

VERBATIM PROCEEDINGS

HEALTH INFORMATION TECHNOLOGY AND
EXCHANGE ADVISORY COMMISSION

AND

DEPARTMENT OF INFORMATION TECHNOLOGY

DR. ROBERT GALVIN, COMMISSIONER

MAY 17, 2010

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

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MEETING RE: HITE/DOIT
MAY 17, 2010

1 . . . Verbatim proceedings of a meeting of
2 the Department of Information Technology and the Health
3 Information and Technology Exchange Advisory Committee
4 held on May 17, 2010 at 12:12 p.m. at the Department of
5 Information Technology, 101 East River Road, East
6 Hartford, Connecticut. . .

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10 COMMISSIONER ROBERT GALVIN: I will call
11 the meeting to order. The first item of business is a
12 review of the minutes from the 3 May 2010 meeting.

13 MS. MEG HOOPER: Any comments, edits?

14 COMMISSIONER GALVIN: Additions, deletions?

15 If not, I'll accept a motion to approve the minutes as
16 submitted for the 3 May 2010 meeting. Do I have a motion?

17 MR. DANIEL CARMODY: So moved.

18 COMMISSIONER GALVIN: Second?

19 DR. KEVIN CARR: Second.

20 COMMISSIONER GALVIN: All in favor?

21 VOICES: Aye.

22 COMMISSIONER GALVIN: Opposed? Oh --

23 MS. HOOPER: Mr. Carmody is making the
24 motion and the second was Dr. Carr. And did we have a

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1 unanimous --

2 COMMISSIONER GALVIN: We are unanimous --

3 MS. HOOPER: Unanimous --

4 COMMISSIONER GALVIN: -- as far as I could
5 tell.

6 MS. HOOPER: There you go.

7 COMMISSIONER GALVIN: Plus there was a
8 silent dissenter.

9 MS. HOOPER: And I'm going to add an agenda
10 item, if I may?

11 COMMISSIONER GALVIN: You may add an agenda
12 item.

13 MS. HOOPER: Just for -- what we're going
14 to do is go around and make sure that the folks on the
15 phone understand who's here. And I will ask each time
16 that you do speak today, that you do acknowledge your name
17 first for our transcriptionist. On the phone I know that
18 we have -- Marie, would you like to introduce yourself?

19 MS. MARIE O'BRIEN: Certainly. Marie
20 O'Brien, President of the Connecticut Development
21 Authority and I'm a member of the Finance Subcommittee.

22 MS. HOOPER: And Tony.

23 MS. O'BRIEN: And Tony Roberto is on the
24 line. He's the Executive Director of the Connecticut

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1 Development Authority and he serves as my backup, but
2 occasionally, such as today, it's good to have both of us
3 on.

4 MS. HOOPER: Absolutely. Anyone else on
5 the call? Okay, if we could start with Marsha.

6 MS. MARSHA MAINS: Marsha Mains, Director
7 of Medical Operations, Department of Social Services.

8 MR. CARMODY: Dan Carmody, CIGNA.

9 MR. MICHAEL HUDSON: Mike Hudson, AETNA.

10 DR. THOMAS AGRESTA: Tom Agresta at The
11 University of Connecticut.

12 DR. CARR: Kevin Carr, Internal Medicine
13 Physician and also I'm senior executive (indiscernible).

14 MS. BARBARA PARKS WOLF: Barbara Parks
15 Wolf, Office of Policy and Management.

16 MR. RICHARD BAILEY: Rick Bailey, Deputy
17 CIO, Department of Information and Technology.

18 MS. MARIANNE HORN: Marianne Horn,
19 Department of Public Health.

20 MS. HOOPER: Meg Hooper, Department of
21 Public Health.

22 COMMISSIONER GALVIN: Bob Galvin,
23 Department of Public Health.

24 MS. LYNN TOWNSHEND: Lynn Townshend,

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1 Department of Public Health.

2 DR. KENNETH DARDICK: Ken Dardick, family
3 physician from Mansfield.

4 MR. MARK MASSELLI: Mark Masselli,
5 Community Health Center.

6 MS. JAMIE MOONIE: Jamie Moonie, CIO at
7 Norwalk Hospital.

8 MS. HOOPER: And then we have Gartner
9 colleagues here.

10 I wanted to interrupt the agenda if I may,
11 sir. This handout on the Board of Directors is color
12 coded to try and make it a little bit easier, but I wanted
13 you all to take a look at this and to give you a heads up.
14 What we're trying to do is to mesh the current
15 legislation for the HITE Advisory Committee, of which we
16 are now as a group advising the Department on the
17 development of the strategic and implementation plan and
18 the new legislation that has yet to be signed. So let me
19 just put that up front, that the Governor has not yet
20 signed the bill that does establish the authority January
21 1. We do not expect any problem with that, but I want to
22 put that out front first. If that bill is signed, the new
23 Health Information Technology and Exchange of Connecticut
24 Board of Directors will have a term starting 10/1/2010,

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1 and the term lengths of time are dependent upon who the
2 appointee is.

3 On the left side of the page in blue is the
4 designated state offices on page 1 that identifies the
5 state agencies and their representatives right now on the
6 Advisory Committee -- hello, Peter -- and the agency that
7 they're representing. As we know, all of -- we have a
8 gubernatorial election and the possibility of
9 commissioners changing as we move forward after the
10 inauguration on -- I believe it's the 5th. So we have
11 indicated that the existing representatives from state
12 agencies really are part of the Board of Directors until
13 there is a change really in the commissioners or in the
14 status of the appointees.

15 On the next page are the appointments.
16 There are two additional appointments to the new Board of
17 Directors effective October 1. Senate President Williams
18 will have an opportunity to appoint a licensed physician
19 and Speaker of the House Donovan will have an opportunity
20 to appoint a consumer or consumer advocate to the new
21 board.

22 Other than the initial term established
23 according to the appointments, four years for the Governor
24 for example, Senate President is just a one-year term

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1 that you're serving. After that initial term, each board
2 member will have a four-year term if reappointed.

3 I'd like to ask you all to take a look --
4 we've put in some of the subcommittees on the very last
5 page of the members that we are aware of. I know that
6 Special Services or Special Populations Committee we do
7 not have a group, quote, "together" just yet. I want to
8 remind you that the Legal and Policy Subcommittee from the
9 Department is -- Marianne Horn is the lead for that, again
10 providing assistance in establishing the committee.
11 Business and Technical is Joe Canfield, and the Finance
12 Subcommittee is supported by Warren, who I'm sorry could
13 not be with us today, but will be with us at our next
14 meeting. The Technical Architecture Subcommittee is
15 Deputy CIO Bailey. Special Services is Sarju Shah. And
16 the State Agency Committee is myself.

17 MS. TOWNSHEND: The Executive Committee --

18 MS. HOOPER: I'm sorry?

19 MS. TOWNSHEND: Is that --

20 MS. HOOPER: And the Executive Committee,
21 I'm sorry I didn't include that, is supported by Lynn
22 Townshend.

23 I wanted you to have this now. If you are
24 interested in either being appointed to the Board or if

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1 you have people you would like to encourage to be
2 appointed to the Board, there are the appointers -- is
3 that right --

4 MS. TOWNSHEND: Mmm-hmm --

5 MS. HOOPER: -- and the designated terms
6 and the representation for those new members. So we would
7 encourage those that are interested to pursue either being
8 reappointed and/or other appointments that you feel would
9 be appropriate to this representation. The Department is
10 not going to be advocating as an agency. We certainly
11 will be working with the appointers to see if they have
12 any -- to encourage them to make their appointments
13 certainly by the due date of October 1st.

14 The new Board of Directors will meet before
15 November 1st and the new authority will be in place on
16 January 1st.

17 In order to assure some smooth transition
18 if in fact this body is not the same members for the
19 Board, this body, this Advisory Committee to the
20 Department is in place until December 31st. It can be
21 confusing or you can color code it and try to have an
22 advantage. So just to encourage you all to look at your
23 term. We do have two that are expiring on November --
24 excuse me, September 30th, which is Dr. Kim and Dr. Carr.

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1 Where new appointments would be made for October 1, we're
2 not going to be asking for an appointment for one day. If
3 that's okay?

4 So with that, are there any questions on
5 the Board appointments? Obviously if you have any
6 questions, you can talk to any of us from the Department
7 and we'll be happy to answer them.

8 COMMISSIONER GALVIN: Well, I have some
9 questions because it's -- it's not very clear to me.
10 We're -- we're going to get a couple of -- two more people
11 that we wouldn't ordinarily -- didn't ordinarily have --

12 MS. HOOPER: Correct.

13 COMMISSIONER GALVIN: Okay. Now there are
14 two more people, one of who has resigned and one of whom
15 was deleted from the Board for non-attendance?

16 MS. HOOPER: Exactly, sir.

17 COMMISSIONER GALVIN: Okay. So there are
18 actually four more people. Alright.

19 MS. HOOPER: Then what we have right now --
20 correct -- and we will be pursuing with -- the two folks
21 that were --

22 MS. HORN: McKinney is one --

23 MS. HOOPER: Right --

24 MS. HORN: Williams I think is the other --

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1 MS. HOOPER: Representative McKinney has to
2 appoint someone. Susan Brueshe was our pharmacist and de
3 facto resigned from the Board. And the other is Josh
4 Rising, who represented expertise in public health under
5 Senate President Williams. Those are two current
6 vacancies that can be appointed now. And the Department
7 is working with those legislative officers. Again, if you
8 have recommendations, please let those individuals know.
9 That's not our job to advocate for individuals. So if you
10 know people and would like to speak to them -- so yes, in
11 addition to the present company, there are going to be
12 four additional seats filled with expertise as defined in
13 the legislation.

14 COMMISSIONER GALVIN: How come I got such a
15 low seat? I'm feeling overwhelmed --

16 MS. HOOPER: Oh, here -- (laughter) -- you
17 can -- there's a little lever --

18 COMMISSIONER GALVIN: I'll -- I'll fix that
19 --

20 (Multiple voices overlapping -
21 indiscernible)

22 COMMISSIONER GALVIN: I don't know if I'm
23 capable of finishing the meeting -- I presume that all the
24 people who are currently in attendance would like to stay

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1 in attendance. But if you don't want to -- you know, if
2 you don't want to continue on the Board, let us know,
3 because it's very difficult to fill these positions in
4 terms of getting some of the appointing authorities to do
5 it.

6 MS. HOOPER: Correct.

7 COMMISSIONER GALVIN: The other -- and
8 there's a time problem. Now all the appointments will --
9 that are made -- my understanding is, and it's the
10 understanding I got from our legislative liaison, that the
11 new Governor will not turn around and say no I want to
12 reappoint everyone.

13 A VOICE: That's correct.

14 MS. HOOPER: Correct. By the legislation
15 these current individuals who are doing the appointing
16 will be doing the appointing before 10/1 --

17 COMMISSIONER GALVIN: And the appointment
18 goes on for a year or two years, or whatever it is --

19 MS. HOOPER: Correct --

20 COMMISSIONER GALVIN: -- for that term. So
21 we're not going to have to go through this on the 1st of
22 January all over again.

23 MS. HOOPER: Correct. The next time that
24 we would have to do it is next October for the one-year

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1 appointees. That when we would have possibly a new Senate
2 President. That's a one-year term.

3 COMMISSIONER GALVIN: Okay.

4 MS. HOOPER: So that for a year starting in
5 October, we'll have -- some of us will be here for one
6 year.

7 COMMISSIONER GALVIN: And just so you all
8 know, when a new governor takes office, all the
9 commissioners submit their resignations. That's the --
10 and deputies. And the new governor will decide who stays
11 or who goes. And I -- I have no idea -- if I knew who the
12 new governor would be, I'd -- I'd let you know --
13 (laughter) -- so you all put your money on the right
14 horse. However, I don't think Commissioner Sarkowski has
15 anticipated -- he's already -- he's already said he's
16 retiring. So you may -- and I may not be here. But once
17 again, I don't know who's going to be the new governor or
18 what their policies are.

19 I can tell you that we met with the Office
20 of Policy and Management today and the new governor
21 expects -- or she --

22 A VOICE: The new secretary --

23 COMMISSIONER GALVIN: No, the new governor
24 on November 15th wants a projected budget. And there's

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1 going to be a transition. And it's my opinion that since
2 all these folks have said that health informatics and
3 electronic records are pivotal to moving forward -- again,
4 we all know the drill -- I would be fairly certain that
5 this group will be asked very early on before the confetti
6 is trampled underfoot to say, you know, what are you guys
7 doing and what are you going to do. So once again, it's
8 incumbent on us to be prepared to do some -- I would say
9 the second or third week in November that somebody would
10 want a briefing about what's going on, where are we, and
11 the like. So that January 1st date is -- the inaugural
12 date is not going to be the date that the new governor is
13 going to want to hear this stuff. They're going to want -
14 - they're going to want to hear it early.

15 A VOICE: Exactly.

16 COMMISSIONER GALVIN: And we -- we would
17 appreciate any recommendations. I know -- for people who
18 might want to serve. I know that the State Medical
19 Society is very interested in having someone who is
20 representative in a broad sense of their interests and not
21 simply just a dues paying member, etcetera, etcetera. And
22 once again if you've got interested folks, you've got to
23 tell them there's going to be a lot of meetings and a lot
24 of time consumed, particularly by the Executive Committee.

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1 MS. HOOPER: Thank you. And I just
2 realized, sir, too, the four new one will be excused,
3 which is the Commissioner of OCA. As it was designed when
4 the appointments were being made, OCA was a separate
5 agency in this new legislation. There is -- the
6 commissioner is the representative from the department.
7 So we would lose again as an official appointee in the
8 capacity as an OCA representative the commissioner of OCA
9 -- that would be the Commissioner of OCA.

10 Also with the Board, if we could be clear
11 that we are going to be coming to ask the Advisory
12 Committee members and the new Board of Directors for some
13 match requirements for the O&C funding. We'll prepare
14 some documents and would appreciate your feedback on that.

15 Marianne, did you have more to add on the
16 Board of Directors? Is there anything that we've missed?

17 MS. HORN: No.

18 MS. HOOPER: Any questions?

19 COMMISSIONER GALVIN: Yeah. I've got two
20 words for you, sustainable funding. And -- and I have a
21 dire prediction that we will be faced by less than
22 adequate results if we don't find a way to get sustained
23 funding. And I -- I can't do that and I can't go out and
24 advocate and lobby for that. But there needs to be some

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1 financial underpinning here.

2 My gut feeling and other peoples' gut
3 feelings is that we were unsuccessful in obtaining the
4 Beacon grant because we didn't have, as they say in the
5 vernacular, any skin in the game. In other words, the
6 State has not invested in the program. And I don't mind
7 getting beat out by the Mayo Clinic or Geisinger or some
8 of the bigger states like Minnesota or New York who can
9 elbow you around behind the goal and high stick you and
10 all that, but I do mind getting beat out by Maine and
11 Rhode Island. And I -- and -- not that I disparage them,
12 but I think that we're -- we're obviously a leader and --
13 etcetera, etcetera -- but Maine -- Maine has invested in
14 it and we haven't. And Rhode Island is investing in it
15 and we don't.

16 And I think as long as we don't get some --
17 you know, get some investment or get a dog in the fight,
18 we're -- we're going to be coming up towards the end of
19 the cue for federal money. And that makes reasonable
20 sense to me. If I was sitting there and I figure these
21 guys have invested money in their provider groups or their
22 payer groups and we're sitting out there with no
23 investment and -- we can't leap from federal grant to
24 federal grant. As I talk to people, I say it's kind of

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1 like somebody -- you know, those old things where you see
2 the lady holding the baby trying to cross the torrent and
3 she's jumping from rock to rock to rock. Well we've got
4 to put some rocks in there first to jump to get to the
5 other side or we'll be doomed to less -- to have less than
6 adequate success. And as I've said in the past, I don't
7 really want to end up appending to people and saying can
8 we buy your service or how about making yours 30 percent
9 bigger for us. But we could go in that direction. So
10 we've got to find a way to get sustainable funding.

11 MS. HOOPER: And you're just the man to
12 make that happen, right?

13 COMMISSIONER GALVIN: That's right.

14 MS. HOOPER: Thank you very much, sir. I
15 want to -- there are a couple of Board announcements
16 before we pass over to Gartner. Lynn.

17 MS. TOWNSHEND: I have a save the date for
18 you. June 10th the Connecticut Hospital Association will
19 be holding a one-half day leadership meeting for anyone
20 interested in HIT. We've asked E-Health Connecticut to
21 provide us with an update -- or provide the group with an
22 update to present there actually on where they are with
23 the Regional Extension Center. We've invited DSS to
24 present with regard to where they are in their process

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1 with CMS reimbursement. And that happens to fall during
2 the week of public comment with regard to our strategic
3 plan. So we will present where we are as the REO in the
4 State of Connecticut and take any public comment and
5 feedback that anyone there has to offer.

6 It is a public meeting and we're limited to
7 70. So, I will be sending out information with regard to
8 how you may sign up. There's no cost. There's plenty of
9 parking if you've never been to CHA. Wallingford is a
10 wonderful town says a girl who lives there -- (laughter) -
11 - so please mark your calendars and we invite you to be
12 there. Is there anything else?

13 MS. HOOPER: I don't think so. Again we're
14 going to be doing the public information period where we
15 can -- and forums where we can have folks coming forward -
16 -

17 MS. TOWNSHEND: There is one other note.
18 At our next meeting of this committee, June 21st, O&C's
19 technical advisories -- technical advisors -- yeah, I can
20 talk -- the technical advisors would like to come to this
21 meeting and ask you if there's any technical assistance
22 that you need or -- and provide information on what kind
23 of technical assistance they can provide. So, I wanted to
24 make sure I had your permission to go forward with that

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1 agenda item at this time.

2 MS. HOOPER: So that's our federal funders
3 coming to see us on June 21st, so we're hoping that
4 everyone can really make sure that they can attend so that
5 there's a good show and good conversation.

6 I know that someone else just called in.
7 May I ask who? Was it Susan or Warren? Lisa? Okay. Is
8 there anyone that would like to identify themselves on the
9 phone? Okay. Thank you very much.

10 With no further ado, I want to acknowledge
11 that the materials that were handed out today by Frank and
12 the Gartner team includes the environmental scan. It's a
13 really important document of the identification of what's
14 going on in the state, and then the Analysis of
15 Alternatives Workshop, which is for today. I want to
16 acknowledge and respectfully give my thanks to Gartner, a
17 great deal of information is here that we have talked
18 about and I think it's very important that we be very
19 careful to read through each of the pieces. Frank, take
20 it away.

21 MR. FRANK PETRUS: Okay. Well good
22 afternoon. The presentation we're going to be using today
23 is the Alternative Analysis that you have in front of you.
24 The other one, as Meg said, is the Environmental Scan.

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1 That really is all the work that we have done with you
2 from a couple of meetings and also the research that we
3 did with what's going on in Connecticut, the focused
4 interviews, the document review, and also what's going on
5 nationally. The Environmental Scan really became part of
6 the foundation for today's Alternative Analysis, as did
7 the workshop that we had a few weeks back where we started
8 to look at the strengths, weaknesses, opportunities,
9 looked at the gaps.

10 And what we've done is had subsequent
11 meetings with some of you and moved forward with the
12 Alternative Analysis Workshop, with a little introduction
13 to provide some context for it, and then we really want to
14 have this as a participatory process. As you may
15 remember, we identified several gaps, but today we're
16 really focusing on what we see as the key gaps and the O&C
17 domain that you will be making decisions on. And some of
18 those decisions will be achieved by you saying those
19 things over there we shouldn't be doing and then what's
20 left on the table might be the right direction, and some
21 of them will be yes in Connecticut this is the approach
22 that might work for this domain to address that gap.

23 We believe that at the end of today that we
24 need to get clarity from you, and you provide clarity and

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1 consensus with each other of where you want to go with the
2 strategic plan. We may not finalize all the decisions
3 today, but we should have from you a strong consensus to
4 move forward. Understanding that this isn't your last
5 bite at the apple. The strategic plan is an application
6 or a planning document that goes to O&C and says this is
7 what Connecticut wants to do, this is how Connecticut
8 perceives moving forward with these five domains.

9 You'll get another bite at the apple when
10 you start looking at the operational plan and start saying
11 this is what we need to be doing to fulfill those needs,
12 this is how it's going to happen, this is the steps, these
13 are the phases, this is the sequencing. So you've got
14 opportunity for input not just today, but today we feel
15 there are some critical gaps that need to be addressed and
16 so we really need your active participation.

17 MS. HOOPER: I'm going to interrupt again.
18 Today's recommendations again as the Advisory Committee,
19 we will run until 4:00 o'clock, I mentioned it earlier, or
20 we'll leave -- we will be done when -- when there is some
21 consensus, even if it's default consensus on what we are
22 going to do and what you recommend for the Department to
23 embrace.

24 Also this is -- the decisions made today

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1 and the advice given today is what's going to be in the
2 document that will be vetted for public review. So there
3 will be another opportunity not just for this committee to
4 provide advice, but also for other leaders and the public
5 to give comments before we submit it to O&C --

6 MR. PETRUS: Absolutely --

7 MS. HOOPER: -- just for clarity on that,
8 okay. Jamie.

9 MS. MOONIE: Jamie Moonie speaking. Just a
10 question. Back to Dr. Galvin's concern about sustainable
11 funding for whatever we decide upon, is that part of the
12 scope of work that you're doing, is to help us analyze
13 what other successful --

14 MR. PETRUS: Well it's one of the major
15 gaps that needs to be -- (indiscernible, coughing) --
16 absolutely.

17 MS. MOONIE: Okay, but not -- not a gap to
18 be addressed, but something that you have experienced
19 throughout the United States as what works and what we
20 possibly --

21 MR. PETRUS: Yes --

22 MS. MOONIE: -- could do here.

23 MR. PETRUS: Yes. We are going to identify
24 some alternatives for your consideration. And I think at

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1 the last workshop we really came out with two trains of
2 thought or two parallel directions. One is what do you do
3 for some baseline funding that will always be there and be
4 predictable, and then what you do to support the
5 sustainability of this through other fees or other revenue
6 streams that would help continue and enhance the HIE. And
7 we'll spend a lot of time on that today I think unless you
8 quickly come to an answer.

9 COMMISSIONER GALVIN: Frank, if I might
10 just --

11 MR. PETRUS: Please --

12 COMMISSIONER GALVIN: -- I was speaking
13 with some lovely people from our -- our financial managers
14 and they're under the impression that the money is going
15 to come in right away, fees and services that -- that we
16 sell. So they were -- the Office of Policy and Management
17 kind of looked at me almost aghast, well what are you
18 going to do with all the money that you get from people
19 using the services. And I tried to explain to them that's
20 not going to happen for quite a while. So there's a -- as
21 you folks are talking -- talking this up, you've to
22 dissuade people, you know, from -- you know, we're going
23 to get a little startup money, then -- you know, once we
24 get this -- once we get this thing rolling like a soap box

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1 derby, we get this little thing rolling down the slope,
2 we're all set. Well that's not going to happen.

3 A VOICE: A good point.

4 MR. PETRUS: Let's look at the objectives
5 for today. The workshop was built upon work you already
6 did with us around the vision, the goals, the principles
7 for the HIE. The -- starting the discussion regarding the
8 value of proposition for the HIE, then the environmental
9 scan, the swat and gap analysis, all of that became the
10 foundation through your participation and through the work
11 that we did with your colleagues and others and through
12 document review.

13 Today's No. 1 challenge is to validate the
14 alternatives for addressing the gaps and what is necessary
15 for the success of the HIE in fulfilling the vision that
16 you've identified. And we're going to do that by
17 reviewing the potential alternatives for the key gaps,
18 prioritizing those alternatives, and we're hoping coming
19 up to a very short list of what you think are the viable
20 alternatives for addressing those key gaps.

21 Next. Rules of the road, we want to really
22 keep focused today on the requirements for the strategic
23 plan. We're not going to drill down the weeds on how
24 you're going to do it, but really what is it that you want

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1 to do and what are the key alternatives for you to move
2 forward with -- and the five O&C domains which you want to
3 keep focused on, and understanding that as we've gone
4 through other meetings with you, you can see that the five
5 domains are interdependent, they're not silos. What you
6 may decide in Policy and Legal may impact Finance, Finance
7 may impact Business and Technical Operation, Technical
8 Architecture -- so we're going to look at them and we're
9 going to understand that they're interdependent and try to
10 reflect that in the work that we've done.

11 Wordsmithing, we don't want to spend a
12 whole lot of time on wordsmithing unless it's a real red
13 flag kind of word that we use or phrase that we use that
14 you think would be detrimental in communicating it to your
15 colleagues and -- and Connecticut State folks.

16 We want to have decisions today about the
17 most viable alternatives. In some areas you might come up
18 with two things you'd like to look at, but we really want
19 to get that list down to where you want to go in these key
20 gaps.

21 Anything we can't resolve today that needs
22 more research, we're going to park it and not spend our
23 time doing it here. We'll agree on okay that needs
24 further research, we can't resolve it today, we'll park

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1 it.

2 Anything concerns about the rules of the
3 road?

4 MS. HOOPER: We may need reminders on
5 keeping us out of the weeds.

6 MR. PETRUS: I hope you will help me do
7 that.

8 MS. HOOPER: Ditto.

9 MR. PETRUS: Got it. Project contact and
10 status, well here's where we are on the project. I'm not
11 going to spend a lot of time on that.

12 Next. Our layer cake approach, we are on
13 Step 4. We are close to the strategic plan. And if
14 you've had a chance to look at all the materials that we
15 have published for you, back to your fundamental I think
16 support was the HIT strategic plan that you published in
17 June 2009. When we take a look at that plan and the work
18 that we've done to date and put that all together, we're
19 trying hard to do in an organized manner, Connecticut
20 right now has more information in developing a strategic
21 plan than we've seen in many other states.

