it a lot, pain management physicians are
15 using it a lot. A lot of states view the data as a law
16 enforcement tool. Although it is we primarily have taken
17 the direction of being a healthcare tool. Dr. Galvin has
18 one of our recent brochures in front of him and what we've
19 done is we now are able to share that data with -- we've
20 had pilots where we've shared the data with two other
21 states. We currently have MOUs with a total of five
22 states and we're bringing several other states onboard.

23 The data is going through a hub system.
24 It's in place, it's functioning, and it's working quite

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 well. We plan to bring on other states onto it and we
2 plan to further expend some of our assets into educating
3 the primary -- the physicians and the pharmacists involved
4 as well as the public.

5 MS. HOOPER: And your view of a state RHIO,
6 responsibility is key?

7 MR. GADEA: Pretty much to coordinate what
8 the private sector can do. I don't -- from our experience
9 and the experience of other states the private sector
10 seems to run this type of system, run it better than the
11 states do. That's not to say there's not a position in
12 the whole process for the state. Primarily the state's
13 position is to protect the data and to protect the public.

14 Once that has basically been laid as the ground rules
15 then pretty much the private sector is a lot more
16 efficient we found in implementing and operating these
17 systems. But they do need to be coordinated at some
18 level.

19 MS. HOOPER: Okay. And just an aside,
20 there was just an announcement. Criminal Justice received
21 HIT awards in the state of Connecticut. So I was going to
22 send you the link to that so that possibly there might be
23 some stimulus funds that could also support that
24 initiative.

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MS. GADEA: Great. Thank you.

2 MS. HOOPER: Hi Peter.

3 PETER COURTWAY: Hi Meg.

4 MS. HOOPER: How are you?

5 MR. COURTWAY: I'm doing well, thank you.

6 MS. HOOPER: From the hospital's -- I'm
7 sorry, your constituency in the RHIO priorities?

8 MR. COURTWAY: My constituency are the
9 hospitals, the in-house systems and other health
10 information exchanges in the state and I guess the basic
11 tenant is that the hospitals view themselves as the
12 locusts of local health information exchange efforts. You
13 know, there's a number of initiatives that are up and
14 running and the belief is that healthcare is mostly a
15 local phenomena, so that there is a strong desire to help
16 coordinate that from a hospital perspective.

17 What hasn't been tested is whether or not
18 all can truly afford to play at that level. The state of
19 the hospitals' finances range wildly in this state, as I'm
20 sure everybody knows, so one of the questions that came up
21 was whether or not the state HIE would be the HIE of last
22 resort I think is how Alistair put it at one point. You
23 know, that others could participate directly at the state
24 level without participating at the regional level.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 There is a desire to have a switch from the
2 region to the state to the national. Whether or not that
3 technically is -- actually comes out that could be a role
4 for it. But I think that there are some things that are
5 in agreement. One of them is from the state HIE
6 perspective it's really rationalizing and coordinating
7 consents and the regulations that govern them. Today in
8 the state of Connecticut everybody has a unique consent,
9 even among the HIEs, there needs to be some
10 rationalization that data should be equally coordinated at
11 the state level to make it easier for all to play, you
12 know, in a compliant manner.

13 The question of whether or not the state
14 HIE should be the master patient index, you know, for them
15 or whether or not just use some other technologies for it.

16 But that is perhaps more of an outcome of some of the
17 other outcomes and technical issues that are there.

18 I think fundamentally what we've talked
19 about was there is a desire to improve public health.
20 Whether or not that's used at the state HIE for bio-
21 surveillance or broader outcomes measurement as well as
22 cost reduction for submission to all state agencies.
23 Today there's, you know, there's different registries,
24 there's different ways of submitting it so some

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 rationalization and bringing that through the state HIE.

2 And then lastly, what we had talked about
3 last week at the Connecticut Hospital Association Chief
4 Information Officer meeting was the question of how the
5 HIE should be employed to reduce state costs, whether or
6 not it's in that data collection and rationalizing the
7 data collection between state agencies or the cost of care
8 for state employees, Medicaid and other covered
9 populations that may be actually at the state that would
10 benefit from an HIE similar to how a region or accountable
11 care organization would benefit from an HIE.

12 MS. HOOPER: So you see that a RHIO and
13 whatever agencies is designed -- designated as a statewide
14 RHIO to be more operational than what I've heard
15 previously?

16 MR. COURTWAY: We believe that there is
17 some operations aspects to this for the state's interests.

18 MS. HOOPER: Understood. Yes.

19 MR. COURTWAY: If the state's interest is
20 to improve the population's health --

21 MS. HOOPER: Understood.

22 MR. COURTWAY: -- their wellbeing that is a
23 piece. And certainly I think we all, you know, both state
24 and, you know, consumer in this state you don't want to

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 create -- anything we do to reduce costs through the
2 coordination of care would be there. And I'm not sure
3 with the different efforts that take place and different
4 state agencies that -- what coordination could be
5 fostered, you know, between DSS, DPH, you know, wherever
6 you're getting your self-insurance arms and the other
7 components that would benefit.

8 MS. HOOPER: Great. Old friend, welcome to
9 the team. Introduce yourself.

10 MR. SCOTT WOLF: Thank you very much. Yes,
11 my name is Scott Wolf. I'm the Senior Medical Director at
12 Aetna and I'm here representing Mike Hudson and his
13 constituency is the group and large employers. I've had
14 the opportunity to reach out to several representatives in
15 preparation for today and I won't repeat, but several of
16 the interests that have already been expressed have been
17 discussed as far as the state being a facilitator and a
18 coordinator. So differences and nuances that I think were
19 also expressed is one, they'd like to see the state use
20 this as an opportunity to bring the best and the brightest
21 of folks in this marketplace to the state for new job
22 opportunities. They feel that this is an area that's
23 innovative, that's, you know, that the healthcare sector
24 is a major driver of the economy in the state of

POST REPORTING SERVICE
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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 Connecticut and they want to see -- they would like to see
2 this as an opportunity to attract, you know, some of the
3 best in the market to come here and eventually be used as
4 a benchmark.

5 They also spoke highly and critically of
6 the importance of the state with regards to privacy and
7 security. Not so much as the employees as consumers, but
8 employees in the relationship to their employers and how
9 that information can be used.

10 From the payer prospective, just to add a
11 comment about also the need to bring the other payers in
12 the state to a forum like this. There's an interest in
13 having the state leverage some of the learnings that are
14 going on in our neighboring states, Massachusetts, New
15 Hampshire, Vermont, Maine in particular, where many of
16 these initiatives are taking place and have done so,
17 specially in Maine very successfully. So there's an
18 interest on behalf of the large employers to have the
19 state reach out to some of our neighbors, leverage some of
20 their learnings to maybe expedite this process. I'll stop
21 there.

22 COMMISSIONER GALVIN: Let me add on to your
23 comments. It's really good to see you again after a
24 number of years --

POST REPORTING SERVICE
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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. WOLF: Thank you.

2 COMMISSIONER GALVIN: -- but I think you
3 said two things that are very important and the second one
4 first is that everybody in every state are doing
5 experiments in developing networks and trying things so we
6 don't have to sit here in isolation and decide how we're
7 going to make something that goes on the axle of a cart
8 that makes it move forward that's sort of circular and has
9 spokes because we can find a lot of information. It
10 usually moves west to east and usually in southern New
11 England we're sometimes the last to innovate but there's a
12 lot out there. There's no sense in us, you know,
13 designing something that's already been designed and
14 worked partially or worked well.

15 But I think that your other remark, which
16 was very potent, is I'm listening to a lot of people who
17 are running for chief executive in Connecticut and every
18 single one of them is concerned about jobs and putting as
19 it's said over and over again, a laser focus on jobs and I
20 think you got it right, that we need to focus on technical
21 jobs. We need to regard medicine, the practice of
22 medicine and the support of medicine by electronic medical
23 means as an instrument, not as a financial sinkhole, but
24 as an opportunity to create jobs and the kind of jobs that

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 are persistent. I hear a lot of talk about, well, if we
2 could get some more heavy manufacturing or another
3 submarine or two, but you know, we're sort of at the end
4 of that cycle and it's very expensive in New England to do
5 heavy manufacturing and other states have got the -- as
6 they say in the westerns, they got the bulge on us in
7 terms of labor costs and energy cost. But that's very
8 potent. There are a lot of jobs to be created, a whole --
9 there's a whole industry to be created here. But thank
10 you for your input.

11 MR. WOLF: I appreciate it.

12 MS. HOOPER: And again on that, it really
13 is a unique opportunity to be together to have this much
14 processed to date and to have the stimulus funds
15 available. Congratulations to Dr. Agresta and E-Health
16 (phonetic) for getting the award for Regional Extension
17 Centers, which is in fact about training the docs to be
18 able to use -- for meaningful use of electronic health
19 records. So again, we've got a lot of awardees that have
20 an opportunity to spend some money right now. Mr.
21 Carmody, do you have any money for us to spend right now?

22 MR. DANIEL CARMODY: That's a good
23 question. No, I'll answer your first question, which
24 talks about the -- what do we see. I represent sort of

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 large employers just like the Aetna constituents. But I
2 think that when you look at an HIE from a state
3 perspective you're given an opportunity to be an enabler.

4 I mean, so there's a lot of gray space that comes in when
5 you're trying to coordinate a lot of these efforts.

6 So it's an opportunity to look at what
7 takes place in that gray space. We talked about, you
8 know, master patient index or master provider index. I
9 mean, those are places that an HIE when you look at what's
10 it going to take to sort of enable the infrastructure the
11 state could play a role on.

12 Just like when you look at transportation,
13 I mean, you know, the federal government has set sort of
14 standards as to what this should be, how it should be
15 built, then you have the state actually responsible for
16 building out the infrastructure. I think an HIE could
17 play in that realm. Obviously there's a wide spectrum
18 there of what we want it to be, but I would probably try
19 to keep it as -- as we start to do some of the visioning
20 exercises I think part of what we want to attempt to
21 accomplish is some of that quick wins that I think we've
22 talked about before, or at least that's communicated from
23 the finance perspective is that at some point in time when
24 we talk about wanting to have folks pay for it we're going

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 to need to make sure that it's successful. And if you try
2 to boil the ocean you're not going to get there quickly.
3 So if we can keep a focused effort initially as we start
4 off and then look to sort of build on that I think that
5 that's something that could be very useful.

6 And even as we -- again, when we start
7 talking about the financing aspect of it I think that
8 there is probably a base, you know, amount that we talked
9 about in committee where it's sort of a right that
10 everybody has to pay on some type of prorated benefit and
11 then there's a transactional fee. You know, that commerce
12 then moves on that or information moves on and as you tap
13 into that in order to generate it you can look to try to
14 have a two-tiered type of financing system.

15 There's a lot of ways to approach it, but I
16 think the state really could play an enabler to bringing
17 the constituents together, talking about what sort of are
18 common information assets. Of course that puts privacy
19 and security over them. That to enable that what we think
20 is a staged road to success or staged implementation of
21 this HIE.

22 MS. HOOPER: Thank you very much because I
23 think that -- pardon me. What we're hoping to do is to in
24 fact get that focus today and as we're going to hear from

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 Gartner in a bit for the strategic and implementation plan
2 we can go as broad as the issues that are presented in all
3 of our discussions with our constituencies. But if we can
4 focus then we're going to have an opportunity to actually
5 accomplish some of those tasks and not look to boil the
6 ocean.

7 MR. CARMODY: The only thing I would add is
8 I think you have an opportunity to also do something
9 around -- it's going to be reporting, reporting out the
10 benefits with quality reporting as well as the benefits
11 because they're going back to our, you know, as the Chair
12 of the Finance Committee if you're going to ask people to
13 pay for it, whether it be, you know, the state in any sort
14 of way, whether it be large health plans or ASO customers,
15 the administrative customers, and/or the taxpayers,
16 everybody is going to want to know how were you
17 successful. So set the benchmark of what you want to
18 accomplish, measure yourself against it and then create
19 those small wins and then build off of those small wins.

20 MS. HOOPER: That's Planning 101. Thank
21 you sir. Mark?

22 MR. MARK MASSELLI: A lovely illusion to
23 boiling the ocean. Unless you're a volcano in Iceland --

24 (Laughter)

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. MASSELLI: -- Mark Masselli
2 representing federally qualified health centers, low
3 income people in special populations. Really see it as an
4 opportunity to equalize access to timely quality data for
5 all regardless of income and/or lack of health insurance.
6 So it's really staying along with that focus of the
7 population we serve. You know, it sort of has -- John
8 referred an ability to democratize this sort of process in
9 many ways sort of resetting the bar if you will and while
10 the hospitals don't have all the money in the world they
11 certainly have more than most in thinking about it from
12 the world of community centers and the like so we have an
13 opportunity there.

14 You know, we've been asking ourselves
15 increasingly about access and I think now we've sort of
16 shifted along the line and said, access to what? So --
17 and so Tom talked about it first, one of the things access
18 to what is certainly to improve patient outcome. But also
19 say that it's an opportunity to sort of think about the
20 sort of reform and refinement in healthcare practices. So
21 again, trying to use it as a vehicle to leverage some of
22 (indiscernible, background noise).

23 MS. HOOPER: And speaking of reform and
24 refinement, Commissioner, you tried to leave before we got

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 started on the roundtable, but now you're back. So I'm
2 sorry, but we're going to ask you. Commissioner Vogel,
3 what are your opinions about the state RHIO and the
4 constituency that you serve?

5 MS. CHRISTINE VOGEL: Well, I ran out of
6 the room to do some reforming. You know, I do have to ask
7 this question I guess to the Department of Public Health,
8 because originally I was seated on this Board representing
9 OPO (phonetic), which really represents access and I have
10 always just assumed that would still be what I'm
11 representing is access. So -- and typically it's access
12 to -- for the consumer but also for the constituent, so I
13 think I've probably broadened my constituent, but I don't
14 know if anybody in the room while I was out of the room
15 talked about one other area and that's OPO receives an
16 awful lot of requests for research data the people who do
17 research around the country and have a need for data.
18 Under Freedom of Information OPO tries to get that data
19 with what we have so I -- I'm still hopeful that the RHIO,
20 however the RHIO is formed within the state still allows
21 research of public health initiatives and -- many other
22 states have data that is much different and organized
23 probably better than Connecticut. Even when we get a
24 request from the Federal Trade Commission for anti-trust

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 issues, you know, they look for data and we're it in a
2 limited way. So, you know, I'd like to just try to add to
3 a constituent base, which would be researchers in order to
4 have access to the different public health data.

5 MS. HOOPER: And so -- Lieutenant Governor,
6 thank you so much for coming. If you don't mind I'm going
7 to put you on the spot in a minute.

8 (Discussion off the record.)

9 (Laughter)

10 MS. HOOPER: Let me ask a different
11 question. Anyway, so what we're doing is in trying to
12 establish just some focus for everybody's efforts our
13 subcommittees have been meeting and Gartner is preparing
14 us with our assessment, gap assessment and in moving
15 forward with our strategic and operational plans. We
16 thought today if we could hear some of the key comments
17 that needs -- the state needs for operating a statewide
18 RHIO what are some of those key points. And I'm so
19 pleased to have this opportunity and I hope it was helpful
20 to our Gartner colleague just to get from the folks here
21 which is now is a quorum, thank you so much sir, so we'll
22 get to the minutes in a minute, what we're trying to do is
23 to determine what are some of the key points. And I'm
24 hearing coordination, privacy, security, some assurance

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 functions from the government side, a model, information
2 sharing for research and improved health outcomes. I'm
3 also hearing operational from the sense of providing
4 actual health information. The master patient index or
5 master provider index showing some quality and cost
6 advantages to this kind of a system.

7 I love the word, democratize, as far as
8 equity for, how are we going to have this going through
9 the state? The \$7,000,000 received by the Department of
10 Public Health is not for those seven staff by the way.
11 More than -- oh, it is? Oh, great. Okay. So we'll all
12 call you, you know, later. Thanks so much and the
13 meeting's adjourned.

14 But those funds -- more than half of those
15 funds are going to be allocated out through either this
16 Board or a new board of directors, but the Department will
17 be allocating funds for actual implementation of HIEs
18 throughout the state. So one of the things that we do
19 need to focus on is -- will be the criteria for the
20 selection of how projects will be funded.

21 So Lieutenant Governor, what we're doing is
22 asking each of the folks around the table, each of the
23 members of the committee, their constituency and what do
24 you see as some of the key responsibilities of a statewide

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 RHIO?

2 MR. MICHAEL FEDELE: Well, I think you've
3 hit upon a bunch of them, you know, the areas that I think
4 are important, I mean, obviously the cost of funding is
5 always of concern to us, particularly in these times and
6 unfortunately I wish could say I see times changing
7 quickly, but so I think that's very important. I think
8 you've hit on the key confidentiality of use, the ability
9 to participate, you know, the question becomes does it
10 become mandatory or is it selective? You know, because I
11 think that's going to be a key component of it because as
12 we know there are times where if we make things -- not
13 that I'm looking to mandate anything, but I think there
14 are times particularly in this area I think the only way
15 it's going to work if we're envisioning the whole thing is
16 everyone has to be part of it, right?

17 So and I think that's where cost and
18 complexity and things like -- I have the same challenge,
19 it's kind of interesting, on the criminal justice
20 information system, right? That's another project that
21 I'm working on and, you know, challenges I have there is
22 not with the state agencies per se on the criminal justice
23 side, but with respect to the municipalities and police
24 departments who already in some cases have record

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 management systems and some are federal standard compliant
2 to interface to a data warehouse cloud world and some
3 aren't. And so the question from the law enforcement
4 community, particularly at the municipal level is, you
5 know, do we participate, you know, why should we
6 participate when we don't have the money to basically
7 throw out what we believe works for us and what incentive
8 do we have in getting to this?

9 So, you know, when I think of costs I'm not
10 just looking at the dollar and cents, you know, costs as,
11 you know, how do you get folks who may have made an
12 investment in a system that works for them and they're
13 very happy with it and may not plug easily into a RHIO or
14 something like that? And then the question is if we make
15 it mandatory how do you address that component and
16 particularly in the case of, I guess the criminal justice
17 side is a little bit different because, you know we do do
18 some municipal grants and things like that, but how do you
19 do it to say a hospital or healthcare facility or clinic
20 or something like that?

21 So, you know, I think that's very important
22 for the success. And all of the other points I think
23 you've laid out, obviously privacy, very, very, very key
24 to it and obviously ease of being able to plug in to

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 implement and to use into the system also.

2 MS. HOOPER: Thank you very much sir. Of
3 course we have our federal standards and expectations for
4 what a RHIO is, we have the Legislative requirements for
5 what a RHIO is, but we wanted to get a focus of where
6 we're coming with this. Do we have a quorum Madam
7 Attorney?

8 MS. MARIANNE HORN: We do but I'm also
9 Madam Chairman representing the Legal and Policy
10 Subcommittee today. So if I could say a few words on Lisa
11 Boyle's (phonetic) --

12 MS. HOOPER: Oh, on her behalf under the
13 state RHIO?

14 MS. HORN: -- are you going to get to that?

15 MS. HOOPER: We are going to do
16 subcommittee reports.

17 MS. HORN: Okay. Okay.

18 MS. HOOPER: But if -- do you think that
19 Lisa Boyle has expressed to you some comments on a state
20 RHIO and it's key responsibilities?

21 MS. HORN: Well, there is some overlap. If
22 I could just say a word or two?

23 MS. HOOPER: Please.

24 COMMISSIONER GALVIN: Why don't you -- why

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 don't you just -- Marianne, why don't you just give your
2 report? I would just like to add on to what Governor
3 Fedele said, and in a little bit different venue. As we
4 develop this whole process, and Tom Agresta has said this,
5 as have others, we have to find some way of making this
6 process and signing up for it and getting the equipment
7 palatable for smaller offices. We've all had people talk
8 to us, a guy -- a very nice young man talked to me from
9 New Hartford and he was saying he's the physician, he has
10 two APRNs and talking about an eight or a \$9,000 or
11 \$10,000 item is very frightening to him and as we develop
12 the whole process I think -- I think he's the kind of --
13 has got to be -- at some stage we're going to be -- we're
14 going to have thousands of people, most of our doctors in
15 Connecticut are onesies and twosies and there are some big
16 groups, but you're going to have an awful lot of one and
17 two, you know, Tom and I in a practice figuring out how
18 are we going to do this? How are we going to get the
19 right gears? Who's going to replace the software and
20 who's going to service it?

21 And I don't have a magic solution for that.

22 I know that you can -- if it costs Tom and I ten grand to
23 set it up we'd get ten grand worth of depreciation spread
24 over how many years, one, three, five, whatever you want

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 to do. But that's really not enough. There's got to be
2 some other ways of group buying or getting a way to do it
3 otherwise we're going to have a lot of people just unable
4 to get into the system. And if you make it mandatory I'm
5 not sure what people are going to do and Tom and I have
6 heard the stories, I'll just leave practice. I'll go do
7 something else, etcetera. Which is very regretful as I've
8 said before.

9 However, the worst part of that is if Tom
10 and I -- and Tom's younger -- a whole generation younger
11 than I am but if we sit there one day and say, you know,
12 Tom, this isn't worth it anymore, and we leave and then
13 Tom goes, oh God, you know, Agresta and Galvin just left,
14 what are we going to do? And they -- so they get Smith
15 and Jones come out there and they come out and they look
16 at the practice and they say, where is the electronic
17 medical records? They say, well, Agresta and Galvin
18 didn't want to do it. And you won't attract the new
19 people because -- you won't find Agresta's and new people
20 like this coming out of sophisticated training programs
21 because if you come out of a sophisticated -- the guy we
22 want comes out of a sophisticated program and then goes
23 back into a three by five file card mentality and just --
24 it's going to kill you. You're going to lose guys going

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 out and you're going to lose again because people won't
2 come back in. And with that we can get to Marianne's
3 report.

4 MS. HOOPER: Actually Marianne, would you
5 be offended? I didn't want to ignore Ms. Mooney, as our
6 consumer advocate I didn't want to forget that you're on
7 the phone. For those that just came in late, Jamie Mooney
8 and Warren Wollschlager are on the phone. Ms. Mooney, did
9 you have some comments about how our state RHIO should
10 operate from your perspective?

11 MS. JAMIE MOONEY: I do and yes, although
12 I'm a hospital CIO I am representing the Office of the
13 Healthcare Advocate and that's really the consumer's
14 patients. And just to layer onto what others have said I
15 see the state RHIO as basically the structure that links
16 all the regional RHIOs together that we've discussed,
17 local RHIOs, and it's role is really to facilitate the
18 exchange of clinical information for better coordination
19 care not only within the state but also the borders. You
20 know, we have Massachusetts one way and New York the other
21 way. Patients do go those directions.

22 I think privacy from the patient
23 perspective is very important, but not to the detriment of
24 appropriate healthcare. So I think that consumers have to

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 be educated about this very complex sort of an issue in a
2 very simple easy to understand manner and then also a
3 very, very huge proponent of opt out. So we have a
4 critical mass and clinical data no matter where the
5 exchange is so clinicians can make informed judgements
6 knowing that what they need is available.

7 MS. HOOPER: Thank you so much Ms. Mooney.
8 Shall we -- and now actually Marianne speaking on behalf
9 of herself and Susan Boyle.

10 MS. HORN: Lisa Boyle. I think Susan is
11 the singer.

12 MS. HOOPER: Yeah, that's right.

13 VOICE: Yes, she is. What does she think
14 of our RHIO?

15 (Laughter)

16 MS. HORN: Yes, Lisa is very sorry she
17 couldn't be here today. And I do want to point out that
18 on her constituency she is an attorney with a background
19 in the field of privacy health data security and patient
20 rights and the subcommittee has attorneys, both from the
21 private sector and the public sector. We've just been
22 joined by an attorney from the Department of Social
23 Services and we have also a consumer advocate, Kenneth
24 Dardy, who joins our subcommittee and Jamie Mooney as

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 well has participated.

2 So those are -- but definitely our
3 constituency is wide and in terms of general themes I'll
4 get more into the specifics of what our subcommittee has
5 been doing, but the HIE should play a meaningful role in
6 terms of prioritizing the uses of the HIE and prioritizing
7 those uses of data. We've heard some other people talking
8 about having a phased in approach and I think you can't do
9 it all at once and certainly patient care and services,
10 public health, quality reporting are very key use cases
11 that we have talked about in the legal subcommittee.