22 A VOICE: (Indiscernible) --

23 MR. PETRUS: The challenge you have is the
24 paralysis around making a decision. And we're hoping that

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1 we can get through that today. You have enough
2 information to make a decision. It cannot be Gartner's
3 decision. It has to be your decision. And we can make
4 recommendations, we can provide some examples of what
5 other states are doing, but ultimately the responsibility
6 will be you or whoever has the key decision making
7 responsibilities.

8 And so that's where we are today. And we
9 are very close and we're very -- from the Gartner
10 perspective and our team, we're very confident we have
11 enough information to move forward with the strategic plan
12 if you tell us what you want to do.

13 MS. HOOPER: May I interrupt you there?

14 MR. PETRUS: Yeah.

15 MS. HOOPER: Someone called in? May I ask
16 who called in? I'm not hallucinating --

17 COMMISSIONER GALVIN: Is there anybody on
18 the line?

19 MS. HOOPER: Yes --

20 MR. PETRUS: Is -- is anybody on the phone?

21 MS. HOOPER: Oh, they might have hung up --

22 MS. O'BRIEN: Again, it's Marie O'Brien is
23 on the phone.

24 MS. HOOPER: Great Marie, thank you for

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1 hanging in there. Frank.

2 MR. PETRUS: Next is the vision. And we
3 could wordsmith vision, but I'm not going to spend time on
4 it. It will be in your strategic plan and we can vet it
5 with the community. Any kind of changes you want in the
6 vision statement, we'll make it. No question there. But
7 the key again for Connecticut -- you all said -- unlike
8 some states like Arizona, you want to build an HIE that
9 will help transform health care, significantly improve the
10 delivery, the cost, the efficiency, and the outcome of
11 health care. That is different than some states that look
12 at the HIE as a push/pull. To really expedite the
13 delivery, the efficiency, and outcome of health care,
14 you've made the change that you really want to go in the
15 quality of care direction and the improvement of health
16 care.

17 MS. HOOPER: Frank, we may want to throw
18 outcome in that first bullet somewhere because we did --
19 we all do agree health outcomes -- I understand quality --

20 MR. PETRUS: Yeah --

21 MS. HOOPER: -- and accountability can be
22 perceived, but -- but your statement is absolutely
23 correct, but can we just have it in the words also.

24 MR. PETRUS: Yeah.

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1 MS. HOOPER: Thank you.

2 MR. PETRUS: I thought it was there. Let
3 me just --

4 MS. HOOPER: Well you have medical
5 outcomes, but again public health from our --

6 MR. PETRUS: Oh, I got'cha, yes --

7 MS. HOOPER: -- in that vision statement --

8 MR. PETRUS: Got'cha --

9 MS. HOOPER: -- population and health
10 status, we're looking for improved health outcomes.

11 DR. AGRESTA: And we in a business and --
12 operation -- in a business operation and technical meeting
13 earlier we kind of did some worksmithing on that a bit
14 while we were -- it's an electronic version, so I don't
15 have it off the top of my head --

16 MR. PETRUS: Great --

17 DR. AGRESTA: -- but we'll send around a
18 revised version of that, that captures all those things
19 and makes it perhaps a little bit more --

20 MR. PETRUS: Great. Okay. We'll park that
21 and we'll look forward to finalize that. Goals. And I
22 think that --

23 MS. HOOPER: That's too --

24 MR. PETRUS: A mom and apple pie. We've

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1 got a lot of goals here. Again, you'll have an
2 opportunity to revise that --

3 MS. HOOPER: Yeah --

4 MR. PETRUS: -- but basically the strong
5 pieces of the goals really again is around the universal
6 improvement of health care.

7 And if we move on to principles -- and this
8 will be important for the strategic plan. This will be an
9 important statement. Going back to what the Commissioner
10 said about having skin in the game, you are saying that
11 our Health Information Exchange effort, the decisions
12 regarding the alternatives you're going to choose will go
13 back to whether or not they reflect and fulfill these
14 principles; enhancing consumer confidence, a foundational
15 and sustainable infrastructure into the future, a doable
16 realistic practical phased implementation. We're going to
17 be reasonable and practical on how we phase this in;
18 inclusive and transparent governance in approach, all come
19 down are welcome. This is a statewide public initiative
20 to improve health care. So we'll keep coming back to
21 these four key principles.

22 One of the things, just quickly in summary,
23 is that the leverage ability, the strengths that we see
24 that can be leveraged and talked about to O&C about what

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1 the State has done and what the stakeholders and the
2 community have done in moving forward with a strategic
3 plan. And some of those that we want to highlight is a
4 proposal for a hybrid consent model that has been
5 developed to date, an understanding of the value of
6 proposition that needs to be made for both providers and
7 consumers, a two-staged approach to funding that I talked
8 about earlier, that there's a stage 1, that they start out
9 funding a base kind of predictable funding, because as the
10 Commissioner said, you're not going to be having fees come
11 in immediately. You have to design it, develop it, build
12 it, implement it, and phase it in. And then stage 2, once
13 it's fully operational and you move forward, that you have
14 a sustainable funding model that keeps it going into the
15 future.

16 This has been a very open process. You
17 have the foundational document, the June 2009 HIT
18 Strategic Plan, and you have legislation that has been
19 passed. These are all very compelling statements to O&C
20 that you're ready, and in your strategic plan telling O&C
21 what it is you want to do to draw down the next set of
22 funding to support the operational plan you need for
23 implementation.

24 Stakeholder support, you know, right from

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1 the top you have strong support. You have support from
2 state agencies, you have Public Health, you have DSS, you
3 have the Pilot Project, you have the Regional Extension
4 Center that's been funded, and you have numerous HIE and
5 HIE-like initiatives underway in Connecticut.

6 Technical, legal, and financial assets that
7 are there, these are the things that we have documented
8 and identified that can be leveraged to support. And I
9 think a few of those that we want to highlight in addition
10 to the funding that you've got is that there is
11 substantial EHR adoption in the health systems and
12 hospitals in Connecticut, and even in some of the larger
13 provider organizations. We're very impressed with that.
14 Absolutely the majority of private providers are 3, 2, or
15 1, and they're -- it's very important for them to
16 understand the value of proposition. It's very important
17 for them to understand the total cost of ownership. It's
18 very important for them to understand cost-effective ways
19 for them to adopt electronic health records in their
20 practice. And with the support of the Regional Extension
21 Center and this initiative, we think that work can be
22 done. Yet right now with your hospitals and your health
23 systems and your larger provider networks, you have a
24 substantial universe, a critical mass for really

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1 supporting and adopting Health Information Exchange in
2 Connecticut. You have a strong commitment from DOIT to
3 support this, along with the State, and you have the
4 technologies identified and the procurement support
5 identified that you could draw on, along with the IT
6 standards that support HIE in the State of Connecticut.

7 So that's the context, strengths. And here
8 are the five domains that we'll be going through -- and if
9 you could move on, Alistair -- we identified 24 gaps. And
10 like the HIE initiative, you don't necessarily need to
11 address all those gaps immediately. So we went through
12 the first filter and then short listed it to about 13
13 gaps. And then we said of those gaps, what are the gaps
14 right now that are in the critical path of moving forward
15 that need to answered, that would then allow us to answer
16 all 24 of the gaps. And so what we're focusing on today
17 are the target gaps, the six gaps, challenges, decisions
18 that need to be made to move forward with the strategic
19 plan. Does that make sense? And I think in our last
20 workshop we went through a methodology that we used to
21 come up with saying those were the key gaps.

22 Next. The summary gaps is -- in the
23 governor's model we really looked at the oversight of the
24 HITE for Connecticut, we looked at the mechanisms for

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1 stakeholder influence and participation, recording success
2 regarding accountability, and a communications action
3 plan.

4 Next. And the finance revenue and
5 sustainability model, the value of proposition that needs
6 to be articulated, the cost implications would be directly
7 related to what you decide will be the products and
8 services of the HIE; centralized model, decentralized
9 model, hybrid model. And we'll talk a little more about
10 that. And a safe harbor, that the HIE will be here long
11 after you all will be gone. That it is something that
12 will have the safety of legislation, the safety of
13 sustainable funding, and the safety that is actually
14 providing value to your constituents, providers, and
15 consumers that they would advocate for. If you build it
16 right and provide the initial baseline funding to make
17 sure it goes forward and it starts demonstrating its
18 value, you'll have significant constituent support for it
19 going forward as it might meet other challenges.

20 Next. The technical infrastructure, what's
21 it going to look like? And we'll spend a lot of time
22 today talking about that major gap.

23 Next. Business Operation: The business
24 plan, the value proposition, the metrics necessary to

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1 demonstrate you're achieving the value of proposition, the
2 mechanisms necessary to oversee the business and technical
3 operations of the HIE moving forward. And legal and
4 policy is really coming up with the necessary
5 infrastructure for opt in, opt out, data ownership, data
6 stewardship, data rights, security, confidential controls,
7 and the standards necessary for enforcing and
8 demonstrating accountability.

9 Next. And here are the ones that we are
10 going to focus on today: Technical infrastructure, what
11 is the HIE going to be? What are the products and
12 services. What are you going to provide? Finance: What's
13 the value of proposition and what's the sustainability
14 model? Legal, consent policy and management. Technical
15 and business operation. Strategy for hosting and sourcing
16 the HIE infrastructure. These are the key ones that we
17 need to have your input and your ideas, and we'll provide
18 alternatives.

19 Technical infrastructure assumptions that
20 we've come up with out of our last workshop and the work
21 that we've done is the level of maturity regarding EHR
22 adoption varies. We also have an assumption that some of
23 the standards required regarding certification and
24 meaningful use haven't been finalized. So there has to be

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1 some flexibility and understanding. And we -- we are
2 bringing to you some of our knowledge. We have some folks
3 on our research side that are sitting on some of these
4 task forces to define these standards.

5 A comprehensive architecture has not been
6 yet defined. There is a significant amount of enthusiasm
7 and dollars invested. And reality is HIE-like and HIE
8 systems that are in place in Connecticut that we need to
9 leverage. And one mandate that O&C is very clear on is
10 that if you do anything, you have to make sure that you're
11 supporting your state's Medicaid and Department of Health
12 initiatives around improving health and around incentives
13 for HIT adoption by Medicaid providers.

14 Current activities, we have the Medicaid
15 assist in HIT effort underway to meet that Medicaid CMS
16 initiative. E-Health Connecticut is the Regional
17 Extension Center. Connecticut also has an HIE pilot
18 underway to support DSS.

19 Okay, next. Technical infrastructure,
20 scope, and definitions. And I'm going to stop here. And
21 this is the first alternative discussion of the model that
22 would work best in Connecticut. If you could go to the
23 next light, Alistair, and then back. We have three that
24 we're going to look at; centralized model, hybrid model,

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1 and the third one a decentralized model.

2 And let's go to the first one. One
3 approach in several states -- and we'll talk more about
4 this to give some examples -- one approach in several
5 states taken is the centralized model. It's basically
6 been states where there has not been a lot of traction in
7 Regional Health Information organizations, that there are
8 one or two or none anything like a health information
9 exchange in the state, and thus the state has taken the
10 responsibility through this effort to build a centralized
11 robust HIE that becomes the HIE for the full state and the
12 gateway to other states and regional HIEs into the
13 nationwide Health Information Network.

14 The centralized model has some strengths.
15 It provides a very strong framework and core
16 infrastructure, a clear set of standards for the whole
17 state that are aligned with O&C standards, aligned with
18 certification requirements and meaningful use, that will
19 be coming down. Comprehensive coverage, everyone can have
20 access to it. A tremendous economy of scale. Least
21 complex in some respects because you're not trying to
22 combine them together with many other HIE-like systems.
23 But it doesn't leverage investments as clearly or directly
24 that may have already been made in HIE. And it may have a

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1 dampening effect on the enthusiasm of some of the
2 leadership in the state that's already taken it upon
3 themselves to move down this path and invest their dollars
4 and their time --

5 MS. HOOPER: Well and as you said, that
6 might fit in some states where there aren't a lot of
7 efforts --

8 MR. PETRUS: Yeah, exactly --

9 MS. HOOPER: -- which may not really be
10 Connecticut.

11 MR. PETRUS: Yeah, could be. Right now
12 we're just looking.

13 The hybrid model -- the hybrid model
14 provides a core infrastructure for the state HIE. And it
15 allows the connectivity for other HIE and HIE-like
16 entities. And it can implement a core set of products and
17 capabilities like a master client index, a master provider
18 index, other kinds of things that it would be responsible
19 for and linking with those other initiatives that are
20 underway in the state. A strong framework and core
21 infrastructure, comprehensive coverage, there's also an
22 economy of scale here that can be achieved. It likely
23 would encourage HIE adoption, but somewhat complex to
24 implement. It's not a simple one.

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1 The next one is the decentralized model.
2 The state only provides a minimal gateway and places
3 greater emphasis on local HIEs, more robust HIEs, and then
4 the state provides a limited set of products and services,
5 provides some framework, can leverage some capabilities,
6 but really the total cost of this might be higher and it
7 might have less responsiveness to the value of proposition
8 for some stakeholders.

9 MR. CARMODY: Why on this one is there --
10 the cost likely to be high? And how does that correlate
11 to the other two relative to cost? So, I'm trying to
12 understand if you're only operating a core infrastructure,
13 why the flow cost is likely to be high compared to
14 centralized or a hybrid model?

15 MR. PETRUS: Do you want to take --

16 MR. ALISTAIR MCKINNON: The lack of economy
17 of scale. So it's assuming that there are a number of
18 organizations that need HIE, that need to go ahead and
19 invest their own where they weren't really thinking about
20 before --

21 A VOICE: A duplicate --

22 MR. MCKINNON: -- they would -- they would
23 halfway go along with the statewide effort that doesn't
24 exist for them because they have to create something

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1 locally because this option says the only thing being
2 provided by the state is the way to link HIEs together.

3 MR. CARMODY: So they're doing this --

4 MS. HOOPER: You're talking about the cost
5 to the HIE system --

6 MR. PETRUS: Exactly --

7 MR. MCKINNON: It's the total cost --

8 MS. HOOPER: -- throughout the state, right
9 --

10 MR. MCKINNON: -- yeah, it's the total --
11 absolute total cost --

12 MS. HOOPER: -- and not the entity in
13 charge --

14 MR. PETRUS: Not to the state HIE. But
15 basically if you -- if you had this model, this model
16 works fairly well when states have a lot of robust HIEs
17 that are already up and running, they've been up for many
18 years and, quite frankly, don't need much from the state
19 at all but maybe a couple of sockets to plug in to tie the
20 state together. The total cost of all those regional
21 health information organizations in that state far exceed
22 what it would have been to do the hybrid or a centralized
23 model.

24 DR. AGRESTA: When we talk about --

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1 MR. PETRUS: And in Connecticut we think
2 that would be more expensive --

3 MR. CARMODY: I just -- I was just trying
4 to make a correlation. I guess what would be interesting
5 as we get into the remainder part of the conversation is
6 how do you look at the alternatives compared to the
7 products and services? I didn't see the --

8 MR. PETRUS: Well let's stay here for a
9 minute and talk about at this high level and then we'll
10 get into products and services. As you take a look at
11 this, what is your initial reaction to the three
12 alternatives that we identify; the centralized, hybrid,
13 and decentralized models?

14 DR. AGRESTA: The hybrid model allows for
15 movement in either direction. The other -- the other two
16 models sort of block you into a way of proceeding that are
17 going to -- you know, everybody has got to sort of proceed
18 along the same path. And the hybrid model permits you to
19 say -- say five years, three years from now the ability to
20 centralize services -- you know in Danbury they say well
21 we've got our HIE, but we'd be glad to give it over if
22 something better came up in the state and some new
23 architecture, etcetera, we'd be glad to let go of what
24 we're doing if it got developed into something else. The

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1 only way to do that is perhaps the hybrid model. So you
2 know, you can then add services onto that hybrid model,
3 you know, it can grow over time. It is more complex to
4 begin with, but I think that that -- if you don't
5 centralize some things, you're not going to be able to do
6 the public health aspects of what you want to do, you're
7 not going to be able to research -- do research on what
8 you're doing in terms of understanding how you're
9 improving chronic diseases or improving things as well.
10 So if you don't have some way of getting standardized data
11 in a standardized format, you're not going to be able to
12 do that as well.

13 MS. HOOPER: I like all of what you just
14 said, Tom, and -- and again the pros and cons. My concern
15 with the hybrid model is that it is very complex to
16 implement, but I appreciate from the State's perspective
17 it would give more assurances. I don't know that we have
18 robust systems in the state. I -- I don't think we do.
19 Do we? I think in Danbury we have a robust system, in
20 Middletown we have a robust system, but it's not a large
21 scale --

22 DR. AGRESTA: I would even argue that they
23 probably don't provide nearly all of the services they
24 want to and will need to over time, and that that listing

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1 might get layered on top of that.

2 MS. HOOPER: And I do appreciate that we
3 have that flexibility. Again under the technical
4 infrastructure domain and when we get to -- you know, this
5 is products and services -- we don't know what we're going
6 to be able to provide depending upon the leveraging that
7 we need to take place as was stated earlier between the
8 Regional Extension Center, DSS, and Cooperative Agreement,
9 there are a number of opportunities to leverage. If we
10 limit ourselves -- obviously, the decentralized model is
11 going to be very costly. But from the State's
12 perspective, and particularly from Public Health, we have
13 to be careful about what we're going to be expecting from
14 a state, and as the Commissioner stated earlier with that
15 actual support. I don't know that the total cost again to
16 a statewide system might have to happen if there isn't a
17 good support for an HIE system to be established in a more
18 centralized model.

19 MR. PETRUS: And a good question here is
20 when we talk about state, we're not talking state
21 government --

22 MS. HOOPER: No, no, state --

23 MR. PETRUS: -- because you're not talking
24 about authority to do this, and so it becomes a statewide

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1 initiative --

2 MS. HOOPER: Right --

3 MR. PETRUS: -- that includes state
4 government --

5 MS. HOOPER: Absolutely --

6 MR. PETRUS: -- hospitals, health systems,
7 providers, patients, etcetera.

8 MR. CARMODY: Does it -- does it have to --
9 does it have to -- I mean as you start this off, I mean
10 there's sometimes a natural progression around depending
11 on the products and services that you can offer, you could
12 go from one model to another and grow into one, so that I
13 don't necessarily know it has to be any one of the three,
14 but I think that when you look at the phasing of it, it
15 could go from a -- you know, a skinny model, which could
16 be, you know, decentralized, or even working our way --
17 just so that we don't tie our hands. I mean eventually
18 getting to a hybrid model, but you start off with -- maybe
19 it's even decentralized, maybe that's -- depending --
20 that's why I was try to correlate the services to the
21 alternatives to say depending on what phase you're in,
22 that could then determine what your infrastructure needs
23 to be. And then as long as you're not tying your hands as
24 the way you phase it, it should be okay.

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1 MS. HOOPER: But if this is -- Frank, if
2 this is a strategic plan, can we do that? Can we talk
3 about reality and then what we wish for?

4 MR. PETRUS: To phase it -- I think the
5 question that's been raised is do phases impact your plan
6 and choice. II think it would be very helpful though to
7 understand what the end game is.

8 MR. PETRUS: And we -- and we in a minute
9 are going to talk about how we saw the stages depending on
10 the model that you picked --

11 MS. HOOPER: Okay --

12 MR. PETRUS: -- but we think there's one
13 approach that fits very well -- and let's go to that slide
14 just to --

15 MR. PETER COURTWAY: Before you go to the
16 slide, Frank --

17 MR. PETRUS: Go ahead --

18 MR. COURTWAY: -- I think if you take a
19 look at the three options, each one has key things that
20 define it. The decentralized one, you know, by definition
21 of how it's laid out here precludes a central repository
22 to be able to do statewide epidemiological reporting, bio
23 surveillance --

24 MS. HOOPER: Right --

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1 MR. COURTWAY: -- you know, population
2 health, you know, initiatives -- so -- so that one -- in
3 choosing that model by de facto is saying you don't have
4 that and some other mechanism needs to be built or still
5 be relied upon, you know, if -- if that's the goal.

6 No. 1, the first one in there basically --
7 it clearly states that it doesn't connect other HIEs. And
8 I think inside the state, at least from the hospital
9 perspective, hospitals are looking a lot at the
10 connectivity. So we are looking at doing the connecting,
11 you know, at a different level, but there's still going to
12 be a need to do the direct interfaces to the physician
13 practices inside that model. And if you went to the first
14 option, by definition it precludes that becoming the
15 switch and actually it probably leaves CNHIN as the
16 switch, whether or not direct or some other component to
17 do it.

18 MR. PETRUS: There is the NHIN directive --

19 A VOICE: Yeah --

20 MR. PETRUS: -- another parallel process
21 that's going on at the federal level.

22 MS. HOOPER: And do want to get to Dr.
23 Dardick -- I'm sorry, Peter, were you done now?

24 MR. COURTWAY: I guess I am, Meg.

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1 (laughter)

2 MS. HOOPER: Doctor.

3 COMMISSIONER GALVIN: He's well behaved,
4 isn't he.

5 DR. DARDICK: I'll -- I'll be brief so
6 Peter can get back if he has other things to say --
7 (laughter) -- but it just seems to me that -- that
8 tactically if we're talking about part of our mission as
9 making this a transformative process, a transformative
10 event, then option 1 makes that statement the most
11 strongly; that is this is a centralized model, we're going
12 to take this on, we're going to be successful with it, and
13 we're -- we're imploring all of you to buy into this
14 system to make it successful rather than having scattered
15 approaches throughout the state, which may lead to greater
16 complexity and perhaps greater difficulty in making it
17 work.

18 MS. HOOPER: Miss Moonie, you had a
19 comment?

20 MS. MOONIE: I'm just -- well I was first
21 going to say that it might be helpful to go through the
22 description -- the descriptions coming out the 1st --

23 A VOICE: Yeah --

24 MS. MOONIE: -- and see what other states

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1 attained before we make a decision --

2 MR. PETRUS: Yeah, that was our --

3 MS. MOONIE: -- but then as --

4 MR. PETRUS: That was our plan.

5 MS. MOONIE: As I'm listening to the
6 comments around me, I'm wondering why we couldn't almost
7 think of a hybrid of alternatives 1 and 2. So for those
8 hospital systems that have invested in an HIE, those could
9 connect in, but then you -- you didn't have to do it that
10 way. So, I mean that's almost saying -- but that would
11 still have that repository in the middle and do those
12 transformative types of things, because, you know, I know
13 from my hospital we'd be -- we're not listed here as an
14 HIE, but we're doing data exchange. We have invested in
15 an infrastructure. And I could just see the CFO looking
16 at me and saying why have I've spent all this money when
17 now we have to trash it and build straight up. So I think
18 there's actually a hybrid between those two that we should
19 start to think about as well.

20 DR. AGRESTA: One has to think about the
21 individual box out there trying to connect and they often
22 sit between hospital systems and not just in one hospital
23 system --

24 MS. MOONIE: Right --

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1 DR. AGRESTA: -- I mean -- and so it gets
2 much more complicated within the pharmacies and the others
3 --

4 A VOICE: Right and --

5 DR. AGRESTA: -- that sit between, you
6 know, hospital systems, you know, they're not owned by one
7 or the other.

8 MS. HOOPER: And I think that's what we
9 need to keep in mind, is that again we're trying to do
10 that overview; where are we going with -- Health
11 Information Exchange in the state includes from the state
12 government side of virus surveillance, reporting
13 requirements, hospitals' private physicians, pharmacies,
14 urgent care clinics, rehabs, skilled nursing facilities,
15 EMS -- do you want me to go on?

16 COMMISSIONER GALVIN: Yeah -- no.

17 MR. PETRUS: Well and that's the hybrid
18 model also -- the centralized model provides this, but
19 with the hybrid model too there's no wrong door. In the
20 centralized model there's one door. Everybody goes
21 through that door with your assistance. You wouldn't
22 necessarily scrap it, but you would still have to go to
23 that door to anywhere outside of your system --

24 MS. MOONIE: Right, right --

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1 MR. PETRUS: -- but with this model you
2 could get both. And then the docs could go through their
3 affiliated hospital system or they could go directly to
4 the state system --

5 MS. HOOPER: Mmm-hmm --

6 MR. PETRUS: -- or they could actually go
7 to the NHIN direct. So that there's --

8 MS. MOONIE: Then how do you make sure
9 you're not getting the data from those docs from two
10 different --

11 MR. PETRUS: And that's where the
12 centralized repository and a master patient index and
13 master provider index and so forth and the necessary data
14 controls that.

15 Anything else on your first impressions of
16 these three objects?

17 MR. COURTWAY: No, I -- I particularly like
18 Option No. 2, the hybrid option.

19 MS. HOOPER: That's what I'm hearing. And
20 again, we want to go through some of your --

21 MR. PETRUS: Yeah, let's -- let's take a
22 look at what we --

23 MS. HOOPER: Oh, oh, wait --

24 MR. MASSELLI: I certainly agree -- the

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1 centralized I'm not convinced. I worry, as Tom mentioned,
2 about all the people in between and the hospital systems
3 that don't have as robust of a system and, you know, does
4 it favor those hospitals over another. I think the
5 centralized system sort of makes a level playing field,
6 but --

7 MR. PETRUS: Well let's take a look --

8 MR. MASSELLI: -- not -- not that No. 2
9 isn't --

10 MR. PETRUS: Let's take a look at the
11 portfolio and how it would work out. If you'd go to the
12 next slide --

13 DR. CARR: So it sounds like we're not in
14 favor of 3.

15 A VOICE: Yeah.

16 (Multiple voices overlapping -
17 indiscernible)

18 A VOICE: You're going to vote me off the
19 island -- (laughter) --

20 MR. PETRUS: It's a good thing we didn't
21 have four options.

22 DR. CARR: I know.

23 MR. PETRUS: If we talk a look at the
24 products and services, we really see that both

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1 alternatives 1 and 2 could go through this phase process.
2 Obviously in Alternative 1 it would all be centralized.
3 And Alternative 2 you decide where some of this will
4 reside regarding the standards.