12 In the legal and policy rule on the HIE is
13 standardizing policies and practices with regard to
14 security and privacy. The informed consent piece is going
15 to be very important I think to have some uniformity
16 throughout the state however we decide to go, whether it's
17 opt in, opt out or some hybrid. And just echoing what
18 Jamie Mooney was saying, education is going to play -- the
19 HIE is going to have to play a big role in terms of
20 bringing people into the system regardless of what kind of
21 a model is selected.

22 And I would just like to also -- I -- and
23 another role at the Department I chair, the Human
24 Investigations Committee, and we have requests for our

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 public health data coming in all the time and it's going
2 to be a real challenge I think trying to establish a way
3 of allowing access to that and ensuring that all of the
4 requirements for privacy are met. That's a big goal for
5 the HIE.

6 MS. HOOPER: It certainly is. I think the
7 IRBs, I don't know about all of your institutions and
8 agencies, but our IRB protocols and training is, you know,
9 a manual of about 1,800 pages. I want to thank you all
10 very much. This was very helpful for all of us. I hope
11 that you all gained something from hearing from your
12 colleagues and I hope that Gartner this will assist you.
13 Sir, would you like to do the minutes while we have a
14 quorum or shall we move onto subcommittee reports? What
15 would you prefer?

16 COMMISSIONER GALVIN: Let's move onto
17 subcommittee reports. We can probably -- we can probably
18 do the minutes after that.

19 MS. HOOPER: We may not have a quorum for
20 very long.

21 COMMISSIONER GALVIN: We do.

22 MS. HORN: We do now.

23 MS. HOOPER: We do, but we may not have one
24 for very long.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 COMMISSIONER GALVIN: Alright. Then let's
2 go ahead and I will entertain a motion to accept the
3 minutes from our last meeting, which was March 15th of
4 this year. Do I have a motion?

5 VOICE: So moved.

6 COMMISSIONER GALVIN: And a second?

7 VOICE: Second.

8 COMMISSIONER GALVIN: Very good. Are there
9 any discussion about those minutes?

10 MS. PARKS-WOLF: Just a small issue. I was
11 here at the last meeting, but it doesn't reflect that in
12 the minutes, Barbara Parks-Wolf.

13 COMMISSIONER GALVIN: Okay. Would you add
14 Barbara's name to the minutes of the 15th of March?

15 MS. HOOPER: Of course. And our apologies.
16 Any other comments?

17 COMMISSIONER GALVIN: Okay. If not, all in
18 favor of accepting the minutes from the 3/15 meeting
19 indicate by saying aye?

20 VOICES: Aye.

21 COMMISSIONER GALVIN: Opposed? Okay.
22 Minutes are accepted. Now we'll move onto the next items.

23 MS. HOOPER: Does it mean that anybody can
24 leave now to reduce our quorum?

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 COMMISSIONER GALVIN: No. No.

2 MS. HOOPER: For the subcommittee reports,
3 Dr. Agresta, would you like to tell us how the business
4 and technical opts are doing?

5 DR. AGRESTA: Yeah. We are wandering
6 through the marshes I would say is where we're at. But
7 the Business and Technical Subcommittee met this morning,
8 it was the second meeting of the committee. We tried to
9 focus on a few things. One area that we recognized was
10 that we were going to need a little bit more direction for
11 our particular subcommittee as we got through this
12 visioning process and as we got working with Gartner
13 perhaps and our role within developing this strategic
14 plan. I mean, we really wanted to kind of figure out a
15 way to prime that pump. So one of the things that we, you
16 know, thought we would probably do is try to ask
17 specifically to have Gartner attend our next meeting and
18 kind of work with us on that process.

19 The other things that we kind of worked on
20 a little bit was we -- one, we looked at the proposed
21 legislation with the thought in mind that we wanted to
22 understand it's impact and where there might be gaps,
23 where there might be areas where it would be important to
24 kind of make recommendations or at least ask questions

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 such that they might be addressed prior to the legislation
2 moving into the next phases. And I don't know the best
3 process, but we figured we'd present this to this group
4 and sort of more formally present it within the context of
5 our own minutes to the group at large.

6 But we thought that the proposed
7 legislation to have a quasi-public agency was a move in
8 the right direction and would really -- would probably
9 allow for a great deal of flexibility and a great deal of
10 movement in a positive way for a governance of an HIE. We
11 did have a couple of areas where we had questions whether
12 the legislation would create a gap, okay?

13 And the gaps that we thought about were
14 relating to continuity because it appeared in our reading
15 of the legislation that there might be a gap in the time
16 that the legislation is enacted what happens to the bodies
17 that are currently working on things and when the actual
18 new board of directors gets appointed, etcetera. And we
19 were concerned that that be addressed in some fashion so
20 that ongoing work could continue and whether that's by
21 continuing the current groups up until the new appointees
22 occur or whether it's by shortening the time frame within
23 which the quasi-public agency is started we thought it was
24 important to kind of point that out and ask for that to be

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 thought about.

2 We thought that it probably made sense,
3 since we now have dollars and we were going to have an
4 implementation plan kind of set up to occur early in
5 September to try to shorten the time frame of when that
6 group actually was formed. And we weren't sure if that
7 was feasible from a business operational perspective or a
8 setup perspective, but we were cognizant that the work of
9 that board of directors was going to need to occur very
10 quickly.

11 MS. HOOPER: Yes.

12 DR. AGRESTA: And so that was some of the
13 areas that we raised as concerns. There is also a
14 question about appropriately engaging the state officials
15 in perhaps a more formal way of voting members in some
16 fashion of a board of directors so that they were engaged
17 in a more significant fashion and that the full
18 representation of the state's interests were met. So we
19 had thought that that might need to be addressed in some
20 fashion.

21 MS. HOOPER: Thank you.

22 DR. AGRESTA: And the other area was that
23 it wasn't clear with the provision of how funding could be
24 sought whether or not there should be at least the

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 provision in there that state funding can also be one of
2 the sources of funding sought because, you know, there is
3 a great deal of benefit and value to the state in terms of
4 providing --

5 MS. HOOPER: That's not in there now?

6 DR. AGRESTA: -- that and I don't believe
7 that's in there. It appears to be one of the areas where
8 it's explicitly not mentioned. And since the state, you
9 know, employs a large number of individuals and therefore
10 pays their insurance and has Medicaid -- it has a lot to
11 gain by reducing healthcare costs and improving quality
12 and so therefore we believe that that also should be in
13 there as one of the funding mechanisms and how that gets -
14 -

15 MS. HOOPER: Well, they heard you, because
16 there is a substitute bill that does include that. So you
17 see you expressed that --

18 DR. AGRESTA: -- there is a substitute bill
19 that's currently not made public?

20 MS. HOOPER: -- there's substitute --

21 VOICE: It's not public yet because it's a
22 draft amendment.

23 COMMISSIONER GALVIN: It's what?

24 MS. HOOPER: It's a draft amendment.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 COMMISSIONER GALVIN: Oh, a draft
2 amendment.

3 DR. AGRESTA: Okay.

4 MS. HOOPER: Then I change my statement.
5 Thank you Ms. Canfield.

6 DR. AGRESTA: So there are things that we
7 don't know that we don't know.

8 (Laughter)

9 MS. HOOPER: And again, there is a draft
10 amendment that is being considered. The Department met
11 with some of the -- and other colleagues met with two of
12 the Public Health Committee coauthors to discuss some of
13 the options and I believe that that is -- that was right
14 up front and so that's what I was thinking is that
15 certainly there are going to be other funds available, it
16 certainly is not limited to just federal and private
17 funds.

18 DR. AGRESTA: Okay. So I think those were
19 the issues around the proposed legislation. We felt that
20 that would probably help the board of directors actually
21 implement something much more effectively.

22 MS. HOOPER: Thank you.

23 DR. AGRESTA: And then the other thing that
24 the group did was they started to -- we started to kind of

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 raise and put together a series of issues that were going
2 to need to be dealt with in the strategic plan and
3 implementation plan and we're going to continue to work on
4 that and we're going to provide that information back to
5 Gartner and to this group at large to hopefully create an
6 iterative process by which it gets refined and improved so
7 that's kind of where we stand.

8 MS. HOOPER: Excellent. Thank you very
9 much. Marianne, would you like to report on Legal and
10 Policy?

11 MS. HORN: Yes and if I could just follow
12 up on your comments on the legislation, they're very much
13 appreciated, and if other people have comments on the
14 current draft of the legislation that would be most
15 appreciated. I think the vision of the legislation was
16 that the current Committee would transfer over to become
17 the new Board of Directors. But I can see where you'd
18 like to have some of the language --

19 DR. AGRESTA: There's an actual gap.

20 MS. HORN: -- yes, there is -- there is a
21 gap there. And I think that that needs to be tightened
22 up. The state funding that would be certainly something
23 that we would make sure was considered in there and the
24 state members being voting members was something that we

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 had looked at as well because that was in our original
2 bill going forward. So I think that's important as well.

3 The Legal and Policy Subcommittee is a
4 pretty active group. We've actually cut back to meeting
5 every three weeks because we were going on a two week
6 schedule and decided we needed to slow that down. But we
7 had a very interesting presentation by Kevin Karr
8 (phonetic) and really helping us to understand some of the
9 technology pieces and how this HIE might play out. And
10 Laurie Forquette (phonetic), I'm probably mispronouncing
11 her name, of the ISO, the International Standards
12 Organization, came in and we started talking about the
13 uses of the data. It helped us to get our minds around
14 what are the legal issues that we're going to have to be
15 addressing here.

16 And the Committee decided that the HIE
17 should play a meaningful role in improving the following
18 categories of uses of data. Basically the first priority
19 patient care and services need to access data and reduce
20 redundancy and improve care and that would be a top
21 priority within the first year. Public health was also
22 recognized as a very important data use, but recognizing
23 that there are some feasibility issues that that time
24 frame may need to get stretched out. We tried to

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 categorize them in one, three and five year priorities.

2 And that the submission of some of the
3 public health data should be split with some data having a
4 higher priority than others. And some systems are clearly
5 more ready to go than others, but that public health was a
6 top priority. Quality reporting was the third area that
7 we felt was very important and should be done within three
8 years. And research and marketing studies would be for
9 sometime down the road. We did -- there's also a use case
10 for legal investigation or inquiry much more
11 controversial, as is marketing, as is research, so those
12 were -- those were sort of in a separate category.

13 We did look preliminarily at some of the
14 consent issues that our group is going to be working on
15 and that there -- the group agreed that there needs to be
16 some kind of uniform informed consent model in the first
17 year in the state that this will be extremely useful.
18 Obviously we need a lot of people's input into that, but
19 that is the subcommittee's opinion at this point and
20 again, preliminarily there should be a hybrid model for
21 determining how data should be included in the HIE. This
22 model should be primarily an opt out except for certain
23 sensitive data, for example, mental health, HIV, substance
24 abuse I would add in, which should be opt in. These are

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HAMDEN, CT (800) 262-4102

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 for discussion.

2 And in terms of the centralized versus
3 federated system we talked about a variety of different
4 things and basically there wasn't consensus on that. It's
5 just the bottom line is that if the data is available and
6 accessible on a real time basis that the Committee felt
7 that was the most useful thing, whether it's an edge
8 system or centralized system. Consumer advocates appear
9 to feel more comfortable with a centralized model because
10 it's easier to control. There are fewer little spots
11 where it could have something go wrong. But there are
12 going to be places where a centralized database is going
13 to be very useful. For example, all of the reporting in,
14 public health reporting.

15 Again, as I mentioned, there's a need for
16 education throughout the process, patient education,
17 professional education, and there's a belief that perhaps
18 we could work toward development of a personal health
19 record and a centralized medical record within five years.
20 And that's where we are.

21 MS. HOOPER: Terrific. So go on. Our
22 Financial Committee, Mr. Carmody?

23 MR. CARMODY: We already hit on some of the
24 topics, but I'll try to go through quick. Dr. Karr

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 provided us an update. He'd gone to the Policy Committee
2 so he sort of gave us an overview of what took place
3 there. We talked about again, different funded financing
4 options, just at a very high level. Again, talking about
5 a potential two-tier type of conversation. Again, one
6 where it would be sort of a base funding to support a very
7 limited piece of functionality and then maybe after that
8 once you start -- once it's up and running that it's more
9 transactional in nature.

10 We agreed that all of the parties who are
11 benefiting from it needed to make sure that they were
12 participating, there was no opt out so you didn't get the
13 issue where you'd get a municipality or whatever saying, I
14 don't want to play. If you're going to benefit from it
15 you really needed to be included. That was sort of a
16 larger piece.

17 We talked about the need that however we do
18 the financing we needed to make sure that the funding
19 couldn't be supplanted by the Legislature or, you know, so
20 if it was designated and you wanted it to go to a specific
21 -- specific place that was talked about extensively.

22 MR. FEDELE: (Indiscernible, talking over
23 each other).

24 (Laughter)

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. CARMODY: He didn't say he was going to
2 use it, he just (indiscernible, talking over each other)
3 thought it was going to go. We also talked about the need
4 that there is Medicaid funding that was available, and
5 again, maybe to leverage the match which was, you know,
6 you put in 10 percent, they match 90. You know, that was
7 for a limited period of time so how could we work that.
8 We also had more constituents that came to the meeting so
9 we had CHIEFA (phonetic), who actually now is part of the
10 subcommittee. We also had somebody from the State
11 Comptroller's Office, as well as the Department of Social
12 Services so we thought that we needed to expand that
13 committee so that we got other folks who could be
14 represented so we thought that that was needed.

15 And that was really it. I mean, the only
16 other thing that we talked about was as we really prepared
17 for the visioning session again, reinforcing the need to
18 be focused, so what was discussed at a prior Financing
19 Committee was again, maybe starting with the E.R.'s
20 working on that particular front, there's 32 hospitals.
21 Talking about limited pieces of information, you know,
22 pharmacy, medical -- pharmacy, labs and maybe some level
23 of gaps in care. And then as you get phase one working
24 through showing the success that would also be a little

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

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 bit easier if you were doing opt out. After everybody's
2 in an emergency room situation it's probably a lot easier
3 to convince the general public because there's a
4 communication plan that needs to be out there that says,
5 look it, you can't opt out of it, but it's when you're in
6 the emergency room setting.

7 MS. HOOPER: Very nice. I want to tell you
8 all how much we do appreciate really again, this is
9 advisory and assisting us in so many ways, but these
10 committees that are getting all this together. The
11 Executive Committee, is that Mr. Wollschlager? Warren?

12 MR. WARREN WOLLSCHLAGER: I don't think the
13 Executive Committee has gotten together since the last
14 meeting.

15 MS. HOOPER: Okay. Thank you Warren. Are
16 there any questions or comments on the subcommittee
17 reports? If not, I think we're close on time. Frank,
18 we'd like you to tell us with all this information that
19 we're gathering tell us how you're making sense of it all
20 and how's our plan coming?

21 MR. FRANK PETRUS: Well, good afternoon.
22 I'm Frank Petrus for those of you who have not met me and
23 our Gartner team here. Quickly introduce yourselves guys.

24 MR. DAN GORDON: I'm Dan Gordon.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. ALISTAIR MCKINNON: Alistair McKinnon,
2 project manager.

3 MR. KEVIN CHARTRAND: Kevin Chartrand.

4 MR. JEFF PERKINS: Jeff Perkins.

5 MR. PETRUS: And not with us today is Erika
6 Chahil. And this is our team that has been working in a
7 variety of jurisdictions on health information technology.
8 Today what we want to go over in the remaining time that
9 we have is typically a kind of workshop that we do that
10 usually runs about a half a day, so we're going to do some
11 stops along the way to synthesize some of what we heard
12 today which was -- Meg knew and some of what we've heard
13 from reviewing about 1,000 pages of documentation, over
14 100 interviews both individual and in groups and there's
15 obviously some great consistency that we heard this
16 afternoon.

17 If we go quickly to the agenda we're not
18 going to go through all of this. You have in front of you
19 the full agenda and you also have worksheets and the
20 worksheets are things for you to take back with you and
21 your work groups as you go through this presentation with
22 them to identify for us any of your comments, things that
23 you see as strengths, constraints, risk, differences that
24 you perceive and some of the imperatives that we're going

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 to quickly go through today. And there's one sheet, and
2 you can obviously make multiple of these, one sheet for
3 each core area that we're going to discuss today, the
4 visions, the goals, the principles and the five domains.
5 So there's eight of these sheets that you have in front of
6 you.

7 Let's move on to the next -- keep going,
8 stop. Right now in the process we're about four or five
9 weeks into the engagement, we're still in data discovery,
10 we're leveraging the work that you have all done from the
11 meetings that we've had with you and also from the
12 Strategic Health Information Technology Plan that was
13 published in June of 2009, which was a great source of
14 information for us. And where we are today is to test out
15 with you what we're seeing as some of the key imperatives
16 or principles that we gleaned from our interviews and from
17 the document review that you had. So we're still up about
18 here. We were here, now we're about here. And then the
19 next workshop we're going to do is the gap analysis.

20 As we synthesize this with you and get more
21 information we're going to say, here's what ONC will be
22 looking for from you for the Health Information Exchange
23 for the state of Connecticut. Here are the gaps, here's
24 the strengths you have, here's the gaps you have, here's

POST REPORTING SERVICE
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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 some possible alternatives for filling those gaps. We'll
2 do the work again and then we'll come back to an
3 alternative analysis and say, here are the variety of
4 alternatives. You identified some alternatives and in
5 financing and business and technical operations,
6 technology, multiple alternatives. And we also hear the
7 difference between a federated and a centralized model or
8 a hybrid for you to have a centralized model for data
9 repository and quality reporting to improve practice, but
10 you might have a federated model for the push and pull of
11 data throughout all of the health information exchanges.

12 And I really want to -- we have alphabet
13 soup out there. Help them to make an exchange, regional
14 health information organization, electronic medical
15 records, electronic health records, at some point we
16 really need to talk about that so we're using the same
17 language. You have a lot of health information exchange-
18 like systems in Connecticut. You don't have a lot of full
19 health information exchange where you're pushing and
20 pulling the total information that is available at the
21 point of care with all the providers, the health systems,
22 the hospitals, the pharmacies, the laboratories, the
23 payers that are involved with that patient. Some of the
24 systems out there have very comprehensive sharing

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 information within their hospitals or within their health
2 system.

3 So the big question that we have to really
4 resolve in Connecticut, or you do, where do you invest
5 your dollars? Do you invest your dollars in building
6 multiple robust health information exchanges in the state
7 of Connecticut or do you invest your dollars in building a
8 robust gateway of a health information exchange that
9 allows the health information-like organizations to use
10 that as no wrong door for the push and pulling of
11 information that is necessary to improve healthcare for an
12 individual provider or for the state of Connecticut? And
13 that still needs to be resolved.

14 And I heard a little bit of both as you
15 guys went around the table. Now -- and again, it's your
16 decision. If you make the decision, let us know as soon
17 as you can, otherwise we'll facilitate the discussion with
18 you on how to make the decision.

19 MS. HOOPER: I think we're looking for that
20 facilitation.

21 MR. PETRUS: Okay.

22 MS. HOOPER: We do -- we heard that there
23 are different views.

24 MR. PETRUS: There's multiple views out

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 there and the bottom line, because there's no one right
2 way that you can pull off the shelf from Maine or New
3 York, Tennessee or New Mexico and say, here Connecticut,
4 unwrap the shrink wrap and do it. You've got to tailor it
5 to the context, the culture, the political environment,
6 your employer environment and your health system
7 environment that best meets your needs. And yes, there's
8 a lot of lessons learned and there's things that we can
9 leverage whether it's going to be a hosted solution or
10 you're going to build it yourself that we can bring to
11 Connecticut.

12 You're the experts on what will work here
13 and what you can really provide a safe harbor for that it
14 can be codified and secured no matter what happens
15 politically, no matter what happens in the environment
16 that this health information technology to improve
17 practice in Connecticut can be here into the future. So
18 that's what you have to start thinking about.

19 And I like folks talking about one and
20 three and five year plans. I like the concept phased in.

21 I like the concept someone talked about, let's
22 demonstrate return on investment. Let's demonstrate
23 benefits if you're going to give buy in. I think it's
24 really critical.

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 Let's move on. Next, let's move on to
2 nine. Nine. We're going to provide some basic straw men
3 and we've actually written for you a vision statement.
4 Again, it's a straw man, it's from what we heard to try to
5 synthesize what we think for Connecticut. And then we're
6 going to also walk through some of the imperatives in the
7 time that we have left. Let's move onto the next slide.

8 What we -- what we have heard -- we have
9 not heard Arizona for example, when they developed their
10 health information exchange way before the Office of the
11 National Coordinator came out with it's guidelines
12 basically as a push/pull system, no data resides anywhere.

13 I don't know if that was for the federated model or --

14 (Laughter)

15 MR. PETRUS: -- veterinarians are part of
16 this now. So the question that we originally brought to
17 you when we did the kickoff and we've been doing with the
18 stakeholder and reviewing we have heard over and over
19 again, this is not just about the exchange of information
20 or data. This is to transform or improve the quality, the
21 efficiency and the outcome of healthcare in Connecticut.
22 That's very important because that means something in the
23 business and technical operations. That means something
24 in the Legal and Policy that you're already looked at.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 That means a lot in the governance and that also means a
2 lot in the technical architecture because where is the
3 data going to reside? Where is it going to be protected?
4 And maybe some of it's that you identified, where does
5 that reside? So it has a tremendous impact.

6 And that's the first thing I'd like to get
7 some sense from you. Is this accurate representation of
8 the components for a vision, that this is about
9 transforming healthcare, not just exchange of data, does
10 anyone disagree with that? Show them the vision that we
11 drafted.

12 MS. HOOPER: Should we put health outcomes
13 as topus (phonetic)?

14 MR. PETRUS: Topus? Little small plates in
15 a Spanish restaurant?

16 MS. HOOPER: Yes.

17 MR. PETRUS: Okay. Well, we put it at the
18 bottom, but that's how we built it. Here's what we have
19 sculpted for consideration and wordsmithing and we're not
20 going to wordsmith today, we only have 45 minutes left.
21 But basically -- and we also created a name, the
22 Connecticut Health Information Exchange Net, we just
23 wanted to get an abbreviation. You can change this of
24 course. This is Mr. McKinnon, so it's Scottish in origin.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 But the visual for that -- the Connecticut
2 Health Information Exchange Network is to provide an
3 immediate and direct link between patients. The patient's
4 entire health record. Their attending physician and
5 others as appropriate, health systems, hospitals, payers,
6 pharmacies, laboratories, at the point of care to improve
7 the continuity of care, the efficiency, itemize the
8 redundancy of necessary cost, quality and outcome of
9 healthcare in Connecticut. And remember, the premises for
10 a vision, it's a desirable, achievable future with current
11 and anticipated resources. So it does build in extensive
12 phased in.

13 You don't have to answer this, but this is
14 something in your packet we'll give to you to take back,
15 but this is what we're thinking of from all that we've
16 heard and what we heard today as the initial forming
17 embryo of a vision for Connecticut Health Information
18 Exchange. Any red flags?

19 MS. HOOPER: Well, you do have --

20 VOICE: (Indiscernible, too far from mic.)

21 MS. HOOPER: -- yes.

22 MR. PETRUS: Okay.

23 VOICE: (Indiscernible, too far from mic.)

24 MR. PETRUS: So basically now we're into

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 wordsmithing, not necessarily directionally.

2 MS. HOOPER: I think -- did you put this on
3 our worksheets sir?

4 MR. PETRUS: Not yet. Not yet. No, this
5 was part of a workshop that we're now considering.

6 MS. HOOPER: Understood.

7 MR. PETRUS: But we will send it to you.

8 MS. HOOPER: I mean, we do -- well, and we
9 also do have some of this information on the worksheet.

10 MR. PETRUS: Yeah.

11 MS. HOOPER: But agreed, we all need to
12 contribute to this comments about this vision. If you'd
13 like to take the time today, but I believe we can wait --

14 MR. PETRUS: Yeah. Well, we'll send this
15 out to you --

16 MS. HOOPER: -- thank you.

17 MR. PETRUS: -- to distribute to everybody.
18 We're in the right direction? Anybody feels we're not in
19 the right direction?