5 Phase 1, you would start out with creating
6 some portal, have access to patient records that
7 physicians could participate and supporting and
8 understanding what their patients are eligible for
9 regarding health care, but you're really taking a look at
10 access to records. Whether it's a centralized model or a
11 hybrid model, that still would be there, it would still be
12 that portal. No wrong door. It goes back to this concept
13 of a wrong door. How do you set it up that you have no
14 wrong door to access.

15 Phase 2 then would move to the more robust
16 capabilities of emergency departments. The continuity of
17 care capability, access ability to patient records and the
18 nationwide health information network, electronic
19 reporting for emergency responders, lab results,
20 medication history and prescribing could all be in Phase
21 2.

22 I'll turn to 1 and 2 and also have a Phase
23 3. The aggregation of health information would never be -
24 - our counsel would be that's not the first thing you do.

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1 This is an intelligence engine, you have to build the
2 access to be able to get the information in there so then
3 you can have the aggregate data necessary to do research
4 and then do business intelligence. And then looking at
5 quality, surveillance, insurance eligibility, health
6 plans, claims data, and -- and the universe. Both 1 and 2
7 could go through these three phases. The question is what
8 resides within the hybrid model at the state level and
9 what helps in connecting the other HIE and HIE-like
10 systems.

11 MS. MOONIE: At the risk of walking into
12 the weeds, I just have a quick question about --

13 MR. PETRUS: Please --

14 MS. MOONIE: I was in a meeting recently
15 where I heard that Medicare beneficiaries do not go
16 through the RX subset. Did I get that wrong?

17 MR. PETRUS: Where's my --

18 MS. MOONIE: Where is Medicare -- where do
19 Medicare beneficiaries pharmacy records live?

20 A VOICE: (Indiscernible) -- pharmacy
21 benefits --

22 A VOICE: (Indiscernible) -- well we have
23 the COO assistance --

24 MR. RICHARD RATLIFF: Do you want me to

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1 comment?

2 MS. MOONIE: Please.

3 MR. RATLIFF: My name is Rick Ratliff. I'm
4 with --

5 MS. HORN: Turn the mic please -- your mic
6 --

7 MR. RATLIFF: Can you hear me?

8 MS. HORN: No, it needs to be recorded.

9 MS. HOOPER: Can you come to a microphone.
10 Thank you very much.

11 MR. RATLIFF: My name is Rick Ratliff. I'm
12 with Excensure. About 90 days I just left Surscrubs.

13 And the answer to the question is the --
14 the PBMs provide services to commercial plans, they
15 provide services to Medicare. So there are Medicare
16 records, there are Medicare medication data that flows
17 through the network that are coming from RX hub customers.

18 So the Blue plans and different -- United Health Care,
19 etcetera, that's providing services to -- to -- for
20 Medicare type plans. That's not a hundred percent, but
21 there is some -- there's a fair amount of data flowing
22 through. So there's data actually on about two-thirds of
23 the United States population flowing through the network.

24 Does that help?

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1 MS. MOONIE: Because I think that's
2 critical, that whatever -- wherever we -- it was the
3 sustinent committee that -- that's where we discussed this
4 last week and that was a big question, you know, how can
5 you grab all this data.

6 MR. PETRUS: Thank you very much.

7 MS. MOONIE: Out of the weeds. Sorry.

8 MR. PETRUS: No, that's a good question.
9 Let's take a look at what some other -- other states are
10 doing that might also help in this discussion --

11 MR. MCKINNON: You didn't actually touch on
12 Alternative 3 --

13 MR. PETRUS: Oh --

14 MR. MCKINNON: -- which is the --

15 MR. PETRUS: It got voted off the island --
16 (laughter) --

17 MR. MCKINNON: Yeah, but --

18 A VOICE: Because I want to confuse --

19 MR. PETRUS: No, go ahead, Alistair,
20 discuss it.

21 MR. MCKINNON: Well the -- I think the real
22 point is that in order to get Alternative 2 -- I suppose
23 this slide is actually the wrong piece -- these things
24 apply to Alternative 2 as well because you have to provide

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1 the infrastructure --

2 MR. PETRUS: Oh, yes -- yes, yes, yes --

3 MR. MCKINNON: So that's the
4 differentiation between Alternative 1 and Alternative 2,
5 is that Alternative 2 has these things as well.

6 MS. MOONIE: These things on page 28?

7 MR. MCKINNON: Yeah --

8 MR. PETRUS: Yeah. These things would
9 actually be -- especially the services for existing and
10 future HIEs, but some of these services here would
11 typically be -- in the hybrid model would be in the
12 central portion of the hybrid model. So that you could
13 have that kind of control necessary for master patient,
14 master provider records, privacy and security, record
15 locator services, because if you're tying them together,
16 you have to have agreement from the authority and its
17 guidance and governance body that all of us in the state
18 to maintain our HIEs and our HIE-like services will agree
19 to these standards and protocols so that we don't get
20 duplication and that we are able to go to any door, get
21 through, and not have the problem with redundancy or --

22 MS. HOOPER: But there is one master
23 patient file?

24 MR. PETRUS: Yeah.

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1 MR. COURTWAY: Alistair -- this is Peter --
2 are you saying that some of these services are not needed
3 in the first model, in the centralized model?

4 MR. MCKINNON: Yes. Because the -- it
5 depends -- you need some of them in order to do some part
6 of the routing, but you don't have the same complexity of
7 routing because you're not working between --

8 MR. PETRUS: You're not -- some of these
9 you would not need because you're going to centralize --
10 you're it. So all of this would reside -- so you wouldn't
11 need some of these services -- you would have these
12 components, but it would be the centralized model and not
13 a service to the other HIEs.

14 MR. MCKINNON: Yeah, I think that's the
15 point. That's really the thing, is that it's the services
16 are an extension of the centralized model, a centralized
17 HIE to work. Whereas with this hybrid model some HIEs are
18 providing partly services and getting partly services from
19 -- that's what makes it more complex.

20 MS. HOOPER: So when we're discussing
21 products and services, we're not discussing functions. I
22 mean what I'm hearing you saying is that those functions
23 would have to be in a centralized system anyway.

24 MR. MCKINNON: Yeah.

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1 MR. PETRUS: Those --

2 MS. HOOPER: This here is described as
3 services in the decentralized?

4 MR. PETRUS: Exactly.

5 DR. AGRESTA: It's just being replicated --
6 I mean all of these things will be part of a central model
7 anyway. And if you have a central model that's going to
8 hook up directly to say someone's EMR, which means you're
9 going to have to have it hook up to every EMR --

10 MR. PETRUS: Well fortunately --

11 DR. AGRESTA: -- I'm not sure it's --

12 MR. PETRUS: Fortunately you have standards
13 that allow for that --

14 A VOICE: Right --

15 DR. AGRESTA: In theory.

16 MR. PETRUS: In theory. But you have, you
17 know, standards and -- and -- there's a question from the
18 public?

19 A VOICE: Yes -- (indiscernible) --

20 A VOICE: What's wrong with the mic --

21 MS. JANET TROSAVEE (Phonetic): My name is
22 Janet Trosavee and I'm a grad student from Northwestern
23 and (indiscernible). And one of the concerns I have did
24 go to the first option, was that you're not just working

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1 inside the State of Connecticut truly, you're going to be
2 more -- you could be in the Northeast or even patients who
3 move around from one state to another and you need to get
4 the information out that would be able to talk to each
5 other from other entities. So if you're focusing on
6 saying that we won't be able to talk to any other HIEs, is
7 really not going to happen because --

8 MR. PETRUS: No, that was not the intent of
9 the centralized model. Whatever you build with O&N
10 support has to fit into the Nationwide Health Information
11 Network --

12 MS. TROSAVEE: Yeah --

13 MR. PETRUS: -- so that that connectivity
14 has to be there.

15 MS. TROSAVEE: So that --

16 MS. HOOPER: Thank you very much --

17 MS. TROSAVEE: -- that's why I was bringing
18 this up because the more the flexibility with the hybrid
19 model, you would have already built into your
20 infrastructure so you could talk to other HIEs.

21 MR. PETRUS: Thank you.

22 MS. HOOPER: Thank you very much.

23 MS. TROSAVEE: Yeah.

24 MS. HOOPER: We want to let everyone know

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1 that we do have a public period at the end, so please
2 don't -- I mean if you have comments or questions, please
3 jot them down, there will be an opportunity for everyone
4 to speak. And also, these are the issues that are --
5 after this discussion today will be brought forward to
6 public forums and posted for comments. So please don't
7 hesitate as this woman did to make your comments, keep
8 them and we will have a public comment period after this
9 discussion.

10 MR. PETRUS: Thank you.

11 MS. HOOPER: Frank.

12 MR. PETRUS: Any other discussion on this?

13 Let's take a look at what some other states are doing.
14 And Alistair and Erika, I turn to you. You've been more
15 intimately involved in the review and research of what
16 other states are doing.

17 MR. MCKINNON: The -- I would say that one
18 of the things with the -- this list of small states that
19 are centralized is that that's the way they set themselves
20 up to begin with. So they haven't -- I don't believe they
21 really committed themselves in the long-term to stay
22 centralized because I think more or less inevitably it
23 ends up as a hybrid model. They don't -- I don't think
24 these states would actually try to stop HIEs existing

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1 independently of them and they'll stay connected to them.

2 MS. HOOPER: Okay.

3 MR. MCKINNON: So, I think it's more of a
4 temporary decision in the short-term when these things
5 stated a few years ago.

6 MS. HOOPER: And don't they all have a more
7 centralized health care system also, fewer payers, fewer -
8 - they don't have 32 acute care hospitals with different
9 boards?

10 MR. MCKINNON: Yeah. They're smaller --
11 small states.

12 MR. PETRUS: And even in Delaware, Delaware
13 and Health Network looked to link with Pennsylvania. And
14 one time there was a discussion that they would become
15 one, so not even --

16 MR. MASSELLI: I think the question is how
17 successful have they been because their -- providers in
18 their community -- in the states fully engaged --

19 MR. PETRUS: Well --

20 MR. MASSELLI: -- or are they unsuccessful
21 -- I don't care if they're centralized or not, how well
22 have they done?

23 MR. PETRUS: Delaware is doing very well.
24 Delaware has been the one that's been around the longest -

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1 -

2 MS. HOOPER: And again they have one health
3 care system with lots of satellites. We spoke with Maine
4 the other day, they have 50 percent of their providers
5 engaged in their effort. So it's got again a different
6 constituency, but also a more centralized health care
7 system. Most of their physicians are through those
8 hospitals and that centralized system. So it is --

9 MR. MASSELLI: (Indiscernible) -- Alistair,
10 that you talked to and said we went down the road
11 centralized and really didn't --

12 MR. MCKINNON: No -- no, these -- these
13 ones -- these ones are all doing okay. The only one that
14 the jury is really out on is Rhode Island because it's so
15 new --

16 MR. MASSELLI: Yeah --

17 MR. MCKINNON: -- that they've -- they've
18 only really got started. So the other -- the other ones
19 have been doing stuff for a while --

20 MR. MASSELLI: Doesn't Providence have a
21 strong HIE -- the hospital system have its own HIE -- I
22 mean not all these states have -- are the only player in
23 the state, right?

24 A VOICE: No, that's right.

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1 MR. MCKINNON: They're are the only player
2 in the states, but they started by themselves. These --

3 MR. MASSELLI: No, I understand --

4 MR. MCKINNON: -- things are started by --

5 MR. MASSELLI: -- that they have strong --
6 like analogous to Danbury or Middlesex, I thought a couple
7 of these had --

8 MS. MOONIE: Lifespan you mean?

9 MR. MASSELLI: Lifespan, yeah. Lifespan is
10 a big player there, so -- I'm just trying to see if
11 there's an analogy for us. They're a little smaller in
12 size, but is there an analogy and have they been
13 successful?

14 MR. MCKINNON: I think they've been
15 successful within the limits of how new they are because
16 it's early days in all cases. Delaware is the one who's
17 been -- been around the longest --

18 MR. MASSELLI: Yeah --

19 MR. MCKINNON: -- they've been up and
20 running longest.

21 MR. MASSELLI: Mmm-hmm.

22 MR. CARMODY: What about the services?

23 MR. PETRUS: They're not doing --

24 DR. CARR: I can speak to that if you want.

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1 So the way it -- Delaware really started -- they said we
2 have an issue with giving lab results to provider offices
3 --

4 MS. MOONIE: Speak up --

5 MS. HORN: We can't hear you.

6 DR. CARR: Yeah, so -- so the way Delaware
7 really started was they said okay we have an issue with
8 giving labs and results -- results to providers. We have
9 a business need that you need to focus on which results
10 from delivery. And so they started with results delivery.
11 And then as they grew with the results delivery, they
12 found that they had this reposit where you have
13 information that was available to them, then opened up for
14 retroactive query and, you know, applied patient consent
15 to that amount of information that they had. And then
16 allowed other providers that weren't the primary
17 recipients of that data to then access that data after the
18 fact. So the -- so originally, you know, Tom wouldn't
19 allow -- results, plus Ralph sends his results to Tom. And
20 then after the fact, they realized oh gee now that now
21 that we've this data accessible, then okay if Kevin wants
22 to access it later on in which he gets consent, then let
23 Kevin access it as well. So it was really a simple
24 beginning.

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1 MS. HOOPER: And again, this is on the
2 technical infrastructure because we have -- Marianne is
3 just looking at the consent model. When we get to the
4 legal side, there's other constraints --

5 MR. PETRUS: Absolutely --

6 MS. HOOPER: -- more advantages --

7 MR. PETRUS: Absolutely --

8 MS. HOOPER: -- to the centralized and
9 decentralized systems.

10 MR. PETRUS: Absolutely.

11 MS. MOONIE: Just as a point of reference,
12 what's the population of Connecticut?

13 A VOICE: 3 point --

14 A VOICE: 3.3 million --

15 A VOICE: -- five --

16 MS. MOONIE: Also in Delaware -- you know -
17 - it's for Kevin actually since you seem to be familiar
18 with the system -- is -- it's a Windows based EMR system?

19 DR. CARR: It's --

20 MS. MOONIE: And the software is free?

21 DR. CARR: Well it's free to the providers
22 --

23 MS. MOONIE: Right --

24 DR. CARR: -- for them to access. The

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1 hospitals are the ones that are really funding it. But
2 it's a portal into -- to be able to access the data, so a
3 web base -- there's a little application that's installed
4 on each of the providers, but its application is installed
5 remotely and then out to those providers. So it's pretty
6 easy for them to access it. It's not meant -- the system
7 is not meant to replace an EMR, but it's -- it's meant to
8 give access to the data, the results, etcetera.

9 COMMISSIONER GALVIN: Kevin, do you have
10 any idea how much that cost per individual practice -- per
11 individual practitioner I should say.

12 DR. CARR: A lot of that is funded by the
13 hospitals because they were trying to get lab results out.
14 And so it's a benefit to the hospital to make sure that
15 you have an infrastructure that can report labs out. So
16 that was their initial business model. The --

17 COMMISSIONER GALVIN: But it still cost --
18 somebody is paying for it?

19 DR. CARR: Yeah, the hospital.

20 COMMISSIONER GALVIN: So there must be a
21 way of getting --

22 DR. CARR: Yeah --

23 COMMISSIONER GALVIN: -- so when we talk to
24 practitioners, we could say, you know, this is a basis of

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1 the model --

2 DR. CARR: I don't have the number, but I
3 could get it for you.

4 DR. AGRESTA: That's how the Indiana Health
5 Exchange started as well, the same -- the same idea, was
6 results delivery. I mean there's significant
7 disadvantages to simple results delivery on a portal if
8 you're a practicing clinician, and you're asking all these
9 clinicians to now adopt, you know, certified health
10 information technology that's supposed to exchange data
11 and then you have to go outside of your system to a
12 portal, you can be darn sure that folks aren't going to be
13 happy from a usability perspective and from a patient
14 workflow perspective. So you need to kind of think about
15 when these systems were initially adopted in these other
16 places, the technology and what people were being asked to
17 do has changed. And -- and I don't think it's going to
18 stay static in Delaware where they are simply going out to
19 a portal. They're going to have to integrate that within
20 the EMRs --

21 MS. MOONIE: Right --

22 DR. AGRESTA: -- and so therefore we should
23 never start thinking about something that is an outside
24 portal. That's a workflow that doesn't work --

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1 A VOICE: Yeah --

2 DR. AGRESTA: -- it needs to be thought of
3 as a workflow that works.

4 MS. MOONIE: Peter and I are doing -- the
5 provider side is investing in (indiscernible) connectivity
6 from our hospitals into the physicians' EMR because --

7 DR. AGRESTA: Yeah --

8 MS. MOONIE: -- we know physicians doesn't
9 want to go to our portal or somebody else's portal to look
10 at those results. If they've got an EMR, they want it
11 delivered --

12 A VOICE: Right into the EMR --

13 MS. MOONIE: -- and that's where we are
14 spending dollars.

15 MR. PETRUS: And that -- that is where --
16 that is where the field is going. But again when Delaware
17 started -- I find you make a very good point -- we need to
18 exchange information, so let's get there --

19 MS. ERIKA CHAHILL: And the assumption at
20 that time was also that not all the providers would have
21 EMRs. So they had to have a channel to get to the
22 information, and that's why they had a portal.

23 MS. MOONIE: And that's still true --

24 MR. MCKINNON: That's only an assumption --

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1 (Multiple voices overlapping -
2 indiscernible)

3 DR. CARR: That will remain true. So -- so
4 the issue is we need to solve both problems as we go
5 forward.

6 MS. MOONIE: There's software out there
7 that exists to do that right now.

8 MS. CHAHILL: Well -- and that's why as you
9 see the phases -- in the first phase is you start with a
10 portal, you start with that kind of phase. And then as
11 you -- as you mature, then you add all the other phases
12 where you actually -- and then your operability becomes
13 greater. So that's basically the approach. And we've
14 also aligned it -- remember we talked about this -- to
15 meaningful use. We looked at the meaningful use
16 requirements to see what specific criteria was being
17 published that -- you know, in terms of the functionality
18 that's -- not a lot in terms of the HIEs, but for -- for
19 the very first stage there are few requirements that we've
20 actually captured in here --

21 DR. AGRESTA: But I'm not sure the first
22 phase shouldn't include -- if we know, you know, what 80
23 percent of the EMRs are in Connecticut, why not just
24 connect to them -- and you guys are building connections -

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1 - why not take that infrastructure and build the
2 connections as part of that first phase so that you can
3 get adoption. I mean the issue is you're asking people to
4 adopt too many things simultaneously as practitioners --

5 MR. PETRUS: The point is you need -- you
6 may need both --

7 (Multiple voices overlapping -
8 indiscernible)

9 MR. PETRUS: -- so -- so you could have a
10 Phase 1 and a Phase 1a. And the Phase 1 is, you know, the
11 option for that last little bit to make sure that people
12 can get access. And then the more complex 1a is, let's
13 just drive it right into the EMR --

14 MS. HOOPER: I think we're going to have to
15 have those options.

16 A VOICE: Yeah

17 MS. HOOPER: We -- we don't have one
18 consistent system nor where everybody is within that
19 system.

20 MR. PETRUS: And the thing that you need to
21 look at -- and I think this is where the Regional
22 Extension Centers get into this -- is what other states
23 are doing with newer technologies around EMR software as a
24 service. And they're getting a lot of traction now.

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1 They're much more robust than they used to be, which
2 really could easily hang off of whatever you look at as a
3 hybrid model. And the other is co-op, so that you could
4 build co-ops so that folks are buying similar EMRs,
5 especially in the private practice arena. So you really
6 have a universal of one or two or three models out there
7 which makes connectivity a lot easier. Let's take --

8 MR. MCKINNON: Well I think it's true to
9 say that in the foreseeable future and the planning
10 horizon that we have here, you won't actually have the
11 majority of physicians practices able to connect up from
12 an EMR. I mean that just won't happen. There isn't
13 enough push --

14 DR. CARR: What's the planning horizon?

15 MR. MCKINNON: I'm saying five years.

16 A VOICE: Well --

17 DR. AGRESTA: I think we're going to --

18 A VOICE: (Indiscernible) --

19 DR. AGRESTA: I think we're going to have
20 more than 50 percent of the clinicians on EMR in the next
21 few years. And if we make this happen --

22 MR. MCKINNON: What -- what percent?

23 DR. AGRESTA: We'll have more than 50
24 percent of the clinicians in Connecticut on EMRs within

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1 the next five years. I'm very confident of that --

2 MR. PETRUS: Okay, then we build that in --

3 DR. AGRESTA: Because right now it's at 20
4 percent. Now they're not fully functional -- 25 percent,
5 but they're not fully functional. But -- but if we -- if
6 we make this, you know, part of what we do, it will drive
7 adoption up too. If we make it so that the workflow is
8 separate and people are going outside and then, you know,
9 kind of getting into a portal and they can get 70 percent
10 of what they need out of a portal or 50 percent, but --
11 then we're going to impede implementation and adoption of
12 EMRs --

13 MR. MASSELLI: I would --

14 DR. AGRESTA: -- it will actually work
15 against us --

16 MR. MASSELLI: -- I would counsel that you
17 would need both options.

18 DR. AGRESTA: You need both options, but if
19 you don't make the one more compelling --

20 A VOICE: Yes --

21 DR. AGRESTA: -- if the workflow becomes
22 more compelling --

23 A VOICE: Yes, I agree --

24 DR. AGRESTA: -- then you're not going to

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1 get adoption --

2 MR. MCKINNON: That --

3 MR. PETRUS: So what I'm hearing is that --
4 and this has to be vetted, but I'm hearing the projection
5 is 50 percent of practitioners and clinicians will have
6 adopted EMRs in the next five years --

7 MS. HOOPER: Well and -- and adopting EMRs
8 is --

9 A VOICE: (Indiscernible) --

10 MS. HOOPER: Dr. Agresta, I would -- I
11 would question though adopting an EMR doesn't really
12 define is that interoperable health information exchange,
13 is it a contribution to the master patient index, is it in
14 fact going to be part of doing the QA work on the
15 information that's there, is within those five years going
16 to include the public health infrastructure --

17 MR. PETRUS: But there's --

18 MS. HOOPER: -- to support all that --

19 MR. PETRUS: If there's certifiable EMRs,
20 then the connection --

21 MS. HOOPER: Correct, if -- and again this
22 is where we're looking for the feds -- now the certified
23 EMRs, do we have a state consensus that we can have 50
24 percent. Again, I -- I know that, Marsha, you're working

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1 on the plan. Do you have some comments on this because
2 the reimbursement plan is going to be a big driving force.

3 MS. MAINS: We don't have any estimates
4 relative to what Tom was referring to. But that's --
5 that's our intention, that they will adopt certified EHRs.
6 And in order to get the Medicaid incentive payments, they
7 have to exchange --

8 MS. HOOPER: Right --

9 MS. MAINS: -- electronic record
10 information.

11 MR. MASSELLI: Marsha, how much money is
12 sitting out there -- what have you calculated now that you
13 might have an obligation --

14 MS. MAINS: Uh --

15 MR. MASSELLI: -- is it \$40,000.00 per
16 provider --

17 MS. MAINS: Per provider --

18 MR. MASSELLI: Pre provider --

19 MS. MAINS: -- and for hospitals -- we --
20 we haven't calculated yet. We haven't done our landscape.
21 That's part of our planning process, is we've got to
22 identify who --

23 MR. MASSELLI: If it kicks off in 20 --

24 MS. MAINS: Next year --

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1 MR. MASSELLI: Next year --

2 MS. MAINS: Right --

3 MR. MASSELLI: So people are going to be
4 thinking about that --

5 MS. MAINS: People are calling now --

6 MR. MASSELLI: That's right --

7 A VOICE: You can say it's a substantial
8 amount of money that would be available.

9 MS. HOOPER: And we need to be in the
10 position of showing a united front on where we want that
11 to go. Kevin --

12 MS. MAINS: And it's all federal dollars.
13 It's a hundred percent federally funded.

14 DR. CARR: I appreciate you bringing this
15 up because I think it really core to what we said our
16 vision is and so even if we agree on what the language is,
17 I think everybody agrees that we're going to make a
18 transformational change in the way that we deliver health
19 care and that the health care ecosystem is going to be
20 different. And so I think if we allowed ourselves to
21 think that we were going to have providers documenting on
22 paper -- doing everything that they do today on paper and
23 then a portal that every once in a while they looked up to
24 see information that they didn't have in those paper

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1 charts --

2 MS. HOOPER: Right --

3 DR. CARR: -- it's going to transform the
4 health care system. It probably be like five years from
5 now, ten years from now, whenever that happens, and it's
6 not -- not necessarily changing things, so --

7 MS. HOOPER: Right --

8 DR. CARR: -- so we really have to start
9 making some assumptions. Yes, providers will be on EMRs,
10 they will take advantage of incentives, and if they don't,
11 they'll start getting penalties, and then they will --
12 then have to use EMR. And that's part of our
13 transformation into the Health Information Exchange --

14 MS. HOOPER: And as the Commissioner has
15 stated to us many times, we don't want to go to the threat
16 side of, you know, being penalized, but we want to make
17 the availability. And I do think that everybody is in
18 agreement here that of course this is where we want to go.
19 Making a stronger statement in the strategic plan is
20 certainly making the case. So, I think, Frank, you
21 captured that.

22 MR. PETRUS: Let's move on to the next --

23 COMMISSIONER GALVIN: I'm sorry, Frank --

24 MR. PETRUS: Go ahead.

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1 COMMISSIONER GALVIN: I don't -- tell me
2 about the penalties? What -- what are you going to do to
3 people --

4 DR. CARR: Well the penalties are not --

5 COMMISSIONER GALVIN: -- no dessert --

6 (Multiple voices overlapping -
7 indiscernible)

8 COMMISSIONER GALVIN: What are they -- what
9 are you going to do?

10 MS. MOONIE: Medicaid and Medicare -

11 COMMISSIONER GALVIN: Well, you know -- you
12 know what the practitioners will do? Guess what? Guess
13 what, stop seeing Medicaid patients and they'll send them
14 all to Mark.

15 MR. MASSELLI: Well it's Medicare --

16 (Multiple voice overlapping -
17 indiscernible)

18 COMMISSIONER GALVIN: Most people --

19 A VOICE: And Medicare --

20 COMMISSIONER GALVIN: Most people I know
21 don't -- they don't take Medicare except their own --

22 MR. MASSELLI: But --

23 COMMISSIONER GALVIN: -- I couldn't afford
24 to take other people. I would get people in my office who

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1 said I went to Smith or Jones or Goldfarth for 30 years,
2 and I'm 65 and they won't see me any longer. I've got my
3 own patients. I can't be taking Jones' and Goldfarth's
4 patients. I think that's an empty threat, particularly
5 with Medicaid. What it will do is you'll end up with
6 people saying I won't take Medicaid. Don't -- don't
7 bother punishing me, I'm only getting 70 cents on the
8 dollar, what are you going to do to me now. And they'll
9 all end up at Mark's places.

10 MR. MASSELLI: Well, I think the
11 opportunity here is for -- for us to -- and Tom's vision,
12 we want something that's robust, successful,
13 interoperative now. And Marsha has hundreds of millions
14 of dollars that's available for them. That's the carrot -
15 -

16 MS. MAINS: Correct --

17 MR. MASSELLI: -- and we want to say look
18 we've got these hundreds of million -- we want Connecticut
19 to realize --

20 MS. MAINS: Mmm-hmm --

21 MR. MASSELLI: -- this is a huge pot of
22 money --

23 MS. MAINS: Mmm-hmm --

24 MR. MASSELLI: -- and the more people come

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1 on and adopt the certified EMRs, have an electronic system
2 that really provides them valuable information -- we don't
3 have to worry about the -- the stake is out there, we --
4 we can't change that, but we can really accentuate the
5 positive here --

6 A VOICE: Yes --

7 MR. MASSELLI: -- and that's the way we
8 should frame this out. Really go for the gold at this
9 point in terms of the system. You know, while we might
10 have to have two processes going on, we're really going to
11 make it, as Tom indicated --

12 MR. PETRUS: Compelling --

13 MR. MASSELLI: Compelling that you will go
14 there and there are some carrots for you to go to.

15 A VOICE: That's right --

16 COMMISSIONER GALVIN: I -- I hear that, but
17 I continue to hear the penalties --

18 MR. MASSELLI: And we're happy to grow with
19 --

20 (Multiple voices overlapping and laughter -
21 indiscernible)

22 COMMISSIONER GALVIN: Yeah, but you know,
23 the reason that people -- and this gets into a lot of
24 stuff usually discussed, people are in onesies and twosies

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1 and threesies practices and they don't want to be in big
2 groups. They want to be -- that's where they want to be
3 right now. And they want to be there because they want to
4 be independent and they want to be able to pick and choose
5 and -- let me tell you -- for an old family doctor, that's
6 all you've got to do is try to push around primary care
7 providers, the State Medical Society will be very negative
8 about that, and -- and they won't cooperate with you. And
9 so threatening them is I think foolish. I think you need
10 to develop the kind of system that Mark just said. You
11 need to make the system very very good, very very helpful,
12 very very affordable. I mean before you -- before you go
13 out and start to cram it down peoples' throats.

14 Now, I -- I don't understand why the
15 systems are going to cost so much. If everybody had -- if
16 everybody has a board and everybody got a console and
17 everybody has got a computer, the cost must be for the
18 software hookup --

19 MS. HOOPER: And the license -- and the
20 purchase -- simply to participate in this so that you can
21 be a part of the master patient index and share
22 information. You're paying for the service -- the
23 products and services.

24 COMMISSIONER GALVIN: And why is that

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1 prohibitive expensive? I don't understand --

2 MS. HOOPER: I don't know that it is.

3 Peter --

4 MR. COURTWAY: I could probably answer part
5 of that question. I agree with you that it's not
6 productive to talk, you know, about -- I think all of our
7 work is around how to facilitate. I do agree with Tom
8 that 50 percent is a good number for us to shoot for. But
9 the way you do it is to take a look at why do these
10 systems cost so much and does everybody need a system that
11 does cost that much. When we started a couple of sessions
12 ago, we talked about the state -- you know, Health
13 Information Exchanges, being the HIE of last resort for
14 those that didn't have it. And there was some discussion
15 with DSS about whether or not to -- look what's happening
16 with EMR, is there a low cost EMR -- I think when we come
17 to that and we talked about that in terms of products and
18 services -- because it may be that we need to adopt as
19 part of an overall adoption plan for a statewide
20 electronic health record a lighter weight EHR that gets
21 provided as a service. And for those that are those
22 onesies and twosies who don't want to make a significant
23 investment, will still want to participate in the
24 benefits. But that's the way to do it, you can have --

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1 but I don't think we'll find that everybody just jumps to
2 one, otherwise everybody would have jumped to one already.

3 So you wind up offering something that's lighter weight.

4 And then those who want to invest more or need to invest
5 more, invest the level that they can afford to. But I
6 think it's all about pressing to figure out what the
7 common set is that drives the adoption --

8 MR. PETRUS: I think this is --

9 COMMISSIONER GALVIN: I agree with
10 everything you say. I think that we -- I think we ought
11 to shoot for 60 or 65 percent. You've got to market the
12 hell out of this.

13 MR. PETRUS: I think this is a good
14 discussion, but I want to just bring us back. I do think
15 EMRs, EHRs is really good. One of the things that I think
16 that's really important is that as you move forward with
17 your HIE strategic plan, don't bite off that full bullet
18 because you have the Regional Extension Centers that are
19 responsible for promoting the training, technical
20 assistance, and expansion for HIT adoption by the provider
21 community, and maybe the better vehicle for the EHR
22 lighter, the EMR lighter --

23 MS. HOOPER: Correct --

24 MR. PETRUS: -- the software as a service

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1 or a co-op. So you may want to take a look at how you
2 merge this together to go forward.

3 Just quickly a couple of other examples
4 that we want to talk about and really close out this
5 section with, you know, a model that Kevin has put
6 together. California and Tennessee has really looked at
7 the centrally managed infrastructure, the hybrid kind of
8 model. And I did some work with Joel early on and their
9 conception. As you know, California is a very large
10 state, a lot of (indiscernible) in California, and they're
11 really looking at the service architecture capability,
12 what centralized services they can provide that would
13 demonstrate value. And Tennessee is doing the same kind
14 of model. Tennessee is a little bit newer than
15 California. But those are the complex kinds of
16 approaches, and look at what on the edge do we provide and
17 the level of services that could act as differences. And
18 this is something I think would be important to look at.

19 The last one is the distributed model that
20 we're seeing in New York, which is very challenging to
21 understand what's going on in New York. Michigan has been
22 around longer in its care plan. And maybe, Alistair, you
23 can talk a little bit about the Michigan model which has a
24 little bit more track record --

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1 MR. MCKINNON: They've rebuilt -- I would
2 say --

3 MR. PETRUS: Lessons learned.

4 MR. MCKINNON: Yeah. It failed --

5 MS. HOOPER: Why did it fail, Alistair?

6 MR. MCKINNON: Because it was too
7 decentralized.

8 MS. HOOPER: And why is it going -- what
9 did they have to change to make it work?

10 MR. MCKINNON: They're starting to build a
11 centralized infrastructure.

12 MS. HOOPER: So they are moving from
13 decentralized all the way through hybrid to a centralized
14 --

15 MR. MCKINNON: Yeah, essentially -- I'm
16 stating --

17 MS. HOOPER: -- in the State of Michigan --

18 MR. MCKINNON: I'm stating that as if it's
19 a blanket definite opinion actually sitting and reading
20 tea leaves because there's a whole lot different things
21 going on and they've been at it for years and a lot has
22 happened, and now they're building a centralized
23 infrastructure. But nobody has really come out and said
24 what we could --

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1 MS. HOOPER: Alright --

2 MR. MCKINNON: -- so that -- I think it's a
3 political --

4 MS. HOOPER: So that -- I'm sorry?

5 MR. MCKINNON: It's a bit political --

6 MS. HOOPER: Oh -- I missed that --
7 (laughter) --

8 MR. PETRUS: And he means capital --

9 MS. HOOPER: Understood.

10 MR. PETRUS: Well let's close out this
11 discussion --

12 (pause - tape change)

13 MR. PETRUS: What I'm hearing is support
14 for centralized, but even stronger support for the hybrid
15 model if I were to simplify the discussion.

16 A VOICE: Mmm-hmm.

17 MS. HOOPER: And those that are focused --

18 MR. PETRUS: No --

19 MS. HOOPER: I'm sorry --

20 MR. PETRUS: -- we've got a question over
21 here.

22 MR. CARMODY: And I just -- I just -- you
23 know, before we close out and move on to the finance
24 piece, I'm still -- we haven't got the prioritized list of

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1 what we want to achieve in relatively short order, because
2 I'm going to tell you, once you get to the finance model
3 and we get into all those options you're going to have --

4 MS. HOOPER: Right --

5 MR. CARMODY: -- we're going to come
6 straight back to the conversation. I don't know what
7 we're financing, how big or small. And so when we decide
8 on a model, I'd rather know -- and I understand that we're
9 going to shoot for the end result, you know, that means
10 that's sort of where we need to go to, but I'd like to
11 understand what that -- what that ultimate scope is. We
12 did spend a whole lot of time on, you know, different
13 phases, would the board members modify the phases. I'm
14 not quite sure why we're jumping into health plan
15 eligibility and submitted claims when you have a 50/10
16 implementation coming down the path and/or, you know,
17 there's two AHIP models right now in Ohio and New Jersey
18 that have a consolidated provider portal where you can
19 already check that. I -- my -- my inclination is I want
20 to get to a prioritized list of how we're going to attack
21 it, trunk it down, and then decide what type of models you
22 need to get to in order to support whatever the business
23 capability and functionality we want to deliver, so that
24 we can go off and then figure out how to finance the

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1 pieces. Because until we do that, we can't do what they
2 need to do. So moving on to the -- I --

3 MS. HOOPER: Right --

4 MR. CARMODY: -- I'm going to struggle with
5 it -- we're going to close something out and we're not
6 going to get there and you're going to ask me, you know,
7 when your next finance committee meeting, and I'll go well
8 we don't know what we're doing, so we -- we could start to
9 noodle around or we can do it as a whole group --

10 MR. PETRUS: No, I think this is why we're
11 having the discussion. Here's what we have proposed as
12 the phase development -- and this is --

13 MR. CARMODY: A general reaction just so -
14 - I'd just say I wouldn't be able -- consumer portal right
15 off the bat, I mean I think it's a later part of
16 implementation because I see you have call centers and
17 customer service and organization -- and I know other
18 organizations that have call centers and customer service
19 -- you're adding a whole lot of layers.

20 You know, the whole eligibility, submitting
21 claims piece, I think that most people would want to work
22 within the core standards and/or working and seeing if you
23 could leverage other portals -- health plan portals,
24 eligibility portals, initially knowing ultimately you're

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1 going to get into a 50/10 implementation where you're
2 going to go through EDA clearinghouses.

3 I found it interesting you went to the
4 continuity of care document because that contains a lot of
5 information. So one of the things I'd like the group to
6 talk about was again --

7 MR. PETRUS: In Phase 2 you're talking
8 about?

9 MR. CARMODY: Actually even in Phase 1 you
10 have a CCD document --

11 MS. MOONIE: But very limited --

12 MR. PETRUS: Very limited --

13 MR. CARMODY: Yeah, but in order to fulfill
14 the CCD document, you have a -- you have to put a lot of
15 information that goes into that --

16 A VOICE: And that's department --

17 MS. MOONIE: Right --

18 MR. CARMODY: And I --

19 MR. PETRUS: Yeah, we tried to phase this
20 based upon what we saw coming down from meaningful use and
21 -- not to -- the consumer portal is just possible. If it
22 was not necessary, I would agree with you, but go ahead.

23 MR. CARMODY: I -- I -- one of the things I
24 hear back and forth when -- especially when the physicians

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1 are talking -- you know, is -- is like how do you step it
2 between leveraging what the hospitals are doing and then
3 getting to that ultimate end stage with the PCPs --

4 MS. HOOPER: Right --

5 MR. CARMODY: I mean we sort of vacillated
6 between like -- because reality I would imagine that well
7 all -- you'd still get onesies, twosies -- and you
8 ultimately need to get there -- because your bigger bang
9 for adoption right off the bat is to work with the
10 hospital systems and then extend out or should we as this
11 board as a state effort realize that they're already doing
12 -- the hospital systems are already doing their part and
13 they already have that covered and do we push to the
14 smaller physicians first. And I'm not quite sure. I hear
15 --

16 MS. HOOPER: Right --

17 MR. PETRUS: Well --

18 MR. CARMODY: -- different viewpoints as
19 you guys talk --

20 DR. AGRESTA: So -- the smaller physicians
21 are not uniform by any means, neither are the larger
22 groups. And so that becomes -- so answering that is very
23 challenging, right, because Mark's larger group has how
24 many different clinical sites that interface with probably

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1 every hospital in the whole state, and the smaller
2 physicians might be, you know, a group that has patients
3 go in and out of only one ER, you know, but -- where they
4 might be sitting, you know, in a region where -- you know,
5 for example in our office I routinely have people come in
6 from five different hospitals and ERs and other things,
7 all with different information systems, all with different
8 ways of sending you data, etcetera. So it's not that
9 simple when we boil it down to the end user. It needs to
10 be somewhat standardized. I don't want to go in five
11 portals. That's not going to happen, you know. I'm just
12 not going to do that. I can't remember five passwords to
13 get on that. So some things needs to be made much more
14 simple --

15 MS. HOOPER: Right --

16 DR. AGRESTA: -- much cleaner.

17 MR. CARMODY: So -- so when we prioritize
18 our list of services that we need to provide, I mean how
19 do you want to -- how should we go about prioritizing
20 them, especially when we get into the structure that needs
21 to support it and then the financing that needs to cover
22 it. I'm trying to figure out how you do prioritization.

23 MS. HOOPER: Alright, if we -- Frank and
24 Alistair, you don't mind, we're going to kind of change

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1 this up just a little bit --

2 MR. PETRUS: No, go --

3 MS. HOOPER: -- from the five domains to --
4 that's lovely, Alistair -- (laughter) --

5 MR. PETRUS: He's got something else he's
6 going to --

7 MS. HOOPER: I don't -- I don't really want
8 to ask any more -- (laughter) --

9 MR. MCKINNON: You -- you shouldn't --

10 MS. HOOPER: I'm not going to. But if we
11 want to look at product services -- we had the discussion
12 the last time about the governance and, you know, how to
13 kind of solve this, the REO operating and the authority --
14 but if we go to products and services, if you're looking
15 at a 50 percent adoption rate, is that hospitals -- I
16 know, 65, 75, okay -- but going to your issue of are we
17 selling EHRs interoperability, actual exchange master
18 patient index to hospitals first because -- because they
19 have so much that is in place and they have the immediate
20 access to all of their attending physicians. The smaller
21 ones, again the Regional Extension Center, the funds for
22 E-Health Connecticut, Inc. is to in fact reach out to
23 those smaller docs, not the hospitals --

24 DR. AGRESTA: It's the priority primary

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1 care clinicians -- there won't be any sub-specialties --
2 MS. HOOPER: Thank you --
3 DR. AGRESTA: -- in that initial --
4 MS. HOOPER: That's a smaller group --
5 DR. AGRESTA: -- and that's a very
6 important --
7 MS. HOOPER: Correct. So the primary care.
8 And then we have certainly all providers of -- of
9 Medicare. So in fact, we're all looking at different
10 audiences ourselves. This is where -- one of the things
11 that was brought up at the Executive Committee meeting
12 last week was okay we need the REC, the Regional Extension
13 Center, DSS, and the Cooperative Agreement and all of us
14 to make that commitment that we're going to leverage
15 together. And then see what product are you delivering so
16 that we can either, you know, enjoy that and support it,
17 or if you're not going to do that, then we do through the
18 Cooperative Agreement that currently DPH has with O&C.
19 But I think that we've agreed from what I've heard, and
20 again it may not be in detail, but there is a governance
21 model for coordination and vetting of the issues, but in
22 fact individual HIEs are going to be operating in the
23 State of Connecticut. If we go with the hybrid model or a
24 version thereof, for now it's -- it's decentralized.

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1 We're aiming toward centralized, but we're not with 32
2 acute care hospitals, 250 skilled nursing facilities, and
3 I don't know how many doctors -- and you all aren't
4 necessarily all on the same page all the time --

5 COMMISSIONER GALVIN: I resent that remark
6 -- (laughter) --

7 MS. HOOPER: I -- I didn't mean you, sir,
8 at all -- (laughter) -- and our --

9 COMMISSIONER GALVIN: Ten thousand
10 practitioners, so primary care.

11 MS. HOOPER: And -- and you know, that --
12 that could be a lot of people to agree. And then in our
13 community health centers we have some divisions there,
14 some not being supported at the community level and some
15 being supported more. So with those disparities, I don't
16 know that a centralized model is something that we would
17 get to soon.

18 But if we agree on some of those basic
19 tenants, what services do you all want the State of
20 Connecticut -- not the government, the Connecticut
21 statewide Health Information Exchange to offer as a
22 service? You're saying to me -- or to us, Dan, that --
23 that -- you know, the client services, the claims --
24 that's not something -- there is a function in place for

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1 that -- oh Kevin is ready to just --

2 DR. CARR: No, I want to answer --

3 MS. HOOPER: No, no --

4 MR. CARMODY: Actually -- because it's
5 getting -- actually I would probably give credit -- Kevin
6 was the one that when we were at the Finance Subcommittee
7 that had a couple of --

8 A VOICE: Why don't we --

9 MS. HOOPER: Kevin, tell us what you're
10 thinking.

11 DR. CARR: It's up here --

12 MS. HOOPER: I know.

13 DR. CARR: Well one of the things that --
14 you know, in the past meetings what Gartner has been
15 really good about is somebody -- you know, we need to --
16 Connecticut needs to come up with this answer, right. So
17 we need to like figure out what services we're going to
18 provide and what services we're going to prioritize, and
19 that needs to be Connecticut's response as opposed to
20 their response or somebody else's.

21 And so what they have challenged -- or what
22 I heard you challenge anyway was to -- for somebody to
23 come up with a model internally within the committee and
24 start vetting it. And so over the past week or so, I said

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1 well, you know, create some slides, let's starting putting
2 -- let's see what it looks like. So -- so this is really
3 what I came up with. This is not a committee output, so
4 please feel free to jab it, stab it, throw darts at it,
5 throw darts at me, spit on me, whatever you want to do --

6 MS. HOOPER: No --

7 DR. CARR: You can --

8 MS. HOOPER: -- don't -- no --

9 DR. CARR: -- probably cut that out --

10 (laughter) -- but -- so -- so the concept really is that
11 there's a health care ecosystem. I mean you have an
12 ecosystem right now that's really fragmented, everybody is
13 doing their own thing, not everybody gets along. But in
14 the future what we would like is a more coordinated health
15 care ecosystem. That's not to say that everybody has to
16 get along, but everybody has to support a certain amount
17 of core services across an entire state.

18 And so the thought is what are those
19 particular services that should be supported across an
20 entire state. So if you look at the meaningful use
21 criteria and use that as a guide as to what needs to be
22 supported, what do we need to really think about when
23 we're talking about Health Information Exchange as opposed
24 to Regional Extension Center as opposed to electronic

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1 health records in a provider's office, what do we need to
2 think about from a Health Information Exchange component.
3 We need to think about, you know, personal health
4 records, how does the information get into a personal
5 health record, how do we exchange information for claims
6 processing, for care management. Payers do a ton of
7 disease management. How do we think about that a little
8 bit differently. Ancillary services, you know, lab,
9 pharmacies, radiology. But then providers are investing
10 huge amounts of money into electronic medical records,
11 practice management systems. How do we leverage that? Do
12 we need to get involved at the state level in that at all
13 or do we just say let the providers keep doing what
14 they're doing and then, you know, allow certain
15 information to go through the Health Information Exchange?
16 But then also there's been a lot of
17 discussion in the committee meetings around, you know,
18 quality reporting, gaps in care analysis, to have this
19 transformation, longitudinal care record access, which is
20 do we have a portal, do we not have a portal, and then
21 public health reporting. So -- public health reporting is
22 very very important, so we need to make sure that that's
23 included.
24 So -- so what I did is just started

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1 thinking for each one of those services, are those
2 centralized services, do they need to flow through a
3 statewide infrastructure, or do they -- or is it okay to
4 have them operate outside of that statewide
5 infrastructure.

6 So to go on to the first slide. So -- so
7 what I started thinking about is, you know, okay
8 Connecticut has got the money right now, so the BTHs
9 really have a landfall. How can we leverage that? Who is
10 at the table very effectively as opposed to trying to
11 bring another thousand people to the table? How can we
12 actually start with who we have right now. So -- so if
13 you think about why public health reporting would be
14 important, if you look at the meaningful use criteria,
15 public health reporting is all over it. And so there is
16 an impression that every state is solving how they will
17 deal with public health reporting. We don't have that
18 answer right now. Unless somebody else around the table
19 has the answer --

20 MS. HOOPER: No, we've tried.

21 MR. MCKINNON: Yes --

22 MS. HOOPER: But that's why we're at the
23 table also.

24 DR. CARR: Absolutely. And so we need to

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1 solve that, otherwise providers across the state are at
2 risk of not getting their meaningful use incentive
3 payments. And if they don't get their meaningful -- if --
4 or if we don't put that infrastructure in place now, we
5 lose this opportunity to incentivize providers to link in
6 and do public health reporting. So what I was thinking is
7 that that should really be a prioritized service that a
8 statewide infrastructure should provide. It's -- from
9 just what I've heard in committee meetings, it doesn't
10 seem to be one of those things where people feel they need
11 to have ownership over at all and most have felt as though
12 it's something that a statewide HIE should provide. And
13 so it's -- and you know, many hospitals that I've talked
14 to have said, you know, if the state HIE does public
15 health reporting or facilitates that process for me,
16 that's great. It's another checkbox --

17 MS. HOOPER: Yeah --

18 DR. CARR: -- that I can check off on the
19 meaningful use criteria. If I link into the statewide
20 HIE, that's taken care of, meaning I'm connected to an
21 HIE. So I get to make that checkbox on my meaningful use
22 criteria. And I'm doing public health reporting. Did I
23 get those two that are really really hard for me to do and
24 really completely out of my control checked off, and then

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1 I'm more likely to get my money and meet all the criteria
2 and I'm happy. So the concept would be, you know, if we
3 had a statewide Health Information Exchange, then
4 providers could link into the HIE, there would be a core,
5 you know, HIE infrastructure in place that would have
6 consent management that would identify information that's
7 flowing through the Health Information Exchange, what
8 information needs to be reported to the Public Health
9 Department and what doesn't need to be reported so that it
10 can go to your system --

11 MS. HOOPER: Right --

12 DR. CARR: -- so you've got, you know, this
13 intelligent router basically sitting on the Health
14 Information Exchange and saying does this need to be -- is
15 this a reportable set of information, yes or no; if it's
16 yes, then it goes to the Public Health Department, and you
17 can leverage --

18 MS. HOOPER: Well actually we have a number
19 of systems that would have to be used for all the
20 different -- but maybe there's one --

21 DR. CARR: Right --

22 MS. HOOPER: Right --

23 DR. CARR: -- but you may be starting with
24 --

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1 MS. HOOPER: Correct --

2 DR. CARR: -- and going from that --

3 MS. HOOPER: -- we're getting into
4 logistics here.

5 DR. CARR: And so -- so you know, the why
6 is, you know, you're utilizing state and federal funds and
7 so you should do something that is, you know, the greater
8 good as opposed to just -- for one -- one hospital or
9 another.

10 The what is, you know, identifying
11 information that needs to be reported to the Public Health
12 Department through the -- as it's flowing through the
13 Health Information Exchange. And build a shared
14 infrastructure or shared -- you know, that can also be
15 leverage for other services. So we're -- we make it clear
16 that public health reporting is not the only thing that
17 we're going to do. It's a service that's supported by an
18 infrastructure, and that infrastructure should also
19 support other services that we prioritize as a group over
20 time.

21 So for this one -- then the question was is
22 patients' consent required, and answer is no for public
23 health reporting, but it would be for other services that
24 we would prioritize.

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1 So the next one is -- you know, so if you
2 start with --

3 MR. MCKINNON: So that -- the question --
4 so that really doesn't stand alone --

5 DR. CARR: Correct --

6 MR. MCKINNON: -- because you -- you don't
7 really have the reason to (indiscernible). And the
8 assumption is that the -- identifying the appropriate
9 (indiscernible) is happening at the exchange level with
10 the individual (indiscernible) --

11 DR. CARR: Because these --

12 MR. MCKINNON: -- a way to identify that --

13 DR. CARR: Correct --

14 MR. MCKINNON: -- and just send the data to
15 Public Health --

16 DR. CARR: I would assume that this one and
17 the next one, which is the CCD document exchange for
18 patient care have to go together --

19 MR. MCKINNON: Right --

20 DR. CARR: Okay. Yeah, so that that -- so
21 that the concept is there's a common infrastructure that
22 has multiple services and you can't do one -- some of them
23 have to come together, otherwise they don't fit.

24 So then -- so the next thing was okay if we

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1 had -- you know, there's also been a lot of discussion
2 around exchange of information for clinical care, so who
3 takes care of patients. So I'll listen, you know, on
4 conference calls or in meetings and I'll say who is
5 actually taking care of patients. So, I heard Peter say,
6 you know, we're taking care of patients, we're doing
7 disease management for them every single day. And I heard
8 the providers say, you know, we're taking care of patients
9 obviously in our clinics and we're, you know, seeing them
10 taken care of and doing, you know, direct services, but
11 also doing disease management. And so what do we need to
12 think about for CCD document exchange.