20 MR. COURTWAY: Frank, this is Peter
21 Courtway.

22 MR. PETRUS: Yeah?

23 MR. COURTWAY: Talk to me a little about
24 the nuance of the direct link between patients and their

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 attending providers?

2 MR. PETRUS: The direct link that we heard
3 was that this is patient-centric, not provider-centric.
4 That the whole reason of doing this is around the
5 patient's right and need for quality healthcare. So
6 that's why we have that.

7 MR. COURTWAY: So there's no implied nuance
8 of patients using the HIE to communicate directly to their
9 attending providers?

10 MR. PETRUS: That could be a phase that you
11 would want. We can do -- somewhere else we're going to
12 talk about accessibility and the question comes from the
13 legal policy as well as business and technical operation.
14 What access rights do patients have to their information
15 and the use of the HIE? Some states are envisioning for
16 example linking it to personal health records like the
17 Microsoft entity and some concerns about the accuracy and
18 -- I won't go there, but that wasn't implied, but it
19 wasn't eliminated either.

20 MR. COURTWAY: Okay. Thank you.

21 MR. McKINNON: The mental image always is
22 that attending means two people at least sit in the same
23 place at the same time. I know you mention that it's not
24 actually necessarily the case in the future.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MS. HOOPER: I think -- and Mr. Carmody,
2 you had a comment?

3 MR. CARMODY: I guess my only question
4 would be where this discussion would be, again, it's
5 clearly patient-centric, which I think is a good thing,
6 but you don't get the sense of it's bi-directional across
7 the other constituents that are there. So it's pretty
8 much from the rest of the ecosystem around the patient,
9 but not within that ecosystem itself. So I think there's
10 room for --

11 MR. PETRUS: Okay.

12 MR. CARMODY: -- just making that entire
13 ecosystem available.

14 MR. PETRUS: That's very good.

15 MS. HOOPER: And again, this is -- this is
16 going to what the actual exchange is. I mean, we spent
17 some time talking about the RHIO and it's
18 responsibilities. We've moved into the operational
19 exchange vision. So understanding one goes with the other
20 of course.

21 DR. AGRESTA: But I think what Dan is
22 saying is that if I was to envision how I would use it in
23 exchange to improve care --

24 MS. HOOPER: Correct.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 DR. AGRESTA: -- part of what I would do is
2 I would exchange data purposefully with a subspecialist.
3 In other words, there's a -- it's not just push/pull my
4 data in to wait for the subspecialist to pull it out, but
5 I'd use messaging techniques and other things to try to
6 enhance that.

7 MS. HOOPER: Correct.

8 DR. AGRESTA: And I think that that matrix,
9 that social, you know, almost social networking type of
10 process --

11 MS. HOOPER: Yes.

12 DR. AGRESTA: -- is really where healthcare
13 is going and we ought to be, you know, thinking about
14 that.

15 MS. HOOPER: Is that where we wanted to
16 encourage it to go also?

17 MR. PETRUS: It can also be around chronic
18 conditions like diabetes or heart disease or some
19 surveillance that you would want to be doing around
20 certain disease entities.

21 DR. AGRESTA: Sure.

22 MS. HOOPER: Marianne?

23 MS. HORN: But because that appears to be a
24 direct one to one link I think it misses the second

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 concept, which is community. The community aggregation of
2 data of the public health throughout --

3 MR. PETRUS: That's right. I think that's
4 great. Because when you take a look at you're talking
5 about healthcare in Connecticut to quality outcome,
6 efficiency and continuity would be looking at information
7 that turns into business intelligence that's actionable
8 for how you do well in this and prevention programming,
9 how you target resources, how do you improve individual
10 practice. Good points.

11 MS. HOOPER: And again, we're going to be
12 bringing up the issue about public health and not just
13 through the healthcare centers, but certainly through some
14 of the other avenues.

15 MS. HORN: Yeah, that was my point. I
16 didn't see where the public health --

17 MR. PETRUS: That's why this is a straw man
18 and was to stimulate this kind of discussion. Any other
19 red flags here?

20 MS. HOOPER: Yeah, can you rephrase that to
21 be straw person?

22 (Laughter)

23 MR. PETRUS: Yeah, I can do that. Straw
24 person.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MS. HOOPER: Thank you.

2 MR. McKINNON: Straw certain being. Oh, it
3 wasn't perceptive.

4 (Laughter)

5 MR. PETRUS: I could have never worked out
6 because as I say I'd rather have it a straw man because no
7 women are straw.

8 MS. HOOPER: Well, we're not going to even
9 debate that one.

10 MR. PETRUS: If we can move on quickly to
11 14? I'm not going to go -- this is the next one that we
12 think is very important. As we move forward and start to
13 talk about a vision, talk about the imperatives for each
14 of the domains that are required for your strategic and
15 operational plan, and as you talk about a federated or a
16 centralized model or different approaches to financing
17 there's got to be some kind of frame work in which we can
18 have legitimate differences and fair fights. And one
19 thing is that if we're going to argue about whether it
20 should be this approach to business and technical
21 operation or financing we say, will it further the vision
22 once you lock that down? That it's going to improve
23 healthcare in the state of Connecticut through the kinds
24 of sharing that we just discussed.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 The other thing that we need to have a
2 debate around is some guiding principles. From what we
3 heard and our experience so far in Connecticut and from
4 lessons learned elsewhere we see four really important
5 principles for this kind of initiative. Number one is
6 consumer confidence.

7 I think Commissioner Galvin at our first
8 meeting said, you know, if you build this right you don't
9 have to worry about opt in and opt out, people will want
10 to be part of it. Providers will want to be part of it.
11 But that begins consumer confidence and I think that we
12 saw with the town hall meetings around healthcare reform
13 how end of life discussions with providers turned into
14 death panels. So it's very important that one principle
15 is that the consumers must really understand and have
16 confidence that you're doing due diligence and protecting
17 their very personal and private personal health
18 information.

19 The second principle we think is important
20 is that the HIE becomes something that none of the
21 individual 80 some HIE-like things you have out there can
22 do by themselves is part of a foundational infrastructure
23 and that the argument needs to be and the vision for you
24 all need to be, what is this foundation that the state can

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 do that is best done through a coordinated quasi-
2 governmental authority that can tie this together? And so
3 it is not a stand alone, but is an extremely important
4 tool and what is in the toolbox of the HIE? And it might
5 be the repository of data for the improvement of
6 healthcare practice. It might be a financing model that
7 makes sense. It might be the gateway to regional and
8 nation health information network. It might be the
9 gateway for Medicaid incentive programs for the adoption
10 of HIT by Medicaid providers. It might be for the
11 Department of Public Health and to the public health
12 information network for CDC. But those as the kinds of
13 things that you would have to come to agreement on.

14 The third is don't boil the ocean phased
15 approach. That you're maximizing your investment in
16 chewable incremental steps that people start seeing
17 return. The fourth is inclusive and transparent
18 governance as you're doing, as being recorded, as being
19 published through the vetting of all the committees. And
20 that we think that if you -- this could be more and you
21 could change these, but here's what our hypothesis to you
22 is as a straw person for the planning principles as you
23 move forward in this group and through your committees to
24 start discussing what are the options as we get to the

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 alternative analysis. Thoughts about this?

2 MR. MASSELLI: I'm just wondering that
3 maybe it's in a phased implementation and sort of
4 sustainable, I mean, as a principle of what we're trying
5 to do?

6 MR. PETRUS: Well I think you could add
7 that as a -- we have it in the finance domain, but I think
8 you could add that as a principle, that whatever you do is
9 sustainable. That's a great add.

10 MS. CATHERINE LaFORZA: I just want to talk
11 about consumer confidence. Number one, I think as we were
12 talking about the role for the RHIO I think maybe it sort
13 of got pushed into the privacy and security but it's a
14 very important role for the state as the procurer of the
15 landscape of messaging to the community at large, to the
16 public at large about why it is it's good for them, what
17 it is, what it's not. Because as you've said, with all of
18 the debates about healthcare there's a lot of fear and
19 misinformation out there and I think that it would be a
20 real disadvantage if the landscape wasn't prepared.

21 MS. HOOPER: And I'm so sorry. For our
22 minutes can we ask your name?

23 MS. LaFORZA: Catherine LaForza.

24 MS. HOOPER: Thank you Catherine. And

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 prior to that there was one of -- you all know Mr. Reed --
2 Lynch.

3 MR. PETRUS: I think that's a great
4 expansion, consumer confidence. Because before they have
5 to have confidence you have to have some kind of program
6 and I think with the E-Health Connecticut folks in the
7 Regional Extension Center this whole thing is people need
8 to be aware of what you're doing in simple lay terms.
9 Second, they need to understand what you're doing so that
10 you really give them some concrete things. And third,
11 they need to have opportunities to participate, which goes
12 into number four. So I think that we can expand on
13 consumer awareness and confidence in a formalized way.
14 Yes?

15 DR. AGRESTA: Yes. Tom Agresta. I would
16 add to consumer confidence provider confidence or, you
17 know what I mean? I really think that's, you know, if we
18 don't pay attention to messaging that very carefully that
19 could backfire as well.

20 MR. MASSELLI: Is that provider confidence
21 or provider value? I mean, you're talking about --

22 DR. AGRESTA: Well, it may be confidence
23 and value, yes. It may be actually adding value to those
24 who actually provide healthcare.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. PETRUS: I think that's an additional -
2 - I would not connect it with -- I would add that as a
3 separate principle. So what I'm hearing is provider value
4 and confidence.

5 MS. HOOPER: Which actually then supports
6 the sustainability.

7 MR. PETRUS: Yeah.

8 MR. COURTWAY: Frank, is there any of the
9 principles that you would say are the ones -- is one that
10 rationalizes? It said there's only the one -- is it check
11 step? One check step. I mean, I hear HIT funding for law
12 enforcement, I hear HIT funding for DSS. HIT funding for
13 DPH. Is one of the planning principles that we are doing
14 one plan for the state that encompasses all agencies in
15 the state?

16 MR. PETRUS: Unfortunately I'm not seeing
17 that in states. I mean, I think you have to coordinate
18 with your DSS around their Medicaid -- state Medicaid
19 health information technology plan. I think have you
20 broadband, I'm assuming there's ARA (phonetic) money
21 coming to the state for broadband would have an impact on
22 this.

23 MS. HOOPER: Yes we do.

24 MR. PETRUS: Law enforcement we've done

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 work on both sides, both on the Florida law enforcement
2 exchange as well as in the health information technology
3 exchange and I do think that that kind of coordination --
4 that may be under the foundational infrastructure. It
5 also might be transparent governance. It may be that
6 those folks should be part of the governance, at least
7 participate as you move forward.

8 MR. MASSELLI: You were saying it wasn't
9 impeding them it was enhancing them, other people's
10 activities so we don't want to get into battles with
11 anyone else --

12 MR. PETRUS: Exactly.

13 MR. MASSELLI: -- so we want to talk about
14 our --

15 MR. PETRUS: Unfortunately what the federal
16 government has done in this case what they did is building
17 the silos to begin with when they built the MMIS silo and
18 the child welfare silo and the food stamps.

19 MS. HOOPER: Yes.

20 MR. PETRUS: ONC's got this and then
21 Medicaid's got this and ONC and Medicaid are trying to
22 create the connect gateway and then the ARA money is going
23 over here and it's also going into three directions, law
24 enforcement, rural services and commercial. So it's

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 unfortunately that that's happened. And the place that it
2 has to come together is in the state and that's your
3 executive leadership, your legislature and your
4 commissioners of your executive branches who have to say,
5 guys, we're building the same thing four or five times.
6 Is there a way that we could leverage some of our
7 knowledge and capabilities?

8 MS. HOOPER: And I do think that again, on
9 the ARA funds that's pretty much one time funding. But I
10 think that we shouldn't be so excited to imagine that
11 there will be other, again, federal or private
12 opportunities. We don't want to be in competition. Right
13 now Mr. Masselli has secured HIT funds through stimulus,
14 DPH, DSS, E-Health. So I think that -- Criminal Justice,
15 broadband is going through DECD, so I think the awareness.

16 But I think it's an excellent question as we look
17 forward. Should all federal funding for Health
18 Information Technology and Exchange be funneled through a
19 state RHIO financial system? I bet not. I bet that
20 politically that wouldn't fly. But how do we then make
21 sure that all of the players are at the table? That there
22 is one plan that is being carried out? I think is what
23 the issues are.

24 MR. PETRUS: And I think you're right. I

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 think ONC says the one thing that the state has to do is
2 make sure Public Health and Medicaid are at the table and
3 are being supported and integrated and the regional
4 extension centers.

5 MS. HOOPER: Yep.

6 MR. PETRUS: Now ONC is going to be putting
7 money into education and training because it is the future
8 employment opportunities in many state health information
9 technologies. So maybe that can be incorporated in the
10 inclusive.

11 MR. McKINNON: And what we've really got is
12 the quote, "mission subplot of the transparent governments
13 and approach." So I think the best you're going to get is
14 that (indiscernible).

15 MR. PETRUS: And I think operationally the
16 place where this will happen once you have the utility up
17 and running will be in the governance structure and in the
18 business and technical operations. That kind of link just
19 happens. Anything else on the principles?

20 Let's move onto the domains and quickly
21 highlight what we see as some of the imperatives and the
22 challenges and constraints. Keep going. The first domain
23 is governance and as we said to you at the kickoff the
24 real critical piece here is understanding you have two

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 tiers of governance. You will be setting up principles, a
2 vision, mission, set of goals. Some of you talked rightly
3 about metrics, measuring the return on investment. That's
4 one level of governance. The overall vision, goals and
5 principles that guide the HIE effort for Connecticut.

6 Then there's another part of governance
7 that talks about the management and operations of the HIE
8 and how that board manages that. How are these -- and
9 somebody talked about the gap between this group and the
10 authority being improved and the question, how do you move
11 that forward and make sure you don't lose governance
12 number one when you get to the tactical implementation of
13 governance number two? And that's been a challenge for
14 many states.

15 Next slide? These are imperatives that
16 from what we've heard, many of which we think are in place
17 by the way, state leadership to mobilize stakeholders.
18 You're a good example. So when you write your strategic
19 plan to ONC you have very tangible governance strengths,
20 activities and results to report to ONC in the strategic
21 plan and as you set up the authority in the operational
22 plan. Because the strategic plan says, here's what we
23 want to do. Here's what our vision is. Here's what we
24 have in place. The operational plan is here's how we're

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 going to do it and here's the date we're going to do step
2 one, step two, step three.

3 We think that many of these imperatives you
4 have in place now. Some are like the value proposition,
5 the steps along the way. But we think that much is here
6 and we've heard today too the last bullet, a safe harbor,
7 an incubator. That this will be here beyond whatever
8 political changes that you see in Connecticut.

9 Some constraints and key activities that we
10 would really like you to focus on in the next slide as you
11 think about this with your group. How do you do the
12 transition? And that was raised earlier, when the act is
13 finally becomes law and how do you move forward with the
14 passage of the legislation and make sure there's no gap or
15 vacuum between what you're doing now and what you're going
16 to be doing in the future and how this facilitation is
17 going to go forward and what really will be the governance
18 role of this new authority to ensure that the vision and
19 principles and goals you have identified become real.
20 Next slide.

21 And the other thing that's really key, and
22 Meg said this earlier, you have 80 some HIE or HIE-like
23 things going on. You have an extremely vital state
24 Medicaid health information planning process that's going

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 on for the incentive money and you don't want to leave any
2 of that money on the table. Your hospitals and health
3 systems and providers, you know, who are adopting HIT
4 should have the advantage of that incentive -- those
5 incentive dollars that are coming down.

6 And you have other initiatives that we
7 talked about earlier that are going on regarding HIT. How
8 do you coordinate those? And so I think both in the
9 Governance Subcommittee and in the Business and Technical
10 Operations Subcommittee these are going to be key things
11 for you to focus on.

12 Are there any other constraints or
13 challenges that you see with regard to the governance
14 domains?

15 MS. HOOPER: We don't have time.

16 MR. PETRUS: That we haven't identified?

17 MS. HOOPER: You know what? I think that
18 will be part of the discussions as we move forward. I
19 think the gaps again, in the governance, regardless of
20 where we are January 2011 right now DPH is it and you're
21 advising us and we're eternally grateful. And where we go
22 in 2011 we should know within the next month or two what
23 legislation will come out.

24 MR. MASSELLI: When you say the strengths

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 is it strategy, things to strategically keep in mind? I'm
2 trying to figure out --

3 MR. PETRUS: For the governance -- for the
4 governance task force it will be the strategies. For the
5 business and technical operations it will be the tactical
6 pieces. You see, that's the two sides.

7 MR. MASSELLI: -- yeah.

8 MR. PETRUS: And that becomes the
9 challenge. Either folks get so governance focused that,
10 well, how do you make that real? Or they become so
11 tactical focused they lose sight of why we're doing this
12 in the first place. Let's move on. Go on. The next
13 domain is the finance domain. The key here of the finance
14 domain I think if there's one word it's sustainability.
15 If you want a second word it would be parody or fairness.
16 Next slide.

17 What we heard from all of you as we went
18 through the numerous interviews and reviewed your
19 documentation, it kept coming back as we've got to make
20 sure that this cost was going to be fair without placing
21 undue burden on any of the key populations. And we did
22 here what you talked about earlier, a baseline funding and
23 then maybe a transactional approach and a sequencing.
24 That all avenues though should be explored and how do you

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 -- really you're really talking about a portfolio of
2 funding. You have ONC funding out and it will keep
3 dropping down, 100 percent, 90, 70, 30, it's gone. You've
4 got the Medicaid funding that's out there. You've got
5 other funding that's coming in. How do you harmonize
6 those dollars and then identify mechanisms that will
7 sustain this and a business model that people see value in
8 that they're willing to contribute.

9 MS. HOOPER: Right.

10 MR. CARMODY: The other thing that we in
11 the Finance Committee, and we talked about this again
12 attempting to try to leverage whatever the collection
13 mechanisms are that we have today. I mean, you don't want
14 to build out a new bureaucracy of trying to collect --

15 MR. PETRUS: Yep.

16 MR. CARMODY: -- and administer and
17 distribute. I mean, you should look what we have today, I
18 mean, even Dr. Karr talked about, you know, there's
19 licensing ways in doing it, so again, trying to leverage
20 those things again. Repurposing what we already do.

21 MR. PETRUS: Right. And if there's this
22 provider everyone's in kind of concept there may be a
23 mechanism that would work a lot easier that -- and again,
24 if you talk about do you have a centralized or a federated

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 or a hybrid? If it's the hybrid you may have to
2 centralize for data repository and all of it. There's
3 this intelligence necessary to support the practice
4 improvements, but you could also do that for the financing
5 and then the federated allows you within your own health
6 systems and provider community to provide the kind of HIE-
7 like that you need then the gateway to go onto regional
8 and the National Health Information Network.

9 Next slide? Some constraints is, you know,
10 one you've got to secure the ONC funding, so we've got to
11 work really hard with all of you to make sure that an
12 approval of the strategic plan, the operational plan,
13 which we will do. But we also need to take a look at
14 making sure that -- that all of you have talked a little
15 bit about financing, we're bring some stuff to the table
16 of financing. Eventually you're going to have to come
17 down and decide what the clear understanding is of the
18 cost going forward to do the development and
19 implementation necessary and what's the maintenance and
20 operation going to be?

21 And the consideration if you go to a hosted
22 solution, which has a different set of costs, but then it
23 has another impact on governance, business and technical
24 operation and legal and policy. So some of these things

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 you're really going to have to in the next couple of
2 months start putting a line in the sand and say, here's
3 the model that we think is best for Connecticut because
4 it's going to impact governance, it's going to impact
5 finance, it's going to impact business and technical
6 operations and legal and policy.

7 MS. HOOPER: And I can't stress enough on
8 the timing of this understanding that next week is May 1st
9 -- I know. I know. I missed October. But where we need
10 to have this -- both of these plans approved by ONC in
11 September or we don't get a release of the funds that will
12 actually support the implementation or the other funds
13 that are actually supporting interstate opportunities. So
14 right now the emphasis is please to contribute to the
15 development of the strategic plan and Frank is making it
16 very clear that we will have some very difficult decisions
17 to make. You have some difficult decisions to make to
18 advise the Department and we'll have difficult decisions
19 to make as to what those -- what will be included in the
20 plan.

21 MR. PETRUS: And as all of you said the
22 last bullet there of a constraint or an action that's
23 really important or a challenge is the return on
24 investment. How are you going to measure the value to

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 ensure consumers, providers and investors are getting
2 value from the health information exchange? Let's move
3 on.

4 Technical. And we keep saying the
5 technical is the easiest believe it or not because once
6 you define -- once you define whether it's federated or
7 centralized or hybrid, data repository, not data
8 repository and we'll finish the landscape assessment we're
9 doing, I'm not worried about the technical plug in place
10 features and how you're going to move forward with that.
11 Yes, it's going to be challenging and a cost to us, but
12 the question is what can we leverage that already exists
13 in record locators, master client or patient index, master
14 provider index, claiming and payment systems that could
15 support the faded in approached to the Connecticut Health
16 Information Exchange, which is really starting to lend
17 itself to a hybrid of federated and consolidated.
18 Federated in some areas and consolidated-like in others.
19 Then you start establishing the architecture that makes
20 the best sense and technology has come a long way.

21 Also in the technical is the whole Health
22 Information Network and Medicaid because billions of
23 dollars are being invested in Medicaid and thus that whole
24 length they call the CMS Connect Gateway, which I don't

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 know, have you seen anything on that yet except the memo?

2 There was a memo between Rick Freedman and Dr. Blumenthal
3 that says, we're going to do this and it's going to be
4 called Connect. And so we all said, that's great. It's
5 the same thing with meaningful use, you know? There's all
6 these meaningful use rules and they said by June we'll
7 know what they are so that has to be taken into
8 consideration in the technical infrastructure.

9 MR. MASSELLI: And you have it there and
10 I'm just wondering if it needs to be accented here, which
11 is security. That ties back to sort of -- it's sort of
12 mixed in with a lot of other things. It goes back to
13 consumer confidence, it goes back to a lot of issues.
14 It's going to loom large in the sort of whole promotion of
15 this and I certainly see it there and yet, you know, at
16 some point I think whenever we're going out we're going to
17 have to sort of underline it.

18 MR. PETRUS: I concur very strongly on
19 that. Especially now that you've said this is not about
20 the exchange of data and information, this is about
21 improving the continuity, efficiency, quality and outcome
22 of healthcare. That means there's going to be data.
23 Reidentifying data maybe, but how do you guarantee the
24 protection of it? And I also heard from Legal that they

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 were looking maybe two tier population everybody is an opt
2 out except for special populations that are more
3 restricted. Privacy and security requirements that would
4 be an opt in. That might work, but that has an impact on
5 the technical infrastructure on how you have those rules
6 built in and the engine necessary to support that.

7 Next? This also after your discussion this
8 afternoon I have a clearer understanding where the group
9 is going.

10 MS. HOOPER: Okay. Good.

11 MR. PETRUS: And because if it was just
12 push and pull you would have electronic eligibility and
13 claim transactions that would make sense as you would have
14 prescribing and refill and you'd have clinical laboratory
15 reporting and results and you would -- might have some
16 electronic public health reporting. But then all this
17 stuff going down, healthcare reporting, prescription fill
18 status and our medication fill history, clinical summary,
19 advanced directives, messaging and shared directory you
20 wouldn't have. So you really have started to carve out
21 for the Technical Infrastructure Committee, guys, start
22 thinking, we want all this. And we want to phase it in
23 and we've got some legal descriptions of how we may want
24 to phase in some of this, so this becomes guidance now for

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 your technical. Next?

2 MS. HOOPER: Which you say is easy?

3 MR. PETRUS: Yes, it's easy.

4 MS. HOOPER: Mr. Varney, do you have any
5 comments on that statement?

6 MR. PETRUS: This young man will have it I
7 tell you two weeks. You probably already have it drawn
8 out, right?

9 MS. HOOPER: Yes?

10 MR. PETRUS: You have the systems designed?

11 MR. COURTWAY: Yeah. I think everybody has
12 a series of systems designed. You know, a lot of this is
13 up and running in Hartford today, it's up and running in
14 Danbury today, you know, there's a lot of plans in place.
15 But it's not about the -- it's not about the technology,
16 it's about the how you're going to employ it.