13 So there's a component -- you know, so --
14 so this is a thought, is that CCD documents could also
15 flow through the Health Information Exchange for that
16 purpose. So you've got it flowing through public health
17 reporting here, you have an intelligent router kind of
18 going over, but then there's -- there's a way -- some kind
19 of a portal or access to the information that where
20 patients could then consent to how information as it's
21 flowing through the Health Information Exchange available
22 to all providers linking it to the network for the purpose
23 of patient care. So whenever we get to legal and policy,
24 you know, we have this question -- so -- so for public

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1 health reporting, you know, consent would be required, but
2 for -- as information is flowing through the Health
3 Information Exchange, again the shared infrastructure, for
4 the purposes of patient care and providers are pulling
5 information out of the HIE for purposes of patient care,
6 then they would have to -- there would be consent applied
7 to it at that point. So that you would have the ability
8 for -- so we've got five directional areas -- arrows --
9 you've got information flowing into the Health Information
10 Exchange and flowing into providers so providers are
11 contributing data and pulling it out of the Health
12 Information Exchange, but then also you have, you know,
13 payers doing care management and they're able to push data
14 if you want, and also retrieve data as well from the HIE,
15 so pull it directly into your system. So that you have,
16 you know, more of a transformational event where payers
17 and providers are both working off a common set of
18 knowledge about the patient and their journey through the
19 health care system as opposed to us operating in a silo.
20 So this becomes a hub for us to share information across -
21 -

22 MS. HOOPER: And would some of that
23 information also be restricted? Like you're not going to
24 -- Public Health or state agencies -- DSS or DPH, we're

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1 not going to pull information from the payer?

2 DR. CARR: Correct. You would -- probably
3 wouldn't ever need to --

4 MS. HOOPER: Well I want their data site --
5 you know -- (laughter) -- but it's not something -- there
6 would be a reason for the connection --

7 DR. CARR: Absolutely --

8 MS. HOOPER: -- again to meet the goals as
9 outlined in whatever the strategic plan --

10 DR. CARR: Yeah. And if -- and if you have
11 this -- you know, this -- the ability to identify
12 information shooting over to your Public Health Department
13 system --

14 MS. HOOPER: Correct --

15 DR. CARR: -- you would then be able to say
16 what I want to accept and what I don't want to accept --

17 MS. HOOPER: Correct --

18 DR. CARR: -- you could create those rules
19 around that --

20 MS. HOOPER: As long as -- because
21 everybody is in that situation of sharing, certainly for
22 some purposes -- and -- and restricted sharing obviously
23 with other limitations --

24 DR. CARR: Absolutely. I mean the concept

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1 is -- you know, it's a shared infrastructure, but it's
2 providing services, and those services have different
3 meanings -- purposes for existing in the world as we will
4 know it in the future. And so what are those services
5 that we want to provide the people who pay for it,
6 because, you know, this public health reporting piece -- a
7 lot of the providers will feel that that's really the
8 state's responsibility --

9 MS. HOOPER: Right --

10 DR. CARR: -- to use a lot of this funding
11 to support that, right. And so they're not going to
12 necessarily pony up a bunch of cash to facilitate public
13 health reporting. But you can then -- once that's in
14 place, and the state and federal funds and other funds
15 have been used to create that infrastructure, you can
16 start using the infrastructure for other purposes, which
17 they will be more likely to add --

18 MS. HOOPER: Correct --

19 DR. CARR: -- the money to provide that
20 additional services --

21 MS. HOOPER: Well that's a little bit
22 risky, but yes --

23 DR. CARR: But it will be cheaper --

24 MS. HOOPER: -- because the state bottom

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1 line is not going to be flush for a while, but --

2 DR. CARR: Absolutely --

3 MS. HOOPER: -- again the self-

4 sustainability has to always be the factor, but right now
5 we do have a certain amount of funds, but with the three
6 different projects we can leverage all three and we have a
7 greater shot --

8 DR. CARR: Absolutely --

9 MS. HOOPER: -- at implementing something,
10 not just supporting the implementation of, but actually
11 doing something.

12 What are your limitations -- what -- what
13 did you struggle on as you put together this model? What
14 are the obstacles that you see --

15 DR. CARR: Just really alignment. So the
16 only -- so the only question that I would have is -- you
17 know, like in Danbury, what would -- how would Danbury
18 link in because you've got all that in place right now,
19 how would you link in. And so -- and so the question is --
20 - within this box there probably would be additional
21 aggregators, so not just hospitals, ambulatory providers,
22 but also other aggregators of data that are consortiums at
23 the community level that would be able to contribute to
24 the statewide Health Information Exchange because you

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1 never want to stifle innovation. You know, if you have,
2 you know, a community that says I've got all this stuff
3 that I need to do at the local level that is not going to
4 be provided by the state, then I need to be able to do
5 that and the state not get in -- be in the way --

6 MS. HOOPER: Or -- right, to --

7 DR. CARR: -- or have to wait for the state
8 --

9 MS. HOOPER: -- for any of us to say no you
10 cannot.

11 DR. CARR: Exactly. So I don't think it's
12 this committee's desire to stifle innovation within a
13 particular community. And so the -- so the question would
14 then be, you know, hey we have a local health information
15 exchange or a REO that's adding value in their community,
16 but then linking it to these additional services that are
17 provided by the state.

18 MS. HOOPER: As they requested or as
19 they're willing pay for it.

20 DR. CARR: Absolutely. But that's not
21 necessarily funded by -- you know, if the state
22 infrastructure has funded the additional services off to
23 the side, then there needs to be additional business
24 models created for those additional services throughout

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1 the public --

2 MS. HOOPER: And the standards and the
3 enforcement of those standards --

4 DR. CARR: Absolutely. That's going to be
5 -- the financing piece is not on here, but I think we need
6 to get --

7 MS. HOOPER: Well merging this with --
8 merging this with the Gartner presentation, there are a
9 lot of pieces that go together here.

10 MS. CHAHILL: I -- I appreciate you sharing
11 this. I actually think that your model is very much in
12 alignment with the functional pieces that we -- or the
13 capabilities that we included in those slides.

14 DR. CARR: Yes.

15 MS. CHAHILL: I do have a question though.
16 One of the aspects of the hybrid model is that the
17 statewide HIE would encourage local HIEs, so that means
18 that it would also be able to support financially to some
19 degree the infrastructure of local HIEs. Is that
20 something that you actually had in mind here --

21 DR. CARR: Well, I think --

22 MS. CHAHILL: -- because you talked about
23 assisting local HIEs, but what about new ones that --

24 DR. CARR: Yeah, I -- I struggled with how

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1 -- with how they get paid. So, I think --

2 MS. CHAHILL: Right --

3 DR. CARR: -- you know, what I would say is
4 that it would be really -- probably our core function to
5 support -- an infrastructure that would support the core
6 services --

7 MS. CHAHILL: Right --

8 DR. CARR: -- that a state needs to provide
9 --

10 MS. CHAHILL: Right --

11 DR. CARR: -- and then figure out how
12 either through other incentives or other mechanisms that
13 you support either -- you know, because if you think
14 about, you know, the way the -- the control that we could
15 potentially have over an entire health care ecosystem --

16 MS. CHAHILL: Right --

17 DR. CARR: -- it's not just in this
18 infrastructure, but it's also in how you incentivize
19 accountable care organizations, how you incentivize other
20 --

21 MS. HOOPER: Right --

22 DR. CARR: -- you know, health care
23 initiatives, and that could -- that could make it so that
24 the local REO could also provide services that are now

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1 sustainable on -- on their own --

2 MS. HOOPER: And I don't know that the
3 model that you're talking about -- but yes, wouldn't we'd
4 love to be able to support local initiatives, but there's
5 no -- again we don't have necessarily the financing
6 mechanism --

7 MS. CHAHILL: The finance --

8 DR. CARR: Yeah --

9 MS. HOOPER: -- let alone for self-
10 sustainability for supporting it at local levels. So, I -
11 - that I think will be a struggle no matter what --

12 DR. CARR: Yeah --

13 MS. HOOPER: -- is how do you -- how do you
14 make it happen and support those that don't have the
15 resources.

16 DR. CARR: Right. I mean I've just seen
17 some states that said -- you know, one state that I worked
18 with in the past they said, you know, we're going to have
19 50 Health Information Exchanges across the state and we're
20 going to give them each a million dollars. And then they
21 did that with a few and then --

22 MS. HOOPER: And hope they get together and
23 have a party --

24 DR. CARR: Yeah. And then two out of the

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1 three didn't survive after their million dollars ran out.
2 And so everybody was like wow that was really great --
3 (laughter) -- so we need to figure out like how we make
4 sure that --

5 MS. HOOPER: Right --

6 DR. CARR: -- like something doesn't --

7 MS. HOOPER: Don't worry, DPH won't be
8 doing that --

9 DR. CARR: Right.

10 MS. MOONIE: Kevin, you just said something
11 that is my worst nightmare, and that's the accountable
12 care organizations --

13 DR. CARR: Yeah --

14 MS. MOONIE: -- because that has not been
15 defined. The way we get paid as providers is going to be
16 shared, I mean the patient could go to a health center it
17 could go to individual physician, it could go to a nursing
18 home. How that mechanically is going to work is
19 (indiscernible) at the moment -- so having the state have
20 some sort of -- and again it goes beyond our local
21 exchanges. Because I could have an exchange, Peter could
22 have an exchange, but the minute my patient goes up to
23 Hartford, then, you know, it's outside of my exchange.
24 So, I think that as a public utility we need to have

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1 functionality that would help us manage that data exchange
2 to get our accounted care dollars --

3 DR. AGRESTA: Absolutely --

4 MS. MOONIE: That really --

5 DR. AGRESTA: -- which -- which means care
6 coordination and it means, you know, individual --
7 individual messaging and transfer of documents. And I
8 don't -- I don't know quite how that would --

9 MS. HOOPER: Can that be in phase 3, Tom?

10 DR. AGRESTA: Yeah -- well, yeah -- I mean
11 I don't want to get into those kinds of things now --

12 DR. CARR: But it's -- it's a --

13 DR. AGRESTA: -- in reality --

14 DR. CARR: Even if you put them in Phase 1,
15 to be honest with you --

16 MS. HOOPER: Yeah --

17 DR. CARR: -- there's so much education to
18 teach people how to use them that --

19 MS. HOOPER: Even --

20 DR. CARR: -- you know -- yeah, I mean it's
21 not -- it's not like you can turn it on and say Tom and --
22 you know --

23 MS. HOOPER: Right --

24 DR. CARR: -- the 50 specialists you refer

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1 to, you know, all turn on --

2 MS. HOOPER: It doesn't work that way, does
3 it?

4 DR. AGRESTA: I might know how to use it,
5 but all 50 of them are not going to know how to use --

6 DR. CARR: But if you think about like what
7 ACOs require, they require communication with people
8 you've never talked to before and ways that you've never
9 talked to them before, alright, and so you're exchanging
10 information in ways that you've never exchanged it before
11 and reporting and then action on the reporting. So we
12 need to build that in so that over time small office
13 providers, others that are linking in, we can start
14 providing that -- you know, like talking to each other in
15 ways that they've never talked before, you know, the CCD
16 document exchange, reporting -- starting with public
17 health reporting, then branch out into other types of
18 reporting that the state feels is important for us to
19 report on, and then kind of lead down the path for
20 additional --

21 DR. AGRESTA: If -- if it's built right,
22 there's -- there's a business model for the groups to kind
23 of put money into, but it's a real challenge.

24 MR. COURTWAY: Yeah, this is -- I think

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1 that you -- again just trying to get the point of, you
2 know, who's going to pay for this and why would they pay
3 for it. There's not a lot of money to add new money or
4 subtract money out of different organizations. I think
5 that the answer is around first of all what products or
6 services will somebody buy today. You know, on the
7 Danbury side we led off with the prescribed
8 (indiscernible) it's already there, it's easy to
9 implement, it's tried and true, it's (indiscernible)
10 shelf, and a clear way to (indiscernible) 400 docs up and
11 going and the like. Now the P model starts generating
12 some money coming in, so it's low risk, you know, high
13 value and (indiscernible).

14 I think that what we'll have to -- I agree
15 with you, you know, on the public health piece and try to
16 get some of that reporting, you know, coming through it.
17 But the other part of the transaction set in terms of
18 charging for things where if you have an individual HIE or
19 -- you know, any HIE -- going down to what's listed here
20 as Phase 2, which is the communication of laboratory,
21 radiology reports going back and forth, that is expensive
22 to do -- that is expensive to do. And -- and I can tell
23 you that because we're doing it and it's expensive to do.
24 You know and -- and any HIE that's in the state that is

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1 trying to do that connectivity is going to repeat the same
2 thing. So they're going to repeat the contracting effort,
3 they're going to repeat the implementation cost, the
4 maintenance cost and so on. So what is sustainable for me
5 -- you asked the question about what would Danbury buy if
6 we already have the exchange up -- if we took a look a
7 little bit differently about how you adopt the HRs in the
8 state and how this transaction needs to flow through an
9 exchange, I'd say, you know, take a look at what the REC
10 is going to do and say can we contract on a statewide
11 basis for interfaces, you know, for X number of EHRs that
12 want to apply or maybe any EHR that wants to apply to
13 normalize that cost out. And now you're giving me as an
14 established HIE the reason to say you know what I'm not
15 going to pay the clinical works, I'm not going to pay
16 practice partners, I'm going to buy from the state and I'm
17 willing to pay the transaction pieces because it's going
18 to be easier, smoother, and whatnot. I think we've got to
19 look at those opportunities of collapsing what -- you have
20 this now just really repeating in the decentralized model.
21 And I think that gets you to the sustainability piece.
22 Despite that, I don't want to pay for financial
23 transaction running through this thing and it may be less
24 expensive than my overall transaction costs, I don't know,

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1 but I wouldn't -- I wouldn't think of leading with that.
2 So, I like the idea of the public health being in the
3 start of it. I like the prescribing. I like the results
4 reporting, you know, pieces to start -- to start screening
5 through this --

6 MS. HOOPER: Well that's --

7 MR. COURTWAY: -- but I think we have to at
8 least address the strategy of that. If the REC is going
9 to be effective of integrating its efforts of
10 recommending, you know, how do you select a system, well,
11 you know, do they know what they would recommend if we
12 don't have the standards yet stacked or how it's going to
13 interface with the HIE.

14 DR. AGRESTA: And I -- and I'd argue that
15 this is a perfect interface with the REC where a group
16 like this can interface and collaborate on things that
17 every -- it's in everybody's interest. You know, there
18 are things that are going to be in everybody's interest.
19 And if there's a unified, you know, group in Connecticut
20 who are saying we all want to go through a one contracting
21 process, one interface building process, one holding --
22 you know, finding the few talented individuals who are
23 going to be the interface builders and they're going to do
24 it across these -- across the REC and across the HIE,

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1 we're not going to double pay for these things, we're not
2 going to -- and try to hire people -- but you have, you
3 know, some common way of approaching it, then I think you
4 start to get lower costs for delivering all the services
5 as well.

6 MS. HOOPER: And we are having --
7 Commissioner Galvin is meeting with the other leaders on
8 those three -- on the other two projects to see what's
9 going there. I do want to get us back --

10 DR. CARR: Yeah --

11 MS. HOOPER: -- and considering the time --

12 DR. CARR: Yeah, let me take two more
13 minutes --

14 MR. MCKINNON: Well --

15 DR. CARR: -- I'll take two more minutes --

16 COMMISSIONER GALVIN: Let me interrupt you,
17 Kevin, if you don't mind --

18 DR. CARR: Yeah --

19 COMMISSIONER GALVIN: -- I like this stuff,
20 I think you've got it together. Let me just say
21 something. We -- we -- at sometime in the relatively near
22 future we have to come up with a game plan --

23 DR. CARR: Yes --

24 COMMISSIONER GALVIN: -- and so this is

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1 like a football game, you know, and --

2 MR. MASSELLI: Start huddling around --

3 COMMISSIONER GALVIN: -- Kevin -- Kevin is
4 going to go down field and run like mad and I'm going to
5 throw the ball to him -- (laughter) -- and if he misses,
6 then he -- we'll have to try something else.

7 I'm very fearful that, you know, of the
8 candidates -- the leading candidates for governor -- a
9 couple of them are guys that made a lot of money in
10 (indiscernible -- and the Lieutenant Governor has a lot of
11 experience in (indiscernible). I think if we're confused
12 or have a confusing model, somebody is going to come in
13 here the first meeting we have in November and say
14 Governor Foley, Governor Lamont doesn't like this idea,
15 start all over again. It will be April or May, and a
16 state which -- you know, we're impoverished for money to
17 do things, and we could really go down the tubes and
18 become a very -- a very backwards state as far as this --
19 or very dependent or something that just the hospitals
20 have. So it's very important -- and maybe some of you
21 guys don't like Kevin's idea at all, but it's very
22 important that we come up with a strategy.

23 I like the thing about the public --
24 getting public health -- because it is -- it's all over

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1 the bill and -- and you get a lot of cover. And it will
2 give us access -- you're doing what the feds want, the
3 feds will give you some money. I don't think we're going
4 to get an appreciable grant from the State of Connecticut.

5 I would like to -- I'd like to get a couple of million
6 bucks just to keep people on salary to keep the ball
7 rolling, but I -- but I think -- if any of you think we're
8 going to come out of the next legislative session with 20
9 or 30 or 50 million bucks, forget it --

10 MR. MASSELLI: So Kevin --

11 COMMISSIONER GALVIN: -- so we have to
12 settle on --

13 MR. MASSELLI: -- CCD -- what's the next --
14 what's the one after?

15 DR. CARR: So -- so this is kind of in
16 order. So you have public health and CCD going at the
17 same time --

18 MR. MASSELLI: And just on the time, what -
19 - what's the -- give me a rough --

20 DR. CARR: So I'm thinking, you know,
21 public health and CCD in 2010, 2011ish --

22 MR. MASSELLI: Okay --

23 DR. CARR: -- time frame --

24 MR. MASSELLI: Yeah --

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1 DR. CARR: -- so then you go into personal
2 health records, harmonization, which is 2012, 2013ish time
3 frame.

4 We're going to bring on the ability for
5 patients to access the data that's been transmitted
6 through the Health Information Exchange. The market for
7 personal health records right now is pretty immature. We
8 can choose to become a pilot or we can choose to allow the
9 market to mature. It's totally up to the group. Or what
10 we're proposed -- or what somebody comes in and proposes
11 for us to become part of -- so the concept is -- and this
12 is what I've seen in several other states is that you have
13 the ability for patients to access personal health records
14 in one of two ways; through a centralized personal health
15 record, so have the connectivity directly from the Health
16 Information Exchange to the personal health record, or
17 from a tethered EMR personal health record, so one is
18 tethered to (indiscernible) or to something else or to the
19 payer. And that that personal health record would be able
20 to go through and access the Health Information Exchange.

21 So you have like a tab on your personal health record
22 that your EMR -- that's tethered to your EMR to your payer
23 systems that says Health Information Exchange and click on
24 the tab and patients can then see everything in the Health

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1 Information Exchange just like a provider would be able to
2 see it. So providers are going to be clicking on tabs in
3 their EMR, and the concept is that patients would also
4 have a tab, which means their -- is their Health
5 Information Exchange.

6 MS. HOOPER: Okay, that's getting --

7 DR. CARR: Yeah --

8 MS. HOOPER: -- what's the product --

9 DR. CARR: Yeah --

10 MS. HOOPER: -- is where we kind of left
11 off with when -- and Kevin, again you've pictorialized
12 what some of the issues are into a workable system that I
13 think everybody appreciates this could be a model.
14 Where's your -- what is -- what is your envisionment after
15 all this discussion in terms of the services?

16 DR. CARR: Yeah. So the service would be
17 basically access to the -- to the documents through a
18 personal health record --

19 MS. HOOPER: Right --

20 MR. MASSELLI: So those are the three --

21 DR. CARR: And then to the next slide --

22 MR. MASSELLI: Okay --

23 DR. CARR: -- so the next one is quality
24 reporting, which would be in 2014, 2015 time frame, which

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1 would include -- now we have -- you'll notice down here
2 there was access for providers down here, public health
3 reporting is down here, but now quality and gaps in care,
4 analytics, so you have the ability to identify data that
5 needs to go into a quality warehouse, and then we can
6 start really doing true gaps in care analysis across an
7 entire community and state, etcetera, as opposed to us
8 doing individual EMR reports out of our own systems and
9 specific reports, etcetera.

10 So then -- so the last one would be okay
11 let's really truly tackle this quality of care issue. I
12 think that's going to take a little bit longer than just a
13 year, two years. We're going to have to work through
14 that. Everybody seems a little bit less comfortable about
15 that --

16 MR. MASSELLI: This is the research folks -
17 - I mean ultimately this is going to --

18 DR. CARR: Yeah --

19 MR. MASSELLI: -- but for public health
20 advocates it might be researched --

21 DR. AGRESTA: No, you're going to need do
22 meaningful use too

23 MR. MASSELLI: Meaningful use as well --

24 MS. HOOPER: Yeah --

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1 DR. CARR: So diabetes care --

2 MS. HOOPER: Right --

3 DR. CARR: -- and providing all of the data
4 that's in my patient population --

5 MR. MASSELLI: Is it too far out for
6 meaningful use for reimbursement purposes --

7 DR. AGRESTA: It's unclear because
8 meaningful use criteria hasn't been finalized --

9 DR. CARR: But I think that would have to
10 be harmonized with --

11 MR. MASSELLI: So you might change that
12 timeline back a little, make it more aggressive --

13 MS. HOOPER: It's four components. And
14 then recognizing that for really QA and quality reporting
15 will take a continuing process for some of the other --

16 MR. CARMODY: I have -- PHR -- quality
17 reporting -- only because --

18 A VOICE: The timelines or the --

19 MR. CARMODY: Yeah, the timelines. Only
20 because -- I mean I'm responsible for our personal health
21 record and I can tell you right now, as you said, it's
22 immature -- it's interesting to -- well I mean I think
23 some people will look at it and they'll go huh. And again
24 getting it to the majority of the people that aren't

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1 actually accessing -- and I think most people typically
2 don't -- is a big -- it potentially could be a big added
3 expense. I think the --- the unlocking of a benefit --

4 A VOICE: Is a quality --

5 MR. CARMODY: -- is really in the quality
6 and reporting and the gaps --

7 A VOICE: Yeah, right --

8 MS. HOOPER: Yeah --

9 MR. CARMODY: -- because now it's action
10 time --

11 A VOICE: Right --

12 MR. CARMODY: -- so we've gone from public
13 health reporting, which we need, the CCDR, which isn't a
14 physician -- which really is the most important piece --
15 the physicians you want to get excited about it, to tell
16 their patients it's -- I mean you can tell the consumer
17 all you want --

18 MS. HOOPER: Right --

19 MR. CARMODY: -- but unless you guys get
20 excited about it and say is this in your PHR or in your
21 record, the person is not going to understand it. And
22 then there's the quality piece that you're going to
23 actually then provide --

24 MS. HOOPER: Right --

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1 MR. CARMODY: -- because now you -- across
2 that whole ecosystem you can derive what did everybody
3 know and did anybody --

4 DR. CARR: I would love to get there
5 sooner. I was afraid that somebody --

6 DR. AGRESTA: I think if we can move back -
7 - and the other thing is that right now as the meaningful
8 use criteria stands, to get meaningful use dollars in
9 2011, practitioners and hospitals need to provide patients
10 with a summary of their data, a CCD document -- it doesn't
11 necessary have to be CCD, but some kind of summary of
12 their data in the format that they choose -- in an
13 electronic format that they choose, will you tell me what
14 that, you know, means --

15 MS. HOOPER: Right --

16 DR. AGRESTA: -- it could be a key that
17 they take home, it could be an e-mail message, or it could
18 be a personal health record. So you can help in that
19 process. If there's a way to kind of -- again it's
20 leveraging dollars, a Regional Extension Center and --
21 from -- you know, all the hospitals need to solve this
22 problem too, you know -- I mean there's a lot of people
23 who are going to have to solve this problem

24 MR. CARMODY: But eventually when you get

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1 to point where you have to turn it into an electronic
2 exchange -- at some point you -- you're a physician and
3 you're going to say I have three options which I can --
4 but beyond that if you don't like the way I can give it to
5 you --

6 MS. HOOPER: It's not available --

7 MR. CARMODY: -- but right now most people
8 have no options --

9 MS. HOOPER: Well and also I mean you can
10 have a repository where you can draw this information for
11 the person. But again this whole exchange function is
12 where we wanted to ultimately end up --

13 MR. CARMODY: Right --

14 MS. HOOPER: -- where there is some
15 interaction.

16 DR. CARR: So it sounds like there's
17 consensus, public health reporting through a statewide
18 infrastructure, probably the same shared infrastructure
19 for CCD document exchange. And then the question is do we
20 -- do you want personal health record and quality
21 reporting --

22 A VOICE: Yes -- yes --

23 MR. MCKINNON: The reason for having all
24 this because the critical mass that until you've got

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1 enough information you can't (indiscernible) --

2 A VOICE: Yes --

3 DR. CARR: I mean all of this can go live,
4 does not preclude that we have some type of a pilot around
5 particular EHR technology or disease or what have you. I
6 mean all of -- that -- it's not going to pop up and go
7 live in 2014, 2015 --

8 MS. HOOPER: No --

9 MR. MASSELLI: Let's go back to the PHR or
10 the public health record, and I'm just trying to figure
11 out -- while I don't mind switching it to four, I'm just --
12 - the larger politics of this, selling it to the General
13 Assembly, making this a key element of what we're doing,
14 we've got other external forces around us, around making
15 sure the public has access to data and we have the
16 practical reality amongst our providers of what makes
17 sense, and you probably have PH -- the public health stuff
18 last, but I also don't want to miss what might be an 800-
19 pound gorilla in front of the new governor sitting in
20 front of us and saying what do I also want to tell the
21 public about this, so --

22 DR. CARR: Yeah --

23 MR. MASSELLI: -- I don't mind -- I think
24 it makes sense changing the order, but I don't -- I don't

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1 want to lose -- focus in on --

2 MS. HOOPER: Well recognizing that again
3 that public health reporting is not just the Department of
4 Public Health -- I mean the state agencies that have
5 access to this information again can be provided. But I
6 do want to recognize -- I'm going to be a little bit of a
7 nudge, it's 2:25 --

8 A VOICE: Yeah --

9 MS. HOOPER: -- so we are here until 4:00,
10 okay. Frank --

11 MR. PETRUS: Yeah --

12 MS. HOOPER: -- Kevin --

13 A VOICE: This is worth the investment of
14 time --

15 MS. HOOPER: Oh, my God, I am so happy,
16 Kevin, that you took the time to do this for all of us. I
17 want to suggest that perhaps in the next minute or two,
18 Kevin, wrap up --

19 DR. CARR: Yeah --

20 MS. HOOPER: -- what you want us to hear.
21 And then if we could take a 10-minute break.

22 DR. CARR: Yep.

23 MR. PETRUS: Yep.

24 DR. CARR: So then -- the only -- the two

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1 things really are the last slide --

2 MR. MCKINNON: (Indiscernible) --

3 PETRUS: Yeah. So -- so this is -- these
4 are the questions --

5 MS. HOOPER: Alistair --

6 MR. MCKINNON: (Indiscernible) --
7 (laughter) --

8 DR. CARR: So what is not in here right now
9 that's included in meaningful use criteria, but not
10 included in the four other slides with prioritized
11 services, is the claims processing piece, which is sitting
12 over here, you know, sending claims to the payers. And
13 the reason that I didn't put it in there is because
14 there's existing systems already in place that do that,
15 and they're kind of tied to -- yeah, they're tied to
16 systems that your providers are purchasing and payers have
17 already invested a ton of money into them, and so I just
18 didn't envision that everybody would start recontracting
19 for claims processing services. That was just my thought.