17 MR. PETRUS: There you go. You see? I
18 told you he'd have it all done.

19 VOICE: We have all of the prescription
20 stuff already done.

21 MS. HOOPER: I know. That's why I came
22 into this very enthusiastic. We're not behind, we're
23 ahead of the game. We just haven't promoted ourselves
24 enough.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. PETRUS: Now we get it together.

2 MR. McKINNON: But you do admit the
3 technology underway is not unbelievably organized to make
4 it all happen when it should happen, which is -- you
5 assume this is easy, it's not easy to get there.

6 MS. HOOPER: I know. I was just --

7 MR. McKINNON: It's just easy conceptually.

8 MR. PETRUS: It's always about the people
9 and the processes, it's not about the technology.

10 MS. HOOPER: -- absolutely. And we
11 understand that. And I think that from the state agency
12 side the technology and Mr. Varney's representation here
13 from DOIT is that no it's not, it might be easy, but it's
14 not simple.

15 MR. PETRUS: That's right. It's a lot
16 easier than all of the other stuff we've been talking,
17 financing, governance, legal and policy and so forth.

18 MS. HOOPER: Understood.

19 MR. PETRUS: The other thing is that is one
20 of the constraints of key action is establishing clear
21 understanding, what's in scope and out of scope. I think
22 you've identified some of that, but there's still that
23 issue of personal health records and whether that's in
24 scope because that's something that there's a lot of

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 discussion out there and some conflict about personal
2 health records because that's in the control of the fascia
3 and there may be information in there that's counter to
4 and inaccurate to what actually has been diagnosed or is
5 in the electronic health or medical record of the patient.

6 Next? We're going to do this, I think
7 we're going to actually do it. Business and technical
8 operations, as we heard, let's -- moving on here in the
9 business and technical operation. Key I think in the
10 business and technical operation is once you decide the
11 direction you're going in the overall governance and
12 principles is how do you tackle -- do you make it operate?

13 What kind of organizational structure and staffing are
14 you going to need, kind of project management office
15 you're going to need, service level management you're
16 going to need -- and do you do this within the authority
17 structure and have your own CEO, CFO, CIO, you know, and
18 all the other functional silos necessary to run this, or
19 do you outsource a lot of this and host a lot of this? Do
20 you say to a university, you're going to do all the
21 predictive analysis and manage and provide security for
22 the data and XYZ, you're going to host the HIE engine and
23 you're going to meet certain service levels? And so
24 basically what the business and technical operation is

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 focusing on is demand management on the stakeholder,
2 providers, health systems, hospitals and supply
3 management, those entities that you're going to bring
4 onboard to manage this and run it and meet the service
5 levels and the return on investment that the providers and
6 that the state is looking for.

7 So it's a real open question because you
8 really have to decide what it is that you're going to be
9 doing and what the responsibility of this authority is
10 going to be. All these things need to be done. Where are
11 they going to be done?

12 DR. AGRESTA: Can we break this committee
13 into three committees please?

14 (Laughter)

15 MS. HOOPER: No, I'm sorry Doctor. Nope,
16 it's all on you.

17 DR. AGRESTA: I need someone with a
18 business background to help me.

19 MS. HOOPER: And you have a month to finish
20 that.

21 DR. AGRESTA: Okay.

22 MR. PETRUS: And coordinate with the
23 Regional Extension Center in providing training and
24 technical assistance and others as well as we talked about

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 earlier in -- for global governance. Next slide? Some of
2 the constraint is really, I think the challenge, and
3 you're going to need to do this for ONC is the metrics and
4 measures. And this is something you can do regardless if
5 you host this or you operate it within the authority. How
6 are you going to measure some of these key components to
7 demonstrate the value investing in the health information
8 exchange?

9 And lastly, how do you work the cooperative
10 relationship with the Regional Extension Centers, the
11 medical society, the hospitals association, the Medicaid
12 Agency, the Public Health Agency, all these key components
13 on top of the 80 HIE-like components that are out there
14 because you're really talking about this unifying and
15 going back to the principles. The Connecticut Health
16 Information Exchange is not a stand alone, but it is the
17 foundational, it is the umbrella with legal authority and
18 support and maybe baseline funding as well in the future
19 that ties this together to the benefit of the improvement
20 of healthcare in Connecticut for the support of providers
21 and for the quality care to patients.

22 So you need four committees. Next? And
23 this goes back to Legal and Policy. This is a committee
24 that seems like it's really done a real yeomen's job so

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 far. And they've kind of impressed, they've already
2 identified here's the data to be shared and we're going to
3 worry about privacy and security around for year one and
4 you did it for year three and now you've done it for year
5 five?

6 MS. HOOPER: Yes.

7 MR. PETRUS: We'd like to see that. That
8 would be great because that is important. You don't have
9 to answer all these questions at one time and a challenge
10 was that much of the confidentiality statutes around the
11 provision of health and human services and the consumer as
12 well came out in the United States Privacy Act of 1976.
13 It's very old legislation, but it's legislation that drove
14 HIPAA, HIV-Aids, mental health and substance abuse, health
15 records, and basically that was set up to provide for
16 confidentiality, informed consent and need to know
17 criteria. It was never set up to be a barrier to the
18 access of quality care.

19 MS. HOOPER: Thank you.

20 MR. PETRUS: And the ability to harmonize
21 those things and going back to aware, understand and
22 participate that patients understand and are participating
23 and the value that by having their information with the
24 appropriate protections and they go to the emergency room

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 at 2:00 a.m. with no I.D. on them and they call up their
2 record they'll know what preconditions are there, they'll
3 know what medications they're on and you will not have the
4 kinds of medical errors that we sometimes see because the
5 folks in the E.R. don't know what they don't know.

6 So it's very important that as you move
7 forward with the legal and policy that you're establishing
8 an infrastructure that keeps it's eye on the principle,
9 the access to quality healthcare, not the prevention of
10 sharing of information. Next?

11 Very simply, legal policy basically we see
12 have four imperatives, that's all. Just to harmonize
13 federal and state legal and policy requirements, create a
14 legal framework for patient and provider participation, a
15 statewide policy that allows for the continuous
16 development of these policies, which you're doing, and
17 enforcement mechanisms. How do you ensure that the
18 privacy and security of personal health records are
19 maintained by all of the entities that are participating?

20 So four very simple things and it looks like you've maybe
21 got two of them already.

22 MS. HORN: Working on them.

23 MR. PETRUS: Next? Some of the
24 constraints. Now where are you with your preemption

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 analysis?

2 MS. HORN: Well, it is -- I have a legal
3 intern coming in on Wednesday to help me get started on
4 that.

5 MR. PETRUS: Oh, poor thing.

6 MS. HORN: Well, I don't think it's going
7 to be --

8 MS. HOOPER: No.

9 MS. HORN: -- not that much has changed in
10 terms of HIPAA, not much has changed in terms of state
11 law.

12 MR. PETRUS: Really?

13 MS. HORN: So I don't think it's going to
14 be -- it's an 800 page document, but I don't think it's
15 going to be a horrible thing to update.

16 MR. PETRUS: And are we all going to get a
17 copy of it to read?

18 MS. HORN: Lisa was sending it to me, it
19 hasn't arrived yet, but I think --

20 (Laughter)

21 MR. PETRUS: (Indiscernible, talking over
22 each other.).

23 MS. HORN: -- it may have to come in many
24 different sections.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. PETRUS: Another one is the whole area
2 of patient consent. We talked about it, opt in, opt out.
3 As I said when we first met and I'll say it here, there's
4 a few key components you've got to get right for
5 Connecticut. Key component number one that you have to
6 get right for Connecticut is are you going to have a data
7 repository and that whole idea of is this about improving
8 healthcare or just data exchange? And it looks like
9 you've decided on that.

10 Another key one that you really have to
11 take a look at is, is the HIE a federated, centralized or
12 hybrid model? And I think you're starting to think about
13 that.

14 MS. HOOPER: Right.

15 MR. PETRUS: The third thing is how do you
16 finance it? You've got some preliminary thinking about
17 that. And the fourth thing is this. Whether you're an
18 opt in state or you're going to be an opt out state for
19 the health information exchange I don't think we'll have a
20 pronounced impact as long as you have the right kind of
21 education program in place for providers and patients. I
22 see your face, you're grimacing.

23 DR. AGRESTA: Come sit in my front office
24 and do opt in.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. PETRUS: Ya think?

2 DR. AGRESTA: Yeah.

3 MR. PETRUS: Okay.

4 DR. AGRESTA: Sit in any primary -- sit in
5 anyplace where you've got to do opt in and it's painful.

6 MS. HORN: It is, isn't it?

7 MR. PETRUS: I think it's painful in having
8 the time necessary to spend in educating the patient and I
9 agree, I think that the opt out provides you more
10 immediate return on investment than the opt in model.

11 MR. MCKINNON: That is a reference to
12 opting and on every visit though.

13 DR. AGRESTA: Oh, no.

14 MR. PETRUS: No. Just --

15 MR. MCKINNON: -- you mean opt --

16 MS. HOOPER: Just on every patient. And
17 then -- are you all nodding on that that what Frank just
18 said?

19 MR. COURTWAY: I think opt in is a barrier
20 to acceptance. Public education is absolutely necessary.
21 The explanation of their rights, you know, if people ask
22 to --

23 MS. HOOPER: Of course.

24 MR. COURTWAY: -- be there, but there is a

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 fundamental difference between explaining to somebody
2 effectively what's an opt in versus an opt out.

3 VOICE: Okay. Could that possibly be
4 another rule for the RHIO to oversee the central process
5 rather than putting it on the onus of the providers?

6 MS. HOOPER: Absolutely. Absolutely.

7 MR. PURCARO: I think you're -- again, I
8 think it's breaking it down to phases. I think it's one
9 thing to say you're going to opt out of, you know, de-
10 identification of information to do quality reporting.
11 It's another thing to say I'm going to do opt out when it
12 comes to -- when you're in an E.R. setting. I think then
13 you get into -- again, I'll go back to the Arizona model
14 where anything beyond whatever we define then you get
15 into, you know, maybe that's an opt in as to where it's
16 going to eventually go. So I think there's a balancing of
17 pieces and parts, but I understand, you know, but at least
18 the physician is one of the most trusted, if not the most
19 trusted aspect of the whole, you know, ecosystem. That's
20 why it's important to understand where they play and what
21 you're asking them to do and what they need to explain.
22 And I think that's why there's multiple ways to approach
23 that conversation.

24 MS. HOOPER: Right. And we're not going to

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RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 answer the full set of questions because we're just not.

2 But we can do that phased in.

3 MR. CARMODY: That's why you have to break
4 it down.

5 MS. HOOPER: Yep.

6 MR. CARMODY: If you try to do too much too
7 quickly and try to tackle everything you'll just overwhelm
8 -- plus again, this was -- there's a communication when
9 you get into what you need to do to the constituency who
10 do you need to explain and what?

11 MS. HOOPER: Right.

12 MR. CARMODY: If you try to do too much too
13 fast too far you're just not going to get there.

14 MS. HOOPER: And we understand that very
15 well. Actually, all of us do in whatever our roles are.

16 MR. PETRUS: So that's a key one I think
17 for Legal to provide advice on how that is sequenced and
18 what ultimately is the direction that that thing wants to
19 -- that thing, Connecticut wants to move in. And the
20 last one is we talked about earlier, is access and rights
21 of the patient in regards to accessing health information
22 through the Health Information Exchange and will that be
23 a future component or not? Next slide?

24 The agreement from reciprocal data support

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 and usage I think is going to be really critical,
2 especially when we talk about research, predictive
3 analysis, wellness and prevention, surveillance, and I
4 mean disease surveillance and tracking to mobilize
5 resources within the state and to improve practices
6 around chronic care for a very specific healthcare need.

7 Next?

8 The next steps we will move forward with
9 the visioning material. We will send out under separate
10 cover the straw person vision statement that we sent out
11 to you so that we can get that back from you. And --

12 MR. MCKINNON: Frank?

13 MR. PETRUS: -- yeah?

14 MR. MCKINNON: What we're going to do is
15 send you the slides so that it can be updated slightly so
16 it won't be exactly the same as your printed copies
17 because we've had some errors and --

18 MR. PETRUS: Everybody's taking notes too.

19 MR. MCKINNON: -- this way we can take
20 some notes. The other thing we're going to do is the
21 worksheets, the paper worksheets we'll give you an
22 electronic updateable version of those and basically and
23 what -- so you can type stuff into them or you can print
24 them out and write on them if you'd like. But that's --

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 we would like any input you want to make regarding these
2 on those sheets.