20 And then the other one was lab results.
21 Both of these require critical mass for us to be able to
22 provide these services of scale. And these are already
23 provided in some other way. And that was the reason for
24 me not knowing what to do with them. That's not to say

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1 that somebody else in the committee doesn't know what to
2 do with them. But these were two that I didn't know the
3 answer because I don't see the critical mass of three
4 hospitals saying I want to go in together and do claims
5 processing and three hospitals saying I want to go in
6 together and do lab results delivery. If that was case,
7 then it would make this much more compelling. I just
8 don't see it. And that's not to say that it's not out
9 there. That's the reason they're not -- I don't -- I
10 didn't know what to --

11 MS. HOOPER: They might not be on your
12 priority -- and they could happen in time, but you're --
13 there already is a system for that interchange.

14 DR. CARR: There is for claims processing -
15 -

16 MS. HOOPER: On the claims, but not --

17 DR. CARR: Peter said -- I have to say what
18 Peter said about lab results -- it's near and dear to my
19 heart -- I would love to have it in there because it cost
20 a lot of money to build point-to-point interfaces. And
21 there are hospitals -- there are providers that sit
22 between two hospitals and three hospitals --

23 MS. HOOPER: Yep --

24 DR. CARR: -- and those hospitals are going

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1 to have to provide -- do lab interfaces to the same system
2 from two different places. It's not going to be
3 coordinated. It's going to be crazy. It's going to be
4 ridiculous, a lot of work. But I don't know where this
5 happens.

6 MS. HOOPER: Okay.

7 DR. AGRESTA: And there's the other part of
8 it, there's lab routing, but the -- the required stuff for
9 clinicians is they're going to have to do orders
10 electronically. In order to do orders electronically,
11 what they really need effectively is some kind of master
12 patient index --

13 A VOICE: Right --

14 DR. AGRESTA: -- that's associated at least
15 with an ordering facility. If -- if the state's master
16 patient index was being able to be used for ordering, you
17 know, then you could get the lab routing part fixed
18 because you'd have the -- you'd have the master patient
19 index as being the way that you kind of ordered stuff.

20 MR. COURTWAY: You know, I think that --
21 sort of like a little twist on mine is they -- while we're
22 all here representing our constituents, really the
23 question is what are we willing to buy from the exchange.
24 So you know, Mike, Dan -- you know, what's your sector,

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1 you know, interested in buying from the exchange? What
2 reduces your costs or gives you greater effectiveness?
3 What are the physicians willing to buy? What are the
4 hospitals willing to buy? What is DPH and the State
5 willing to buy as is fundamentally, you know, transitioned
6 from some trying to wrench some cost out so that they can
7 be put in there. Whether DPH will even need a maven --
8 I'm not sure what a maven is, but -- (laughter) --

9 MS. HOOPER: That is a platform --

10 MR. COURTWAY: -- you know --

11 MS. HOOPER: That's alright, it's just a
12 platform with a number of applications --

13 MR. COURTWAY: Right. So -- so is the
14 repository itself (indiscernible), and it's a matter of
15 putting analytics on there. But I think we all have to
16 channels in terms of what would we buy from it, because
17 ultimately what we're building -- if we're not willing to
18 buy it, then it's not going to be sustainable.

19 (pause - tape change)

20 COMMISSIONER GALVIN: (Indiscernible) --
21 consortium of hospitals; one centered around Hartford and
22 one centered around New Haven. And then when you look at
23 your institution as combined with New Milford and -- you
24 know, there aren't too many people out there waving in the

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1 breeze -- Backus is -- but you go down to New London and
2 they're part of the Yale system. All the ones in the
3 southern tier of Fairfield County are part of the Yale
4 System --

5 MS. MOONIE: No --

6 COMMISSIONER GALVIN: Well they're --

7 MS. MOONIE: Us and Stamford --

8 MR. COURTWAY: (Indiscernible) -- will you
9 be putting Danbury --

10 COMMISSIONER GALVIN: Yeah -- (laughter) --
11 you're going to be looking at a consortium of hospitals
12 that will probably do a lot of things in common. Hartford
13 Hospital is not going to set up a separate system for
14 Windham. And then you've got Charlotte Hungerford,
15 Johnson -- I don't know who -- what Johnson Memorial is
16 going to look like, but probably not -- maybe not a
17 hospital. And Backus out there in the breeze. And then
18 you've got the two -- Charlotte and Day Kimball that are
19 kind of -- all -- all the doctors in the Charlotte
20 Hungerford catchment area go only to Charlotte Hungerford.
21 And the same way out -- out at Day Kimball. So it's not -
22 - it's not that hard. There will be a couple here and
23 there that don't fit in, but I think you're going to see
24 more. I think we're going to end up with two large

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1 systems plus the Danbury, New Milford system, and a few
2 extra.

3 MS. MOONIE: I've got to just raise the
4 clinical care flag again because what we're building does
5 not facilitate -- that train is coming --

6 COMMISSIONER GALVIN: Yes --

7 MS. MOONIE: -- I think that we have to --
8 and it -- a statewide MPI is the very critical component -
9 -

10 A VOICE: Yeah --

11 MS. MOONIE: -- because then you at least
12 know where that patient is going.

13 A VOICE: Exactly.

14 MR. PETRUS: Let's -- let's summarize a
15 little bit just before we take a break to see we're on the
16 same point here. And Kevin, thank you. Kevin had shared
17 this with us as we put this together and tried to tie in
18 his thoughts. But having -- having some look at (1) is
19 there a consensus of the group, and beginning with the
20 technical infrastructure, technical direction of the
21 hybrid model? Any violent opposition to that? Again
22 you'll get another bite at the apple as we go forward with
23 the plan.

24 MS. HOOPER: So we're all -- do you

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1 understand what he's asking --

2 A VOICE: Yeah --

3 A VOICE: Yeah --

4 MS. HOOPER: We're nodding in agreement.
5 This is not set in stone --

6 MR. PETRUS: No --

7 MS. HOOPER: -- and it's a variation on
8 what might be listed here --

9 A VOICE: Right --

10 MS. HOOPER: -- but right now we are not
11 only in a hybrid, but we are promoting that that hybrid
12 would be sustained.

13 MR. PETRUS: And as Kevin talked about in
14 the services --

15 MS. HOOPER: Or modified as time --

16 MR. PETRUS: But really the kind of value
17 add or value of proposition, public health data, and then
18 the initial thoughts around meaningful use and the CCD
19 doc. Is that --

20 MS. HOOPER: And I think the public health
21 data is not -- it's more about the reporting requirements
22 --

23 MR. PETRUS: Right --

24 MS. HOOPER: -- already for existing health

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1 care providers.

2 MR. PETRUS: So instead of reporting into
3 the different registries, the system would be able to pull
4 that data for you and handle that responsibility --

5 MS. HOOPER: Correct --

6 MR. PETRUS: -- through the intelligence
7 that was in the exchange --

8 MS. HOOPER: Right, it's more about the
9 reporting function to ease that up --

10 MR. PETRUS: Absolutely --

11 MS. HOOPER: -- for the health care
12 provider --

13 MR. PETRUS: Absolutely --

14 MS. HOOPER: -- am I correct, Kevin --

15 MR. PETRUS: -- and it starts to build the
16 --

17 DR. CARR: Yes --

18 MR. PETRUS: -- the aggregate database and
19 intelligence capabilities for a future phase as your go
20 forward. And to do -- to do that you're going to need
21 some common services that we've identified in the earlier
22 slide; master provider index --

23 MS. HOOPER: Yes --

24 MR. PETRUS: -- master patient index,

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1 record locator, security infrastructure, etcetera.

2 The second phase, I'm hearing that still
3 needs some work about do you move with the personal health
4 record first, which is not quite as challenging
5 technically, but as far as the maturity, the products out
6 there we don't know where that's going to be, either a
7 direct cord to it or a tethered approach --

8 MS. HOOPER: Right --

9 MR. PETRUS: -- but part of -- meaningful
10 use was identified. And that's going to be part of
11 meaningful use is to allow access to consumers to their
12 health information in electronic format, whatever that may
13 be, compliant with HIPPA and other security and
14 confidentiality statutes. And other phase would be
15 quality reporting at some point.

16 So we're -- we're clear on this first phase
17 --

18 MS. HOOPER: I think --

19 MR. PETRUS: -- embryonic thoughts on the
20 first phase? The second or third phase --

21 MS. HOOPER: Oh, we're a toddler in Phase 1
22 --

23 MR. PETRUS: Okay. And then there's --

24 MS. HOOPER: -- we're not embryonic --

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1 MR. PETRUS: -- then there's the issues of
2 claims processing and lab results delivery that still need
3 to be flushed out. Is that a good consensus of where you
4 are --

5 MS. HOOPER: Is anybody not on that same
6 page?

7 MR. HUDSON: I'm on that same page --

8 MS. HOOPER: Yes, Michael --

9 MR. HUDSON: -- I just think in terms of
10 sequencing, it's important to find out where we can unlock
11 financial value and to whom because therefore you're then
12 starting to create an avenue for a sustainable financial
13 model.

14 MR. PETRUS: Good, Mike.

15 MR. HUDSON: So I would say even if you
16 logically create -- do some things that might not be in a
17 preferred sequence, if you can start unlocking the
18 financial value, then you can create, you know, a tail
19 wind to help the thing move instead of --

20 MR. PETRUS: And I think as some people
21 said earlier about the political issue around personal
22 health records, you know, it might give value because of
23 the optics of it; that -- look at what we're going to do
24 for you the taxpayer and consumer. The optics of that

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1 might be something that would help --

2 MS. HOOPER: And leveraging the three right
3 now, the stimulus funds available under three different
4 ruse, but leveraging that. Again that's a one-time shot.
5 But we are looking for -- I'm sorry, you're both sitting
6 together, AETNA and CIGNA -- I think you could cough up
7 quite a bit, don't you -- (laughter) --

8 MR. HUDSON: Well that gets back to
9 understanding -- (laughter) -- what are your propositions
10 --

11 MS. HOOPER: Well -- but also the value and
12 the services involved because --

13 A VOICE: You've already twisted his arm --

14 MR. HUDSON: But I think when you put
15 things -- (laughter) -- you put -- you put prescribing in
16 there because that's --

17 (Multiple voices overlapping -
18 indiscernible)

19 MR. HUDSON: -- that's a real direct
20 business model --

21 MS. HOOPER: Correct --

22 MR. HUDSON: -- and I think then you can
23 start looking at so what -- what could we do to better
24 manage high risk, at risk patients, and help people avoid

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1 unnecessary readmissions to hospitals. Then you can start
2 getting at immediate value that can be unlocked --

3 MS. HOOPER: And that -- our improved
4 health outcomes --

5 MR. HUDSON: Right --

6 MS. HOOPER: -- your bottom line is ours --

7 MR. HUDSON: And it's not just --

8 MS. HOOPER: -- it's just different
9 language --

10 MR. HUDSON: -- and it -- also keep mind
11 that a lot of it is not necessarily the insurance
12 companies --

13 MS. HOOPER: No --

14 MR. HUDSON: -- a lot of it are the
15 employers of Connecticut --

16 MS. HOOPER: True --

17 MR. HUDSON: -- as well as the state and
18 federal government too. So the people who have paid --

19 MS. HOOPER: Right --

20 MR. HUDSON: -- all of the inefficiency of
21 the past -- I mean from my perspective we have to be
22 flexible in how we share in the benefits of the
23 improvements --

24 MR. MASSELLI: I'm not understanding your -

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1 - I understand you're -- we're -- we're not going to be
2 managing patients. You're going to be managing patients.
3 So walk me through me through how you unlock the value
4 with the data? What -- what are you -- give me a real
5 time -- a real application --

6 MR. HUDSON: Sure. I mean there's like
7 better -- how about better -- you know, better disease
8 management, better discharge planning. That's --

9 MR. MASSELLI: But you're -- you're -- this
10 doesn't do -- it just gives you the data --

11 MR. HUDSON: It gives us the data. Right,
12 you start to get the flow of the data, like for an example
13 on managing high risk patients, people at high risk of
14 readmissions --

15 MR. MASSELLI: But you --

16 MR. HUDSON: -- the continuity of care
17 documents on discharge planning -- you know, that doesn't
18 -- that doesn't happen automatically --

19 MR. MASSELLI: Okay --

20 MR. HUDSON: -- that doesn't happen
21 automatically and it does take a lot of work to make it
22 happen --

23 MR. MASSELLI: So you're thinking it's --
24 it's about timing here --

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1 MR. HUDSON: Pardon?
2 MR. MASSELLI: You're saying it's about
3 timing --
4 MR. HUDSON: I think it's timing, yeah --
5 MR. MASSELLI: -- if we can get it sooner -
6 -
7 MR. HUDSON: -- because I think --
8 MR. MASSELLI: -- you're going to unlock --
9 if we give you the data, then you got your own application
10 for how you're going to go after that --
11 MR. HUDSON: Right --
12 MR. MASSELLI: Okay. I just wanted to be
13 clear --
14 MR. HUDSON: Yeah, but I think if you don't
15 design in doing some of these things -- if they're not in
16 by design, they will not be in by accident --
17 MR. MASSELLI: Mmm-hmm --
18 MR. HUDSON: -- so that's where I think
19 when you're looking for people to say well how do we fine
20 --- how do we pay for all this stuff, it's like well who's
21 going to get the benefit --
22 MS. HOOPER: And -- and again what is all
23 that stuff --
24 MR. HUDSON: Right --

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1 MS. HOOPER: -- but I think we've gotten
2 closer, and the benefit will be in fact to everybody
3 that's represented here.

4 MR. HUDSON: Yeah, absolutely.

5 MS. HOOPER: Can we go for --

6 MR. PETRUS: I just --

7 MS. HOOPER: -- a seven-minute break --

8 MR. PETRUS: I just want to close out
9 technical. Is --

10 MS. HOOPER: Oh, good, close out technical.

11 MR. PETRUS: The -- so now that you have --
12 the strategic plan, what is it that Connecticut wants to
13 do? We're starting to get some formation here of what you
14 want to do --

15 MS. HOOPER: Yes --

16 MR. PETRUS: -- and where you want to go in
17 some sense of sequence. And we'll get to value of
18 proposition and business operation. And then the next is
19 the creation of the enterprise architecture. If you're
20 now saying here's where we need to go and what do you need
21 to be buying in the development of the enterprise
22 architecture and having an enterprise architecture concept
23 using industry standards for the development of
24 Connecticut Health Information Exchange, that looks at the

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1 business, the functionality, and requirements of these
2 business processes to begin with.

3 MS. HOOPER: Correct.

4 MR. PETRUS: The information -- what
5 information needs to be shared, processed, stored --

6 MS. HOOPER: Yeah --

7 MR. PETRUS: -- reported, pushed, pulled?
8 What's the technology necessary to support that and
9 provide for the appropriate security? And what's the
10 overall solution or combination of solutions, products
11 that you will have to make that happen?

12 Next is to move into a collaborative
13 approach for the procurement. Where do you start
14 procuring this? Monitoring and adopting the standards,
15 some of which are federal standards, some of which you're
16 going to have to tailor. And the legal and policy group
17 has been working on that. And then the necessary overall
18 adoption of the broadband initiative in the state as well
19 as the Regional Extension Center that some of you talked
20 about earlier I think is really critical. And I think --
21 don't underestimate the Regional Extension Center's
22 capability here. It needs to be more than just a clearing
23 house of information and brochures and training and
24 technical assistance. There's a lot that can happen in a

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1 partnership between you and the Regional Extension Center
2 --
3 MS. HOOPER: Well we're pursuing --
4 MR. PETRUS: -- and for division with O&C.
5 That might help flesh out --
6 MS. HOOPER: Yes --
7 MR. PETRUS: -- some -- some of this -- and
8 especially around the concept of unlocking the financial
9 value --
10 MS. TOWNSHEND: Break time --
11 MR. PETRUS: So technical, I think from the
12 Gartner perspective we've got --
13 MS. HOOPER: I think you've got some good
14 meat now and we've got some applicability --
15 MR. PETRUS: Yeah --
16 MS. HOOPER: -- because our next domain is
17 finance. And you have 10 minutes to do that one --
18 (laughter) --
19 MR. PETRUS: Alright, let's take a 10-
20 minute break and we'll have it --
21 (Whereupon, a short recess was taken.)
22 MR. PETRUS: Alright.
23 MR. MCKINNON: We're breaking the equipment
24 --

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1 MS. HOOPER: Let's --

2 MR. PETRUS: Alright, let's talk -- two
3 things in financial domain; one is the value of
4 proposition, which is really important. And I -- and
5 we're -- typically we would not spend as much time on it
6 because we thought we had spent a lot of time on it, but
7 we did get feedback that it wasn't clear the value of
8 proposition with regard to the Connecticut HIE. So we
9 thought it was important because some folks felt there was
10 a gap there. And then the other piece of the financial
11 domain that we want to talk about is the revenue and
12 sustainable funding, which is probably more of a challenge
13 than the -- or equal challenge as the technical
14 architecture was. And we have an hour. We'll be okay.

15 So in the financial domain assumption, we
16 really want to take a look at the approach to -- and it
17 was mentioned here, the approach that really demonstrates
18 the value. What is the value that's going to be brought
19 that would look at the potential of investment from a
20 variety of individuals in the health care system that
21 would promote a sustainable model and not put undue burden
22 on any of the key players? And as we move forward with
23 this model, obviously the technical architecture has to be
24 spelled out, but the value of proposition has to be

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1 spelled out. And right now we have a commitment from O&C
2 for Connecticut and we have an idea that has been raised
3 regarding a two-staged approach to funding.

4 The first stage looking at base funding for
5 limited functionality to begin the foundational layer of
6 the HIE, which might lead back to some pieces of this that
7 might be the foundation of the kind of service, master
8 provider index, master --

9 MR. MASSELLI: Well that's -- that's the
10 important one. How far does that get us to what phase
11 because --

12 MR. PETRUS: I don't know --

13 MR. MASSELLI: Okay, well that's --

14 MR. PETRUS: I don't know, quite frankly.
15 What we have to talk about is what is necessary to build
16 the foundation of the HIE to move in the direction of a
17 hybrid to meet these kinds of services in a phased model.
18 And then you might say -- we might have to even take the
19 first stage and divide it in two stages --

20 MS. HOOPER: Mmm-hmm --

21 MR. PETRUS: -- depending on where the
22 baseline revenue is or isn't. And we might have to post
23 out to a second stage for the sustainability funding that
24 might through subscription or fees.

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1 MS. HOOPER: Mmm-hmm.

2 MR. PETRUS: And I think that's --

3 MR. MASSELLI: But nobody has worked up a
4 model or even --

5 MR. PETRUS: Not yet. We've got --

6 MR. MASSELLI: -- or taken those other
7 states and said here's the model --

8 MR. PETRUS: Yes, we have some other states
9 that are in the presentation we're going to share with
10 you.

11 If you can go to the next, Alistair. Value
12 of proposition. Define clearly the value of proposition.
13 Here's two approaches. One approach is just to take a
14 quantitative approach that demonstrates the economic
15 benefits. The other is take a look at qualitative and
16 quantitative benefits over time to organizations. And
17 this we feel is the strongest -- the stronger approach
18 than the pure quantitative. Is that there's qualitative
19 benefits as we've talked about for example for the
20 personal health record. There are issues there that might
21 not be as easily to quantify, but the qualitative benefit
22 of patients becoming active participants in the delivery
23 of health care might be harder to quantify than the
24 management of chronic disease, than the management of

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1 appropriate discharge orders from hospitals that follow up
2 and prevent a return to the hospital.

3 The next slide -- the next slide. So if we
4 look at examples of quantitative benefits, this is some
5 that we see in the national arena. The next slide. And
6 qualitative benefits. And let's go back to the -- to the
7 options. How does Connecticut want to state the value of
8 proposition, purely in quantitative benefits or in a
9 balance of qualitative and quantifiable benefits? And this
10 has implications for the business plan that the business
11 and operations domain has to focus on and how they
12 establish the business plan and reach out. This has an
13 implication on governance and how you communicate to
14 participants in the HIE, to patients, and to the state on
15 the benefits that you bring in through all the work that
16 you're doing through the authority to develop an HIE
17 within the State of Connecticut.

18 DR. AGRESTA: This seems like a no-brainer.

19 A VOICE: Mmm-hmm.

20 MR. PETRUS: That's what I think.

21 A VOICE: Yeah.

22 MR. PETRUS: But there were people -- there
23 was feedback -- we got a lot of feedback that people were
24 not clear on the benefits.

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1 MS. HOOPER: And were those from
2 representing for instance small physician groups, was it
3 from hospitals, was it from consumers, was it from
4 advocates --

5 MR. PETRUS: Hospitals and consumers.

6 MS. HOOPER: Hospitals and consumers.
7 Peter, we're going to put you on the spot. Is there an
8 issue -- again, you're in the forest, so we don't need to
9 explain it to you. Do you think that from the various
10 hospitals is there clarity needed for the benefit of this
11 effort?

12 MR. COURTWAY: I would think so.

13 MS. HOOPER: Okay. And Jamie is nodding
14 right along with you.

15 MR. COURTWAY: Because everyone is
16 struggling with it, you know, to get down to the exact
17 details. It's one thing to say well it's going to improve
18 patient safety, but what does that really mean --

19 MS. MOONIE: Mmm-hmm --

20 MR. COURTWAY: -- you know, we got to get
21 down to both aspects of that I think.

22 MS. HOOPER: Is that something doable, to
23 get that message clear?

24 MS. MOONIE: It has to be or else the

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1 hospitals will not invest --

2 MS. HOOPER: Understood --

3 MS. MOONIE: -- mom and apple pie. Given
4 the constraints we're under in terms of reimbursement
5 issues, declining patient, you know, volume, all these
6 other things, I know that I'm going to be pushed to really
7 clearly articulate not only quantitative -- qualitative --

8 MS. HOOPER: Of course --

9 MS. MOONIE: -- but quantitative benefits.
10 Why should we invest, we have too many other things to --

11 MS. HOOPER: And I think from the consumer
12 side can -- is that primarily because of the privacy,
13 security, and also what does this do for me?

14 MR. PETRUS: Exactly. The latter.

15 MS. HOOPER: Understood.

16 MR. PETRUS: More -- more than the security
17 piece.

18 MS. HOOPER: Okay. Those are things that
19 are addressable.

20 MR. PETRUS: Yeah, I think so --

21 MS. HOOPER: Okay --

22 MR. PETRUS: -- and I think -- I don't want
23 to say no-brainer, but the challenge -- the challenge
24 really becomes then the quantifiable, is how do you define

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1 and measure the quantifiable benefits.

2 MS. HOOPER: Correct.

3 MR. PETRUS: And the reporting that's
4 necessary. And you've got --

5 MS. HOOPER: Which is extensive.

6 MR. PETRUS: Right. You've got the
7 reporting for Connecticut, the reporting for O&C, the
8 reporting for the stimulus dollars --

9 MS. HOOPER: Yes, sir --

10 MR. PETRUS: -- and you have reporting
11 within Public Health, and you're going to have reporting
12 between your Medicaid agency as well.

13 MS. HOOPER: Correct. There are different
14 levels. The funding reporting is -- is distinct. And
15 certainly the benefits need to be reported through both
16 Public Health and through the sharing of information,
17 laboratory information, management systems, the Medicare
18 manage care --

19 MR. PETRUS: And meaningful use and all of
20 that -- we -- we think that is critical.

21 MS. HOOPER: But I do think that defining
22 and measuring those benefits is not only doable, it needs
23 to be done --

24 MR. PETRUS: Right --

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1 MS. HOOPER: -- and we would be looking for
2 other states and their models to make sure that we're not
3 being exclusive --

4 MR. PETRUS: And for the strategic plan --

5 MS. HOOPER: Yes, sir, that's -- we're --
6 we're hoping --

7 MR. PETRUS: -- you need to start to
8 articulate what are you going to measure.

9 MS. HOOPER: Exactly.

10 MR. PETRUS: Okay.

11 MS. MOONIE: You need the critical mass
12 because if only six hospitals sign up --

13 MS. HOOPER: Correct. And that's why --
14 and also we have -- I know that you're both here
15 representing a variety of constituencies and then we also
16 have CHA on the line. But we do need -- obviously for the
17 hospital -- I was wondering if there was a particular
18 group that needed to be -- that you did hear from? So I'd
19 appreciate knowing from the hospitals and from the
20 consumers, again a diverse group -- Dr. Agresta, do you
21 feel that there is -- that message and that definition and
22 metrics needs to be outlined for physicians also? Do you
23 feel that there's a better understanding there?

24 DR. AGRESTA: Well, I think -- the

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1 physicians I think, given a reasonably good description of
2 the value of proposition, are going to see the value --

3 MS. HOOPER: Yes --

4 DR. AGRESTA: -- because they're in the
5 midst of trying to actually grapple with, you know --

6 MS. HOOPER: Correct --

7 DR. AGRESTA: -- this whole process in a
8 whole lot different light than a hospital might be --

9 MS. HOOPER: Absolutely --

10 DR. AGRESTA: -- and I think that the value
11 -- you have to be very careful about how you lay out this
12 value of proposition because it is a no-brainer. You need
13 to have your quantitative and qualitative, but -- but
14 you're correct, it actually needs to contain data that is
15 understandable at the organizational level or the
16 individual level. So the message needs to be delivered
17 correctly because the hospital that also owns a lab system
18 is going to see a reduction in their laboratory and their
19 imaging order. Because we're not duplicating services,
20 it's going to lose some resources associated with this --

21 MS. HOOPER: Correct --

22 DR. AGRESTA: -- and so the stakeholders
23 that are going to lose -- and you know, we've got to be
24 realistic about it -- insurers tend to -- you know, stand

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1 to gain a fair amount. And so therefore the employers
2 stand to gain a fair amount by reduction in duplicative
3 services ordered. So the -- the difference between where
4 the value is -- you know, where -- who accrues the value
5 at what stage in that process needs to be sort of mapped
6 out. The value to the doc and the patient might be that
7 they don't have to leave the room to go look for
8 something, and therefore you get three extra minutes to
9 sit with a patient and explain something --

10 MS. HOOPER: Right --

11 MR. MASSELLI: Well is this -- is this an
12 area where wordsmithing is important? I'm just looking at
13 -- California -- I don't know if you can -- but I mean
14 when we get down to this, we're going to have some -- I
15 mean is this --

16 MS. HOOPER: Yeah --

17 DR. AGRESTA: But you're not going to get a
18 --

19 MR. MASSELLI: -- try to keep it simple --

20 DR. AGRESTA: No, no --

21 MR. MASSELLI: Okay --

22 DR. AGRESTA: -- I don't think it's too
23 simple --

24 MR. MASSELLI: -- so you're going to -- I

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1 mean I guess the question is is it going to be too complex
2 and people aren't going to --

3 MS. HOOPER: Well --

4 DR. AGRESTA: No, I think you need to go
5 with a very simple, you know, vision of the value. And
6 then below that you need to have, you know, one page --

7 MS. HOOPER: A sample --

8 DR. AGRESTA: -- description of the value
9 to the different stakeholders. And then there's got to be
10 meat behind it.

11 MS. HOOPER: I do think --

12 DR. AGRESTA: And the meat has got to have
13 --

14 MS. HOOPER: Pardon me --

15 DR. AGRESTA: -- you know, some -- some
16 data that's out there from the literature from other
17 places --

18 MR. MASSELLI: But are we able to do any of
19 that? Are we able to do anything more than semantic
20 descriptions at this point --

21 MS. HOOPER: I --

22 DR. AGRESTA: Well --

23 MR. MASSELLI: -- because once you start
24 getting into that meat, you're going to do some guarantees

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1 of which -- you know, the technical people are going to
2 say hey this is complicated for us to do --

3 MS. HOOPER: Right --

4 MR. MASSELLI: -- whether it's a lab issue
5 or something else --

6 DR. AGRESTA: But I don't think --

7 MR. MASSELLI: Is it aspirational or is it
8 --

9 DR. AGRESTA: No, I think there's data. I
10 mean there's -- there's research out there that starts to
11 talk about, you know, the cost savings that are accrued by
12 doing -- by reduction of 10 percent in laboratory -- you
13 know, I mean you could actually model it. So what we
14 haven't done in Connecticut is we haven't done any of that
15 modeling, we haven't looked at, you know, from the
16 literature -- if we were to reply to this, what would that
17 -- you know, what would it look like.

18 MS. HOOPER: I do think for -- again for
19 the strategic plan we're -- we're in agreement. And the
20 outline is here on page 36 and 37 of the quantitative and
21 qualitative benefits in a value of proposition. And then
22 we have New Mexico, California, and Rhode Island's
23 examples of how that's put together. I think that for the
24 purpose of the strategic plan, we're clearly saying -- I

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1 don't hear any opposition to the value of proposition is
2 both quantitative and qualitative. I don't think that any
3 of us are going to disagree on what those values are. And
4 what I'm appreciating is that we do need to be clear in
5 the language when we develop them. And I very much
6 appreciate, Tom, the substantive kind of examples, in fact
7 not just from New Mexico or Rhode Island, but okay we see
8 that the U-Conn Health Center would benefit from this, we
9 see that AETNA would appreciate this --

10 A VOICE: Right --

11 MS. HOOPER: -- we see that community
12 health centers would appreciate this, we see where
13 hospitals would appreciate that, you know, some specific
14 examples. Again not only identifying what the value of
15 proposition is, but validating that there is value already
16 assumed by the different partners around the table.

17 MR. PETRUS: And I think that mapping out
18 makes a lot of sense and I appreciate that image because
19 where we could support you is mapping it out and then
20 saying what metrics are readily correctible as you phase
21 this into the -- and tie in effect here for the
22 quantitative --

23 MS. HOOPER: Correct --

24 MR. PETRUS: The qualitative one is

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1 something that I would strongly recommend that you work
2 with the Regional Extension Center on because a lot of
3 that is about perception --

4 MS. HOOPER: Mmm-hmm --

5 MR. PETRUS: -- and levels of satisfaction
6 --

7 MS. HOOPER: Right --

8 MR. PETRUS: -- by the stakeholders, which
9 is something that they're going to have to do as part of
10 their process around HIT adoption. And whereas HIT
11 adoption, what do they perceive as benefits, which would
12 be more qualitative. And this might be a great
13 partnership that you might want to think about. So I just
14 throw that out as a thought.

15 MS. HOOPER: Good.

16 MS. MOONIE: Does that say mapped out by
17 participant?

18 A VOICE: Yes --

19 MS. MOONIE: Okay. Because I'm just
20 looking at the Rhode Island one and this hundred million
21 dollars worth of value, the amount to the providers is
22 very small -- but -- it would be very -- quantitative --
23 that would be very important to have that defined --

24 MR. PETRUS: Yes --

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1 MS. MOONIE: -- by participant.

2 MR. PETRUS: Exactly. Whether docs or
3 hospitals, the health systems, yeah, I agree. And it
4 might be the same indicator, but the value may be
5 different for the different stakeholders.

6 MS. MOONIE: Correct.

7 DR. AGRESTA: Right. And it might accrue
8 at a very different time.

9 MR. PETRUS: Exactly.

10 MS. HOOPER: Yeah.

11 DR. AGRESTA: You know, the time for
12 quality improvement doesn't happen right away. It
13 happens, you know -- except for maybe adverse events and
14 medications or something like that.

15 MR. PETRUS: You could really start
16 developing a metrics model that would -- (inaudible) -- by
17 different providers.

18 Anything else on value of proposition?
19 Okay, let's move on to funding models. Finance, funding
20 mechanisms -- revenue sustainability is very critical.
21 The ideas that have been floated by all of you have been a
22 stage 1, stage 2 approach. Startup funding, where that
23 begins and where that ends for the core infrastructure I
24 think is an excellent observation that you need to -- you

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1 may have three stages of funding

2 We're going to quickly go through the
3 different kind of funding schemes that we're seeing out
4 there. One is the transaction fee where participants pay.

5 The next slide please. We'll go through in
6 detail the subscription fees --

7 MS. HOOPER: Mmm-hmm --

8 MR. PETRUS: -- private sector funding,
9 performance based incentives, and claims based payers
10 assessment. And there is a third model that's embedded
11 into this, is state funding through the allocation of fees
12 or taxes, if you want to call them that, or subscriptions
13 on --

14 MS. HOOPER: No, we're not calling them
15 that --

16 MR. PETRUS: No. Then they're not called
17 that either -- (laughter). That really is the way the
18 state leverage is revented to be able to invest in the
19 HIE. So the fees may not come directly to the HIE, but
20 may go through a legislative process of adding fees.

21 Transactions fees. I think you're all
22 aware of transaction fees and the pros and cons. Thoughts
23 on transaction fees?

24 MS. HOOPER: Again you -- you have some

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1 assessments from the other states, correct?

2 MR. PETRUS: Yeah. We'll get there.

3 MS. HOOPER: Okay.

4 MR. PETRUS: But I thought -- like we did
5 with the technical architecture which led to a good
6 discussion --

7 MS. HOOPER: Right --

8 MR. PETRUS: -- any initial thoughts about
9 transaction fees?

10 MS. HOOPER: Can I ask again, Tom, sorry --
11 and actually, Kevin too -- and if Dr. Kim were here --
12 from the physicians, that's assumed, correct, that there
13 are transaction fees involved if there was a statewide
14 HIE?

15 DR. AGRESTA: Yeah. The problem would be
16 if you did it per transaction --

17 MS. HOOPER: Okay --

18 DR. AGRESTA: -- you harm the physician who
19 has the most transactions, which is actually the
20 physician, the primary care physician which actually is
21 the one who's got to communicate with all the labs, all
22 the specialists --

23 MS. HOOPER: Okay --

24 DR. AGRESTA: -- every -- so --

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1 MS. HOOPER: And do we want to encourage
2 that --

3 DR. AGRESTA: -- because they spend 80 --
4 no, 90 percent of their time in their offices and so
5 they're actually doing the most volume --

6 MR. MASSELLI: If we paid them for the
7 transaction --

8 DR. AGRESTA: It would be a wholly
9 different thing --

10 MS. HOOPER: Now you've got a different
11 kind of --

12 DR. AGRESTA: If you -- if you do a
13 transaction fee base for them --

14 MS. HOOPER: Right --

15 DR. AGRESTA: -- you know, then they will
16 only access it if -- if they believe it's critical, and
17 they'll miss, you know, a good percent --

18 MS. HOOPER: And again transaction fee
19 being kind of a broader term, but per transaction -- Mark,
20 from the community health centers perspective, the same?

21 MR. MASSELLI: The same.

22 MS. HOOPER: Yep. Peter --

23 MR. PETRUS: Even if there's a tiered
24 scale, there would be discounts for volume --

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1 DR. AGRESTA: Yeah, I think what we heard
2 in the Finance Committee meeting was a difference in
3 transaction fee, that it needs to be predictable over time
4 so that -- with a cap or something --

5 MS. HOOPER: Correct --

6 DR. AGRESTA: -- so -- now you can get to
7 the point where we're spending -- you know, Mike's
8 organization was spending, you know, \$10,000.00 this month
9 and then \$5,000.00 the next --

10 MS. HOOPER: Correct --

11 MR. MASSELLI: Well we see it right now.
12 When we do (indiscernible), the labs -- the lab won't send
13 it back because it's 35 cents (indiscernible) -- they send
14 it back. So you know, they're -- they're not willing to
15 send it back -- although they can. It's just -- you know,
16 so you already know there's a disincentive around that, so
17 you have to figure out some method --

18 MS. HOOPER: Well now that's the issue that
19 -- again the transaction isn't necessarily what you all
20 who are represented around this table will pay, but it's
21 what our other stakeholders will or will not pay. And you
22 know, exchanging information isn't just based on what
23 you're all putting in --

24 A VOICE: That's right --

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1 MS. HOOPER: -- but I appreciate that from
2 the primary care physicians' perspective -- in fact, we
3 don't want them to participate where their time is going
4 to be more spent on the computer than with the patient.

5 DR. AGRESTA: And -- and I think the
6 transaction fees in places where they establish them, like
7 Indiana Health and other places that established
8 transaction fees, they started doing transaction fees at a
9 time when the process of delivering lab results was a
10 courier with a packet of paper --

11 MS. HOOPER: Yes --

12 DR. AGRESTA: -- going around to offices
13 or, you know, mailing them out --

14 MS. HOOPER: Yes --

15 DR. AGRESTA: -- well no lab delivers stuff
16 that way any more that I'm aware of. You know, they'll
17 send it to your system and you've got to print it, you
18 know, or they will -- you know, but -- but most of what
19 we're doing now doesn't -- or they can just fax it to you
20 and it's your paper and your fax machine that receives it
21 --

22 MS. HOOPER: Right --

23 DR. AGRESTA: -- so the -- the -- even
24 thinking of it that way, we've got to realize that the

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1 systems that were set up originally to do transaction fee
2 based approaches --

3 MS. HOOPER: Yeah --

4 DR. AGRESTA: -- they may have a business
5 model they can sustain, but I'm not sure that we'd get buy
6 in to begin with. And the only way to figure that out is
7 to actually go out to those places and say what does it
8 cost you --

9 MS. HOOPER: Right --

10 DR. AGRESTA: -- how do you do it, and
11 would you be willing to pay the same amount or less --
12 nobody is going to be willing to pay more --

13 MS. HOOPER: Mmm-hmm --

14 DR. AGRESTA: -- would you be willing to
15 pay less --

16 MS. HOOPER: It depends if the value is
17 more though --

18 DR. AGRESTA: I don't know --

19 MS. HOOPER: From the hospital side,
20 transaction based, yes? No?

21 MS. MOONIE: The same issue.

22 MS. HOOPER: Right.

23 MR. COURTWAY: The same issue. Unless I
24 can tie that transaction to some other internal

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1 transaction cost so that I know what I'm balancing off one
2 way or the other. It becomes difficult.

3 MR. PETRUS: Well the question --
4 (Multiple voices overlapping -
5 indiscernible) --

6 MR. PETRUS: -- that some states struggle
7 with is do you charge the transaction fee on the push or
8 the pull or both.

9 DR. AGRESTA: But the same issue for a
10 group that sends it out now -- I mean they used to mail
11 us, you know, in mail the discharge summaries. There's no
12 group that mails me a discharge summary in mail. They get
13 faxed to me now. And -- you know, you know why. It gets
14 there faster and it --

15 MS. HOOPER: Okay. Frank, I think we're
16 leaning against transaction fees, but I know you --

17 MR. PETRUS: So what I'm -- the benefit
18 doesn't always outweigh the cost in --

19 MR. CARMODY: I wouldn't take that --

20 MS. HOOPER: Not to wipe it off --

21 MR. CARMODY: Well I just think that again
22 are we going to look at any of these as a planning
23 mechanism --

24 (Multiple voices overlapping -

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1 indiscernible)

2 A VOICE: That's right --

3 MR. CARMODY: -- you have to look -- I
4 think -- I mean you brought up -- you brought up that it
5 could be tiered, it depends on where you put it in, it
6 depends on the stages --

7 A VOICE: You've got --

8 MR. CARMODY: -- so I think all of the
9 pieces -- you know, I think all of the ones that you have
10 down there are going to validate -- I think it's the
11 combination of the business model --

12 A VOICE: Correct --

13 MR. CARMODY: -- of how you -- of where
14 you're at and what stage --

15 MS. HOOPER: Because I do think -- the next
16 one being subscription fees is something that ties more in
17 line with don't charge me for every -- you know, for 4,000
18 transactions. But a subscription fee based on, you know,
19 your level of interaction or your ability to exchange
20 also.

21 A VOICE: Right.

22 COMMISSIONER GALVIN: Be very -- be very
23 careful about collecting fees because fees go into the
24 general, which is guarded by the legislature as if it were

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1 their own personal fortune. All my licensing fees and all
2 my penalties go into the general fund. Do you think I can
3 get any of that money out? I can't even waive licensure
4 for people who do case evaluations on malpractice because
5 they won't let you touch it. If you go in and say I want
6 -- well you can't touch the general fund --

7 MR. PETRUS: Would I -- would I be correct
8 in assuming if this went to the authority, it wouldn't go
9 to the -- into the general fund?

10 MS. HOOPER: Correct. We need to make sure
11 to --

12 COMMISSIONER GALVIN: You've got to make
13 sure because ordinarily everything goes into the general
14 fund and then you have to beg --

15 MR. PETRUS: Well if that's the case, then
16 -- then you've got a real problem here --

17 MS. HOOPER: Correct -- no --
18 (Multiple voices overlapping --
19 indiscernible)

20 MS. HOOPER: Well we're reviewing this as
21 if we are going to be an independent authority --

22 MR. PETRUS: So we've got -- we've got --
23 transactions benefits may not always outweigh the cost.
24 You should think about whether it's push or pull if you're

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1 going to go to it, tiered, capped. There's a variety of
2 approaches, but transaction fees could be a real
3 challenge. A couple of challenges that we see -- one
4 challenge is I think it could discourage participation in
5 some stakeholders. And the other challenge is the
6 complexity that you put on your infrastructure and be able
7 to account for the transactions, especially when you start
8 putting tiers and caps and buying discounts.

9 Next, subscription fees. Can you go to the
10 next slide, Alistair. Fees based on a schedule, annually,
11 monthly, quarterly. Different variations are possible
12 here. We see different types of levels of participation,
13 organizations, types. Again it's a tiered approach. This
14 provides much longer sustainability and also provides for
15 more predictability for the stakeholders. But it does
16 have challenges for some subscribers in adopting health
17 information technology. And there's some challenge here
18 between the dependent of this on new members that come in
19 --

20 MS. HOOPER: Right --

21 MR. PETRUS: Initial thoughts on
22 subscriptions?

23 MS. HOOPER: There can be some big upfront
24 costs that will discourage some of our smaller players,

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1 not necessarily to a disadvantage that, you know, the
2 system can't support itself, but --

3 MR. PETRUS: I'm paying for something --

4 MS. HOOPER: I think --

5 MR. PETRUS: -- I have no benefit from yet

6 --

7 DR. AGRESTA: Well how do you -- I mean any
8 of these financing things, the authority --

9 MR. PETRUS: Your committee is working on
10 that --

11 DR. AGRESTA: Well, I know -- but any of
12 them, how do you actually collect it? Where does it go
13 into? And does a new legal, you know, framework need to
14 be put in place to actually put the force of law behind
15 collecting any of this if it's a public utility or a
16 public good?

17 MS. HOOPER: Well the -- the model that's
18 established now -- Marianne, do you want to speak to --
19 the ability obviously to do that enforcement as to pay for
20 what you're getting, and if you don't pay, then you don't
21 get? I mean it could be that simple. But as a quasi
22 governmental agency -- did you want to add something,
23 Marianne, on that one?

24 DR. AGRESTA: Yeah, how does that work?

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1 MS. HORN: Yeah, I think they're not going
2 to be tied to the general fund. We'll obviously look into
3 that. And this authority is going to have to set up a
4 mechanism to become self-sustaining and --

5 DR. AGRESTA: But -- but how? Does it have
6 the -- it won't have the force of law behind it, so it
7 will sort of still be going out and --

8 MS. HORN: Right --

9 DR. AGRESTA: And can the force of law get
10 put behind what an authority does? I don't even know if
11 it's possible.

12 MS. HORN: Well it could. Not under this
13 legislative go around. I think --

14 MR. PETRUS: But how does any entity
15 collect fees though?

16 MR. CARMODY: (Indiscernible) -- Executive
17 Committee of how you -- whatever -- whatever model we come
18 up with, at some point you have to be able to then turn it
19 into --

20 MS. HOOPER: Correct --

21 A VOICE: Sure --

22 MR. MASSELLI: But is this a four million
23 dollar bread box or a 40 million dollar --

24 MS. HOOPER: Right --

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1 MR. MASSELLI: I mean what we are --

2 MS. HOOPER: It's --

3 MR. MASSELLI: -- I mean what's the scale
4 that we're talking --

5 MS. HOOPER: And we're back to your initial
6 question of what is that we're selling.

7 A VOICE: Right.

8 DR. AGRESTA: Right.

9 MR. MASSELLI: And I guess, Marsha -- I
10 mean I sort of look to DSS on this one with the ability to
11 get -- well -- or has -- has anybody started thinking
12 about the model of we can get 50, 60 cents on the dollar
13 reimbursement right from-- when we make an expenditure --

14 MS. MAINS: The incentives --

15 MR. MASSELLI: No, no, but right now the
16 state gets how much match? What's your percentage match
17 from the feds?

18 MS. MAINS: For administrative purposes --

19 MR. MASSELLI: No, for --

20 MS. MAINS: -- or reimbursing for --

21 MR. MASSELLI: -- for reimbursing for --

22 MS. MAINS: Fifty percent.

23 MR. MASSELLI: Fifty percent. I thought it
24 went up to 60 --

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1 MS. MAINS: Uh --

2 MR. MASSELLI: -- I thought it all went up
3 -- but I guess the question is is there anything on that
4 reimbursement -- on the structure of paid -- of
5 reimbursement where you can bump it up because you're
6 trying to get some back. Providers may take a little hit,
7 but it's lessened because what we've done is we've used
8 the federal vehicle for getting reimbursement. And -- and
9 I don't think it's a big number spread out over all of
10 your transactions. But I'd be looking at that model.
11 Sitting down with DSS and saying let's look at how we can
12 at least get 50 cents on a dollar -- going back to the
13 providers and saying they've lowered it by 50 percent
14 already. Then you look at well if you get a little bump
15 on your rate, but -- I'd be fine. You know, there's --
16 there's probably a model that you could create. But I
17 just don't know if it's 45 million or 400 million --

18 MS. HOOPER: Right --

19 MR. MASSELLI: -- what is it -- it's
20 probably in the 40 million dollar range we're going to run
21 an operation or something like that --

22 MS. MAINS: Well the push -- the push back
23 from the feds would be that we're providing --

24 MR. MASSELLI: Should be --

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1 MS. MAINS: The push back from the feds
2 could possibly be that we're providing incentive payments
3 for meaningful use, which is the exchangeable electronic
4 data --

5 A VOICE: Right --

6 MS. MAINS: -- so we are incentivizing the
7 providers. We're not paying for it up front. We're --
8 we're paying for it --

9 MR. MASSELLI: Well you --

10 (Multiple voices overlapping -
11 indiscernible)

12 MR. MASSELLI: -- now I'm talking about the
13 run rate, the operational level --

14 A VOICE: Yeah --

15 MS. HOOPER: Right --

16 MR. MASSELLI: -- where it seems to me DSS
17 has some flexibility about how it wants to deal with its
18 transactions with providers. I just think this is an area
19 where we --

20 A VOICE: The state --

21 MR. MASSELLI: -- we certainly should be
22 exploring -- it would certainly go back to, you know, the
23 insurance folks at the same time and saying hey if we
24 could take up 50 percent of it off on DSS, could we come

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1 back to the -- to the insurance companies on 25, and then
2 we're talking to providers who might be then in the real
3 world saying yes I'm willing to do that understanding that
4 -- so --

5 MS. HOOPER: Now we --

6 MR. MASSELLI: I mean some of this really
7 trying to figure out what are some of the -- what are the
8 experiences that Delaware or these other --

9 MR. PETRUS: And that's what we started to
10 put up --

11 MS. HOOPER: And we -- we did --

12 MR. MASSELLI: These weren't -- these
13 weren't about their total costs. These -- I can't really
14 calculate on what this means --

15 MS. HOOPER: Okay. We did talk with Maine
16 and they had a one-third, one-third, one-third deal. I
17 want to go back to, Tom, your point about, you know, the
18 enforcement kind of thing. Again, nobody is going to be
19 mandated to be a part of this HIE. We need -- we still
20 haven't really talked about whether we would -- there
21 would be an HIE kind of default for those that didn't have
22 their own -- you know, that kind of issue. The fee based,
23 subscription based, however this goes through. We do have
24 -- I'm thinking of our Finance Committee -- Dan, Kevin,

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1 Marie O'Brien, and Tony Roberto are on that. This is
2 obviously one of the big issues that you're all dealing
3 with. And you did address some of that in --

4 A VOICE: Yes --

5 MS. HOOPER: -- in your slides, Kevin.

6 A VOICE: Do you want to give a --

7 MR. CARMODY: As far as like where we're at
8 on -- as far as -- I mean we can -- part of what we've --
9 we came up with what the tiering was going to be. We
10 haven't really gone to the next step to talk about what we
11 think --

12 MS. HOOPER: Which is --

13 MR. CARMODY: How do we want to go into it.
14 I mean actually we're starting to get into -- this
15 afternoon's conversation now gets us to a point where we
16 can say --

17 MS. HOOPER: Correct --

18 MR. CARMODY: -- conceptually --

19 MS. HOOPER: Mmm-hmm --

20 MR. CARMODY: -- if this is where we're
21 heading --

22 MS. HOOPER: Right --

23 MR. CARMODY: -- you know, now we can start
24 thinking about what makes sense when you start to apply it

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1 based upon how we prioritize it.

2 MS. HOOPER: Correct.

3 MR. CARMODY: We didn't have that before,
4 so we sort of struggled. You know, we said having a
5 brainstorming session to talk about all the difference
6 nuances depending on how you prioritize it, you could
7 start to, you know, model it different ways --

8 A VOICE: Sure --

9 MR. CARMODY: -- I think we want to get
10 back and -- one of the questions I actually will probably
11 ask of Warren -- or if you guys see --

12 MS. HOOPER: We will pass the message on --

13 MR. CARMODY: Is -- actually is -- so how
14 do we -- besides, you know, using the collective brain
15 power, let's think about how we want to do it, is how do
16 we want to start to model it. Is that some services that
17 we can get from Gartner or is there -- you know, is it,
18 you know, the Office of Management -- I mean who can help
19 us with actually building the model. I mean there's
20 actually an effort that you have to go through. I mean,
21 you know, between Mike and I we could probably whip up an
22 excel spreadsheet, but I mean -- actually, I think I'd
23 want to do a little bit more than that.