3 MR. PETRUS: And they go to the single
4 point of contact, Meg, you?

5 MS. HOOPER: Actually, Ms. Lynn Townshend
6 will be our point of contact.

7 MR. PETRUS: Okay.

8 MS. HOOPER: We're working with Gartner
9 and the official locator.

10 MR. PETRUS: Okay.

11 MS. HOOPER: The worksheets you're going
12 to send in Word? And you're going to send it in 2007
13 Word, not Doc Apps. okay? Because State systems we don't
14 have Windows 7 yet, okay?

15 (Laughter)

16 MS. HOOPER: So save it down. You know
17 how to save it down

18 MR. MCKINNON: WordPerfect.

19 (Laughter)

20 MR. PETRUS: No, Wordstar 2000.

21 (Laughter)

22 MR. COURTWAY: Two things. One in regard
23 to forms and styles, is the intent to have the committees
24 do this or the constituents work on this?

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MS. HOOPER: I think actually there were
2 both. I think what Frank had asked is that these are
3 worksheets for consideration with your committee --

4 MR. COURTWAY: Okay.

5 MS. HOOPER: -- but also we would want to
6 encourage individual comments. Frank, correct me please
7 if I'm wrong, but we need as much input as you can find.

8 MR. PETRUS: As quickly as possible. So
9 my sense is if you're not having a committee meeting
10 soon, if you think you have enough information from the
11 meetings you had to give us some feedback --

12 MS. HOOPER: Correct.

13 MR. PETRUS: -- and again, we're not
14 looking to finalize, what I hear from you, what do you
15 see as strengths? Do you see any gaps in what we've
16 identified? Any risk or constraints that you think we
17 should be aware of that we didn't identify?

18 MS. HOOPER: Correct.

19 MR. PETRUS: And the other thing is the
20 vision so we can lock that down. You may want to send
21 out to your committee and have them give you some
22 feedback.

23 MR. COURTWAY: One other question back on
24 the domains? One thing noticeably missing is identity

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 management.

2 MR. PETRUS: Under technical.

3 MR. COURTWAY: Is it -- that's a technical
4 issue? In terms of the -- I'm referring within -- not so
5 much in the technical sense but in terms of the
6 identification of an individual's information coming into
7 the exchange, the question of now of bio-metric, what
8 forms of identification, perhaps more in my mind moving
9 over into how you obtained consent to know that you have
10 the consent on the right person.

11 MR. GORDON: Operations should -- is it
12 operations?

13 MR. COURTWAY: Operations? Business
14 operations?

15 VOICE: Yeah.

16 MR. PETRUS: I think it's both. I think
17 it's both. I also think even be a governance issue at
18 some level and it might be a legal policy issue. The
19 thing that you saw through this summary is part of these
20 domains are very much integrated.

21 MS. HOOPER: Can we -- we're not done yet
22 folks, hold on. Frank, are you done with the
23 presentation so far? Again, Alistair, are you going to
24 be sending our a revised document or just revised

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 individual pages so we can --

2 MR. MCKINNON: No, a revised document.

3 MS. HOOPER: -- okay. You know, on the
4 paper -- I mean, you could just send us the revised
5 pages.

6 MR. MCKINNON: No, they'll be electronic.

7 MS. HOOPER: Oh, alright. A PDF we can
8 open, the Doc X's we can, okay?

9 MR. MCKINNON: We'll take care of it.

10 MS. HOOPER: Alright. Is there any --
11 hold on. We have questions for Gartner on this
12 presentation to date. Then we'll open the meeting for
13 public comment. Do we have any folks --

14 MR. WOLLSCHLAGER: I'm sorry Meg. Warren.

15 MS. HOOPER: Yes Warren?

16 MR. WOLLSCHLAGER: Just while we still
17 have Gartner I think at the next meeting the best date
18 for folks was for the gap analysis meeting --

19 MS. HOOPER: Was it May 3rd?

20 MR. WOLLSCHLAGER: -- May 3rd, yeah, in
21 the afternoon.

22 MS. HORN: 1:00 to 4:00.

23 MS. HOOPER: 1:00 to 4:00 on May 3rd and I
24 believe in this room.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. WOLLSCHLAGER: We don't have any
2 confirmed location yet.

3 MS. HORN: It'll be here.

4 MS. HOOPER: We're now confirming that it
5 will be in this room, 1002, May 3rd from 1:00 to 4:00.

6 MR. WOLLSCHLAGER: Okay.

7 MR. MCKINNON: And can we also confirm
8 that that meeting just about the gap analysis?

9 MS. HOOPER: It is just about the gap
10 analysis.

11 (Laughter)

12 DR. AGRESTA: Well done.

13 MS. HOOPER: My great grandmother's name
14 is McTige (phonetic), so I'm great with Alistair.

15 MR. PETRUS: She understands him, which I
16 don't.

17 MS. HOOPER: Yeah, no problem. So it will
18 be just about the gap analysis.

19 MR. PETRUS: And it will be a working
20 session.

21 MS. HOOPER: It will be so please choose
22 your -- whether you're able to attend and actually
23 contribute. Can I ask for public comment? We have one
24 of our microphones can be made available for any public

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 comments on any part of this meeting. Yes sir? Mr.
2 Lynch?

3 MR. JOHN LYNCH: John Lynch. One comment.

4 MS. HOOPER: You may come up. We'd love
5 to make sure we get the words right.

6 MR. LYNCH: Okay. First of all, I'd like
7 to commend the Committee. I've seen more action today
8 and more direction today and it's encouraging to see the
9 activity starting to shape up and take place. My one
10 I'll call it concern came from the Finance Committee
11 where you started talking about emergency department.
12 Remember, E.D. has to talk with someone else, so in that
13 exchange it's not a one way exchange to the emergency
14 department, but let's say the primary care docs who would
15 also need to have the summary back from the hospital so
16 that we can take care of those patients in that gap so
17 they're not getting readmitted, etcetera. That's a very
18 critical time for the primary care docs to receive that
19 summary data and really ensure that continuity of care.
20 Thank you.

21 MS. TOWNSHEND: Thank you. Any further
22 public comment? Yes sir? And your name?

23 MR. JIM ALBERT: I'm Jim Albert from
24 Charlotte Hungerford Hospital.

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MS. TOWNSHEND: Okay. We need you on a
2 mic. there.

3 MR. ALBERT: I can speak loud enough, I
4 was in the military.

5 MS. TOWNSHEND: Oh, you can. Okay.

6 MR. ALBERT: Hi. I'm Jim Albert from
7 Charlotte Hungerford and I just had a question. A lot of
8 the hospitals are starting their own strategies and
9 working on their strategies for HIE, electronic health
10 records, meaningful use, and we're kind of desperately
11 waiting for some definition of what the functions of the
12 state HIE will provide because that effects whether or
13 not we provide them at the local level or if they're
14 provided at the state level or if they're provided at
15 both. And I know you talked about hybrid, but then you
16 also gave a wish list of all the functions that the HIE
17 would provide, which seemed to very duplicate a lot of
18 the local HIE functions as well. So there's kind of two
19 messages coming across here. And I know you don't want
20 to leave the doors closed on any of those options, but
21 from the hospitals' perspective I think it's important
22 because time is ticking along and we're on the hook also
23 to meet our meaningful use requirements and receive
24 stimulus funding. So we're waiting for the state HIE

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 definitions and functions to come out so that we can plan
2 accordingly.

3 MS. HOOPER: Understood. Absolutely and
4 we -- I think all of us need to not only hear that but
5 appreciate that and the Department is very much aware of
6 that responsibility. Dr. Agresta?

7 DR. AGRESTA: Jim, I just was wondering,
8 in kind of defining it from the state level one of the
9 things that might be helpful for us that have to kind of
10 actually do that definition is somewhat of an impact
11 analysis from you guys about what it means for us to
12 define it in different ways and perhaps -- because I
13 think it would help us understand --

14 MR. ALBERT: We discussed that too.

15 DR. AGRESTA: -- yeah. And if we could
16 forward or make that available to us it would be very
17 helpful not just from the hospitals' perspective, but we
18 need to think about this in the Regional Health Extension
19 Center type thing too. Like, what is it going to mean
20 from a primary care provider or from a sub-specialist or
21 whatever because I agree with you, it's sort of the
22 chicken and egg phenomena and who goes first, who blinks
23 first is really going to be hard to decide, but we need
24 to think about what the impact is and there's nobody

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 better to provide that than the folks who are going to
2 get impacted.

3 MS. HOOPER: Right.

4 MS. TOWNSHEND: Thank you.

5 MS. HOOPER: Any other public comments?

6 Can I go back to -- I'm so sorry Lynn, hold on before you
7 -- on the gap analysis meetings, Warren, May 3rd it is
8 not in the afternoon. So wrong, I need to restate my
9 statement.

10 MS. TOWNSHEND: Then Commissioner Galvin
11 can't be there.

12 MS. HOOPER: May 3rd -- well, we have it
13 scheduled from 9:00 to 12:00 is what we all have on our
14 calendars.

15 MS. TOWNSHEND: Warren sent out an email
16 that it was 1:00 to 4:00. We can take care of this off
17 line.

18 MS. HOOPER: We'll let you know.

19 MR. WOLLSCHLAGER: We did it based on the
20 Commissioner's availability.

21 MS. HOOPER: So it is the afternoon?

22 MR. WOLLSCHLAGER: Yes.

23 MS. HOOPER: I'm sorry. Thank you Warren.

24 So it is May 3rd from 1:00 to 4:00?

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 MR. WOLLSCHLAGER: Right. That's why we
2 don't have a spot yet.

3 MS. HOOPER: Commissioner Bailey and I
4 were under the impression I was in the morning, but we
5 will wait for a confirmation of a location Mr. Varney.
6 The penthouse would be great.

7 MR. VARNEY: Yes. 1:00 to 4:00?

8 MS. HOOPER: There you go.

9 MS. TOWNSHEND: 1:00 to 4:00.

10 MS. HOOPER: No other public comment? I'd
11 like to ask Lynn Townshend to make a few comments?

12 MS. TOWNSHEND: Thank you very much. For
13 those of you who don't recognize me I'm Lynn Townshend.
14 I'm not sure if Michael pointed to me, I kind of waved.
15 But I'm looking forward very much to working with all of
16 you and all of you and everyone who's involved with HIE,
17 EMR, HITE, whatever alphabet soup you'd like to call it.

18 This is going to be quite a ride and I'm glad you guys
19 are along to help smooth the path. So thank you very
20 much and let me also give you my email because I know
21 that Meg asks that you send once you get this in
22 electronic format and get it all filled out send the
23 sheets to me. So when you do that my email, and it's an
24 odd spelling, so let me -- lynn.townshend@ct.gov. You

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 forget the H I won't see it, and that happens
2 unfortunately quite often.

3 MR. MCKINNON: I think you're actually
4 going to be sending it to them because I'm going to send
5 it to you.

6 MS. TOWNSHEND: You're going to send it to
7 me?

8 MR. MCKINNON: You're going to send it to
9 them.

10 MS. TOWNSHEND: Then I'll send it to you.

11 MR. MCKINNON: And then they know what to
12 reply.

13 MS. TOWNSHEND: I'll also include my other
14 contact information when I send that out. So thank you.

15 MS. HOOPER: Yeah. We haven't bought her
16 any business cards yet. Any other comments, suggestions?
17 Don't forget, our next meeting for this full group
18 Monday, May 17th from 12:00 to 2:00, gap analysis is May
19 3rd. Thank you very much for your committee work. Thank
20 you for coming here. Warren, my apologizes for running
21 six minutes over closing time. Warren, do you have
22 anything to add sir?

23 MR. WOLLSCHLAGER: No, I'm good. I
24 appreciate the Commissioner dedicating so many assets to

RE: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE
APRIL 19, 2010

1 this important effort.

2 MS. HOOPER: Thank you sir and take care
3 of the puppies now. Motion to adjourn?

4 VOICES: So moved.

5 MS. HOOPER: Second?

6 VOICE: Second.

7 MS. HOOPER: Thank you all very much.

8 Have a great day.

9 (Whereupon, the hearing adjourned at 2:08
10 p.m.)