24 MS. HOOPER: And I do think again in the

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1 additional work that Gartner has done for today, there are
2 some modeling. I do think we're going to -- I'm hoping
3 that the Finance Committee -- you both that are here
4 today, you're getting an idea of what some of the
5 discussion is. I'm hearing a variety of alternatives,
6 some negotiations may be required --

7 MR. MASSELLI: Sector payments --

8 MS. HOOPER: Correct --

9 MR. MASSELLI: -- you know, it's Medicaid,
10 it's the insurance group, it's the providers -- I mean
11 you've got sort of a sector constellation here --

12 MS. HOOPER: Correct --

13 MR. MASSELLI: -- and why don't you guys
14 come up with how big is the bread box.

15 MS. HOOPER: Well --

16 MR. MASSELLI: Roughly. I mean it's not --

17 A VOICE: Pardon the interruption. Your
18 conference contains less than three participants at this
19 time. If you would like to continue, press star 1 now or
20 the conference will be terminated.

21 MS. HOOPER: Can I ask who's still on the
22 phone please?

23 A VOICE: Just end --

24 MS. HOOPER: I'm not really crazy about

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1 paying for --

2 A VOICE: Who hangs up --

3 MR. PETRUS: Is anyone on -- on the line?

4 MS. HOOPER: Oh, we have to leave it open?

5 A VOICE: No.

6 MS. HOOPER: The attorney said we don't
7 leave it open.

8 MS. HORN: Well nobody is on the line.

9 MR. PETRUS: Is anybody on the line?

10 MR. MASSELLI: On the telephone?

11 MR. PETRUS: On the telephone?

12 MS. HOOPER: Thank you, Frank.

13 MS. TOWNSHEND: Just very quickly, since
14 there was a request for caffeine at the break, there is
15 now coffee if you'd like to help yourself.

16 A VOICE: Thank you.

17 MR. PETRUS: This gives you a sense of the
18 study that was done in 2009 by HMISS of where the funding
19 was coming at that point. And again this was before the
20 O&C initiative that was out there for Health Information
21 Exchange. And obviously these may change a little bit,
22 but as you can see 61 percent have government grants or
23 contracts in place, so there's a blending of funding.
24 Seventy-one percent grants. Forty-three percent recurring

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1 subscriptions --

2 A VOICE: Mmm-hmm --

3 MR. PETRUS: -- and 48 percent recurring

4 model, type of entity, and size of that model -- it was a

5 tiered model for -- and this -- this breaks it down a

6 little bit. So that you're seeing out there a variety of

7 funding mechanisms. The question is what would work in

8 Connecticut --

9 MR. MASSELLI: But no transaction? Is

10 there -- am I missing --

11 MR. PETRUS: In this model -- subscription

12 based --

13 MR. MASSELLI: Oh, subscription --

14 DR. AGRESTA: No, there's --

15 MR. MASSELLI: No --

16 DR. AGRESTA: There are some transaction --

17 MR. MASSELLI: But not up here, right? I

18 mean --

19 MS. HOOPER: Well it doesn't indicate --

20 MR. MASSELLI: There doesn't seem to be --

21 MR. PETRUS: And this survey --

22 MR. MASSELLI: -- subscription --

23 MR. PETRUS: Go to the next one. Here you

24 have transaction fees in California as an example --

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1 MR. MASSELLI: Ten dollars PCP meaning once
2 a year? Is that -- not --
3 MS. MOONIE: That can't be --
4 MR. MASSELLI: No. No, no. You don't get
5 that much --
6 A VOICE: I hope not --
7 A VOICE: No, that doesn't --
8 (Multiple voices overlapping -
9 indiscernible)
10 A VOICE: What's the base of that, Kevin --
11 MR. MASSELLI: We have a lot of --
12 (Multiple voices overlapping -
13 indiscernible)
14 A VOICE: Per transaction --
15 MS. HOOPER: That one could be the end of
16 it --
17 MR. PETRUS: California was per
18 transaction.
19 MR. MASSELLI: Per transaction?
20 MR. PETRUS: Per transaction.
21 A VOICE: Yeah, the problem --
22 MS. MOONIE: Per transaction or per patient
23 visit? Because look at the ED --
24 A VOICE: Yeah, 25 --

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1 MS. MOONIE: -- per patient visit that's my
2 guess --

3 MR. CARMODY: But then you start having --
4 because I talked to them about that, so the \$25.00 one was
5 an interesting one where they had, you know, done an
6 analysis. And I'm not quite sure it was as complete as it
7 could have been. Part of the issue -- so why am I going
8 to pay for -- I mean they had like three tiers to this.
9 They had pharmacy, they had lab, and then they had -- they
10 wanted to do administrative costs. So the first question
11 I had is did you do any -- did you really do any analysis
12 on what's the value of the administrative costs of what
13 you're trying to do. And the answer was no. So then we
14 said okay well let's table that for a second. Then you
15 get into the other two and you said so you're going to add
16 another -- another cost to it, but, you know, why don't we
17 talk to Surscripts or why don't we talk to -- you already
18 have the ability to access patient history on pharmacy and
19 you already have a mechanism in order to that, which is
20 already on the transaction basis, so why are you creating
21 this other funding mechanism when you can already collect
22 patient history through that mechanism and run it that
23 way. So I think to come up with funding mechanisms, you
24 have to figure out were -- were people already --

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1 A VOICE: Mmm-hmm --

2 MR. CARMODY: -- can you ask them were
3 their costs already in the system to say well why are we
4 going to charge an additional above and beyond --

5 A VOICE: Right --

6 MR. CARMODY: -- when somebody could
7 already go there. Again Tennessee was a good --

8 MR. PETRUS: Reallocate them --

9 A VOICE: Yeah --

10 MR. CARMODY: In Tennessee they built up an
11 infrastructure and they didn't do the business model and
12 not a whole lot of people are using it. Although they did
13 actually capitalize on the contract piece and they went to
14 AT&T and you were allowed to buy into a contract that made
15 sense, so --

16 A VOICE: I think --

17 MS. MOONIE: There's --

18 A VOICE: A California stat there --

19 MS. MOONIE: And look at the 21 cents per
20 transaction --

21 A VOICE: Yeah --

22 MS. MOONIE: -- that makes more sense.

23 DR. AGRESTA: But even 21 cents per
24 transaction --

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1 MS. MOONIE: No, we're not saying it's
2 fair. We're saying it makes sense versus \$10.00 per
3 transaction.

4 MS. HOOPER: I think we'll let Finance --
5 can you -- can you let Dan and Kevin -- I mean some more
6 conversation would be great from your perspective --

7 MR. MASSELLI: But --

8 MS. HOOPER: -- but we really --

9 MR. CARMODY: -- budgeting, but at some
10 point somebody has got to know --

11 DR. AGRESTA: You're going to have to make
12 --

13 MR. PETRUS: Go to the next --

14 DR. AGRESTA: -- eventually make some
15 assumptions --

16 MR. CARMODY: Assumptions, right --

17 DR. AGRESTA: So again you just have to say
18 look this is what we think depending on the services that
19 we have. So now we have some priorities --

20 MR. CARMODY: That's right --

21 DR. AGRESTA: -- of what you are thinking.
22 So now --

23 MS. HOOPER: Great --

24 DR. AGRESTA: At least if nothing else, we

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1 can come back and say these are the assumptions, this is
2 how you could tier it by various constituents, and then
3 what do you -- then at some point we're going to have to
4 start, you know, going out to some other folks and say
5 well let's just talk about volume wise --

6 A VOICE: Right --

7 DR. AGRESTA: -- I don't think we have
8 anybody on the Finance Committee that can do it in volume,
9 so maybe we'll come to Peter and say Peter talk to us
10 about volume, what are you seeing from your HIE --

11 A VOICE: Right --

12 DR. AGRESTA: -- how you're exchanging data
13 and/or can we leverage what volume we should expect if
14 we're going to do X. And so then we get to build in the
15 assumptions, build the variables, you'll have fixed and --
16 fixed and variable costs --

17 MR. PETRUS: And that's -- we'd look at
18 recommended action -- going back to what you said earlier
19 -- it's really time phased -- so how do you phase this in
20 going back to what you were talking about here, what are
21 the costs going to be, and we'll do spreadsheets around
22 that and build --

23 (pause - tape change)

24 MR. PETRUS: -- part of the state

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1 infrastructure. You know, you can see the New Jersey
2 model failed. That would not work. But are there other
3 models that might work in Connecticut that would provide
4 that baseline funding that would lessen the burden on the
5 state providers.

6 MS. HOOPER: Right now no.

7 DR. CARR: I guess my biggest concern is I
8 don't -- I don't know if I've heard the answer to the
9 question so -- who is providing support to that committee
10 to help do the --

11 MS. HOOPER: That is Warren and Gartner to
12 work with you on the Finance --

13 DR. CARR: I mean how many hours do we have
14 in Warren's and Gartner's time -- (laughter) -- so is it
15 like five hours of time to help out with --

16 MS. HOOPER: An excellent --

17 DR. CARR: -- with the excel spreadsheet or
18 --

19 MS. HOOPER: An excellent question --

20 MR. PETRUS: It's part of our strategic and
21 operational planning process --

22 DR. CARR: Right --

23 MR. PETRUS: -- that we would work with you
24 around that and provide that kind of support. I couldn't

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1 tell you exactly the hours.

2 MS. HOOPER: I do think again for the
3 strategic plan that's setting some models and some ideas,
4 the implementation plan, which -- you know, the strategic
5 plan we need to finish in the next three weeks --

6 A VOICE: Right --

7 MS. HOOPER: -- it's going to public
8 review, it's going to O&C as a preliminary. September is
9 when the full kit-and-caboodle goes with the
10 implementation plan. So from that framework, I think the
11 strategic plan is for this advisory group to, you know,
12 let us know what are some of the viable models that we can
13 aim for, and then how to actually make that work --

14 DR. CARR: So -- so are deliverable in the
15 next three weeks would be like, you know, what types of
16 charges --

17 MR. PETRUS: Excuse me. The first -- the
18 first thing you have to do is how are you going to match
19 the O&C dollars --

20 DR. CARR: Right --

21 MR. PETRUS: -- No. 1, the bottom line, you
22 know what that number is and you know what the match has
23 to be.

24 MS. HOOPER: Well -- and the Department is

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1 checking on some, if not all of that responsibility
2 because being the recipient -- I don't know -- however,
3 we're still waiting for Dr. Agresta to get back to us on
4 the REC funds and what the match requirement -- actually,
5 you don't have to get back to us -- but I don't know --
6 again in trying to leverage the three pools, I don't know
7 if the O&C match for the REC funds, or the Regional
8 Extension Center funds -- and Marsha on the --

9 MR. MASSELLI: No, they were -- I think you
10 said the other day they -- they clashed right --

11 MS. HOOPER: Well --

12 MR. MASSELLI: -- in terms of the match --

13 DR. AGRESTA: Yeah, it's nine to one --

14 MR. MASSELLI: Nine to --

15 DR. AGRESTA: -- in year one there's nine
16 to one 1 matching --

17 MR. MASSELLI: Right --

18 DR. AGRESTA: -- and then it's seven to
19 three, and then one to --

20 A VOICE: Year 1 and 2 is nine to one --

21 DR. AGRESTA: It's year 1 --

22 A VOICE: -- and then after that, it flips
23 immediately --

24 DR. AGRESTA: One to nine really is a real

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1 --

2 A VOICE: It varies --

3 DR. AGRESTA: The business -- the
4 sustainability and business model for that is much more
5 challenging --

6 MR. MASSELLI: Yeah --

7 MS. HOOPER: Well -- and this is what we
8 want to be clear, that we're doing this for an HIE based
9 on what we're putting together. We want to be supportive
10 and helpful that this in fact is going to be able to not
11 only help set some direction, but be supportive for --
12 certainly for DSS' plan and for the Regional Extension
13 Center. These all have to be in one line. There's --
14 there's not -- you know, this is -- these all have to be
15 somewhat supportive and helpful to each other because
16 they're all going to bring to the same conclusion. I
17 think on the Finance if we can ask them to get some ideas
18 -- yes, sir?

19 COMMISSIONER GALVIN: Okay, but you've got
20 to come up -- as Frank was just telling you, we've got to
21 come up with some money for the initial match.

22 MS. HOOPER: Oh, I'm sorry. To the match
23 issue, we have identified in the Department of Public
24 Health and I think I mentioned it at the beginning, that

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1 we might be coming to you for a match for the Cooperative
2 Agreement funds. I don't know -- Marsha, do you have a
3 match requirement on the -- on the reimbursement? Yeah, I
4 didn't think --

5 A VOICE: You have 10 cents for the
6 administration match --

7 MS. MAINS: Administration.

8 MS. HOOPER: Which you already got that
9 covered --

10 MR. MASSELLI: Frank, you're talking about
11 a first year match obligation --

12 MR. PETRUS: Yeah --

13 MR. MASSELLI: -- and it could be --

14 MR. PETRUS: The first -- the first year
15 match I think is 10 cents --

16 MS. HOOPER: Well for -- actually, our
17 first --

18 MR. PETRUS: -- and then 30 --

19 MS. HOOPER: -- six months for this
20 Cooperative Agreement is zero. Then we go to 10 percent.
21 Then we go all the way up to 50 percent on the third and
22 fourth year. So --

23 MR. MASSELLI: Well we can use our --

24 MS. HOOPER: We are -- that's what we are

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1 going to be coming to you with, a legal document for you
2 to sign saying how much time you're committing.

3 MR. MASSELLI: Yeah.

4 MS. HOOPER: We also have internal --
5 certainly all of us here are paid --

6 MR. MASSELLI: Sure --

7 MS. HOOPER: -- at various sources and your
8 taxes -- thank you very much -- and -- so there's --

9 MR. MASSELLI: What's -- what's the number
10 we're trying to get in the first 12 months? I mean what's
11 --

12 MS. HOOPER: Where's --

13 MR. MASSELLI: Is it material that we to
14 worry about that we don't have --

15 MS. HOOPER: Right --

16 MR. PETRUS: Seven hundred thousand --

17 MR. MASSELLI: Seven hundred thousand --

18 MR. PETRUS: I think it would be 700,000 --

19 MR. MASSELLI: Lisa's billing hours alone
20 is -- (laughter) -- really, that's just not --

21 A VOICE: I think it's --

22 MR. MASSELLI: I think we -- we're over the
23 hump --

24 (Multiple voices overlapping -

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1 indiscernible)

2 MS. HOOPER: Our match in the first year --
3 in the second year actually is \$100,000.00 --

4 A VOICE: Is that all --

5 MS. HOOPER: No, we're -- I -- so Frank, I
6 would say --

7 DR. AGRESTA: We got it --

8 MR. MASSELLI: We got it --

9 MS. HOOPER: -- from the Cooperative
10 Agreement match -- but again for the REC --

11 MR. PETRUS: I thought that your -- your
12 full grant was, what, seven --

13 MS. HOOPER: In the third and fourth year -
14 - no, it's -- we're one to nine --

15 DR. CARR: One to nine --

16 A VOICE: Okay, got'cha --

17 MS. HOOPER: -- so, I wouldn't say that we
18 need to focus on that first. We certainly have this
19 outlay of funds between the three groups, but again I --
20 I'd really like this group to address, you know, how we
21 can work together to --

22 MR. MASSELLI: So Frank, are you looking
23 for us to sort of say pick one of these or --

24 MR. PETRUS: Not today --

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1 MR. MASSELLI: -- the sector -- there's
2 stuff that I would be --

3 MR. PETRUS: What I've heard --

4 MR. MASSELLI: -- worrying of us coming up
5 with a transactional -- any fee --

6 MR. PETRUS: What we heard from you I think
7 so far makes sense on how to move forward with this and --
8 I got it on this one -- it goes back to this, mapping the
9 benefits --

10 MR. MASSELLI: Yeah --

11 MR. PETRUS: -- coming up with that metric,
12 then coming up with the financing model that supports that
13 kind of metrics based upon the benefits of the
14 stakeholders. That's what I'm hearing.

15 MR. MASSELLI: Yeah.

16 DR. CARR: And so it's -- I just want to be
17 clear from the Finance Committee --

18 MS. HOOPER: Yes, because we're jumping on
19 'ya --

20 DR. CARR: Yeah. So the HI -- so are we
21 looking for the Finance Committee to -- HIE sustainability
22 and Medicaid matching funds --

23 MS. HOOPER: No --

24 A VOICE: No --

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1 DR. CARR: No -- just HIE --

2 MS. HOOPER: No, we're good --

3 MR. PETRUS: I think the first bullet, time
4 phase cost model --

5 MS. HOOPER: And REC --

6 MR. PETRUS: -- to align with the portfolio
7 services, what's the cost. The second bullet, how do you
8 sustain it.

9 MR. MASSELLI: So do a three-year
10 projection. Here we are --

11 DR. CARR: Just a total budget and --

12 MR. MASSELLI: -- three-year, total --
13 here's the full operational budget -- you know --

14 MS. HOOPER: I think for this stage of this
15 -- and then we do need to get into the details later, but
16 right now out of these financial models what can work in
17 Connecticut --

18 MR. MASSELLI: But I -- I think if you're
19 not building -- I know it's still on the back of the
20 matchbook -- if you're not building a three-year financial
21 model, what are you doing --

22 MS. HOOPER: Right --

23 MR. MASSELLI: -- because all the other
24 things are just sort of vapor because at some point we've

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1 got to know what size this thing looks like. And it
2 sounds like we've got some -- I would -- I would go back
3 to these states and ask them really what their
4 expenditures are like and look at it and see what you can
5 model off and -- you know, obviously we know it's -- it's
6 going to be, you know, less than a shot in the dark when
7 you start gathering that data --

8 DR. CARR: But the -- without the services
9 --

10 MR. MASSELLI: Yeah -- no --

11 A VOICE: That's okay, if Peter is behind
12 giving us the costs -- I mean --

13 (Multiple voices overlapping -
14 indiscernible) --

15 A VOICE: I mean it goes so easy --

16 MR. MASSELLI: That's the --

17 MR. PETRUS: Let's go over this cost model
18 -- absolutely right.

19 MS. HOOPER: Okay.

20 A VOICE: TBI can't come and give us --

21 MR. PETRUS: Now we have 20 -- 20 minutes -
22 - 20 minutes and several quick points to go --

23 MS. HOOPER: Yes, sir --

24 MR. PETRUS: -- okay --

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1 MS. HOOPER: -- then go.

2 MR. PETRUS: Legal and policy -- I'm going
3 to go real quick on legal and policy --

4 MS. HOOPER: But -- and Frank, please don't
5 forget that we do have -- we want to leave five minutes
6 for public comment.

7 MR. PETRUS: Got it. Legal and policy
8 consent -- the next one, Alistair -- the next one, keep
9 going -- in legal and policy we've identified four -- four
10 alternatives. One alternative is the hybrid model for
11 consent that enforces an opt out for all but most
12 sensitive data. Basically this would be an opt in state -
13 -

14 A VOICE: Mmm-hmm --

15 MR. PETRUS: -- or an opt out state, except
16 for sensitive data. No. 2, a patient consent model that
17 enforces opt in for all data with fresh consent at each
18 visit. This is what's happening now with the DSS model,
19 is that every visit you do a new consent to opt into the
20 exchange --

21 MR. MASSELLI: That's because of the
22 substance abuse, HIV, all of the things that people have
23 to worry about --

24 MR. PETRUS: Yeah. (3) Establish a basic

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1 consent model that enforces an opt in for all data during
2 the first visit, so that you're basically an opt in state.

3 (4) Establish a patient consent model that enforces opt
4 out for all data with education and notice at the point of
5 care. HIT E-Connecticut will be responsible for managing
6 individual patient consent and coordination with
7 providers.

8 Okay. So let's go back to the first one.
9 The hybrid model, this is the one that I think has come
10 out of the legal and policy work group that basically says
11 you are an opt out state except for sensitive -- special
12 populations; substance abuse, mental health, HIV --

13 MS. MOONIE: Can I just ask a question
14 about that?

15 MR. PETRUS: Yes.

16 MS. MOONIE: Don't physicians need to know
17 that stuff?

18 MS. HOOPER: Most do.

19 MS. MOONIE: I just -- I just want to lay
20 that -- from the office -- I'm being a public advocate
21 now, not CIO -- for treatment don't you need to know that
22 I'm, you know, doing this other stuff --

23 DR. AGRESTA: Yes, I need to know that. If
24 you come into my office now and you choose -- and we don't

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1 have the HIE, and you choose not to share that with me --
2 A VOICE: That's --
3 DR. AGRESTA: -- then I don't know it now.
4 I think that it's more complicated however than it seems
5 at first blush because when you come in get care from me
6 and I take all that history -- I mean if you share it with
7 me or you share it, you know, a prior time with me, it may
8 all be in the notes -- melded into one note in such a way
9 that to opt out of the individual pieces of data within
10 that note may not be possible --
11 MS. MOONIE: But --
12 DR. AGRESTA: -- and so I think you have to
13 kind of think about how that works. Now there's -- there
14 are whole other groups. There's like a substance abuse --
15 A VOICE: Right --
16 DR. AGRESTA: -- you know, providers and
17 mental health care providers who --
18 MS. HOOPER: Well --
19 DR. AGRESTA: -- you might be able to
20 corden off their data --
21 MS. HOOPER: Well --
22 MS. MOONIE: But actually today -- I mean
23 just today the way you deal with your medical record,
24 those things are all protected now --

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1 DR. AGRESTA: Yes --

2 MS. MOONIE: -- so in terms of like if
3 someone comes in and asks for their medical record, they'd
4 say, you know, I want to pick up my medical record, you
5 already have to like go through that analysis of what's --
6 what's, you know, subject to heightened scrutiny --

7 DR. AGRESTA: Yeah, but we --

8 A VOICE: And --

9 DR. AGRESTA: -- and they --

10 MS. MOONIE: -- and I'm not sure everyone
11 is doing it exactly right, but I think --

12 MS. HOOPER: We're -- we're not going to
13 have notes --

14 DR. AGRESTA: When they -- for example when
15 a patient signs for me and says I want my records sent to,
16 you know, whatever, they sign a consent form and they have
17 to kind of specifically say I don't want this and I don't
18 want that sent right now. And right now we're not -- you
19 know -- out of my office, you know, we're not
20 automatically faxing stuff. When we fax stuff, it becomes
21 more problematic, but you can go in and redact it with a -
22 - with, you know, a black marker, essentially is what has
23 to happen because we have no electronic way of kind of,
24 you know, redacting that information. And if you did

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1 redact it and a human reads the other side of it, they can
2 interpret what's been redacted anyway --

3 MR. MASSELLI: Just --

4 DR. AGRESTA: -- I mean there's no --

5 MS. HOOPER: Well, I think --

6 DR. AGRESTA: You know, I mean it's really
7 very easy to do --

8 MS. HOOPER: Again, we need to move on --

9 MR. MASSELLI: Yeah, you can figure out
10 everything --

11 MR. PETRUS: For the sake of time, where --
12 where --

13 MR. MASSELLI: (Indiscernible) --

14 MR. PETRUS: -- I really would like to have
15 more discussion --

16 A VOICE: Well, I -- well this is not --

17 MR. PETRUS: Where --

18 A VOICE: -- this is business --

19 MR. PETRUS: Where are you leaning is
20 really --

21 MS. HOOPER: This information is not going
22 to be shared on an EHR --

23 A VOICE: That's fine --

24 MR. PETRUS: Where would you be leaning

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1 though -- I think that -- what I'm trying to get at is
2 where are you leaning?

3 MS. MOONIE: I like -- I certainly opt out
4 --

5 MS. HOOPER: Yes --

6 MS. MOONIE: -- I think that's where the
7 whole committee is leaning toward --

8 MS. HOOPER: We don't disagree --

9 MS. MOONIE: -- and I'm just asking from a
10 clinical -- from a provider perspective are you at a
11 disadvantage if we allow patients to say I don't want my
12 substance abuse to be part of this record.

13 DR. AGRESTA: I think you -- you are not
14 treating them as fully as you might be capable of doing.
15 And I can guarantee you that happens all the time in terms
16 of care --

17 MS. BOYLE: But we're back to transforming
18 --

19 DR. CARR: -- and -- and I -- and I'm --
20 right, if you want to transform health care. But -- but I
21 also think patients have a right to -- you know, to move
22 on beyond their past in some ways, but -- but I think it's
23 challenging when you actually think about operationalizing
24 it. And that's -- but that's -- it might be simple to say

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1 oh we're going to opt in -- you know, opt out except for
2 the sensitive data. But when you think about actually
3 doing it --

4 MR. MASSELLI: It's very --

5 DR. AGRESTA: -- in our current EMRs the
6 way they're structured, you have to -- you'd have to go in
7 there and figure out how to set up all the fields such
8 that they were --

9 MS. BOYLE: And a lot of them already have
10 (indiscernible) functioning --

11 DR. AGRESTA: Correct, it's not --

12 MS. BOYLE: -- they already have -- I mean
13 --

14 DR. AGRESTA: But it's not the same thing
15 though --

16 MS. BOYLE: I mean I --

17 MS. HOOPER: I'm going to ask the legal
18 committee to -- we are absolutely supportive of that from
19 the Department of Public Health. We don't release this
20 information. It's -- it might not even be a patient
21 opting in or opting out. It's not necessarily going to be
22 there. A patient can still talk to their doctor about
23 whatever. What goes on in EHR is not their full record,
24 it's not a full electronic medical record. It's an

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1 electronic medical -- or health record of selected
2 information --

3 MR. MASSELLI: Well --

4 DR. AGRESTA: It would be good for us to
5 show you -- I think it would be actually good for us to
6 show you what it would be -- we can mock up -- in a test
7 system we could kind of show you a dummy patient --

8 MR. MASSELLI: We can --

9 DR. AGRESTA: -- and show you want that --
10 what it means. Because I think that -- this is key to
11 understanding --

12 MR. MASSELLI: Right --

13 MR. PETRUS: A dummy patient or an example
14 of a patient --

15 MR. MASSELLI: Yeah --

16 (laughter)

17 A VOICE: Who gets to be the dummy patient
18 --

19 MR. PETRUS: And -- what I'm -- what I'm
20 hearing though is leaning towards an opt out --

21 MR. MASSELLI: Yeah --

22 MR. PETRUS: -- so -- so work needs to be
23 done to address the challenges of special populations.

24 MS. HOOPER: Both from -- this isn't just

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1 from a clinical perspective, but certainly from the Public
2 Health the reporting baseline information we have some
3 serious restrictions that we're happy to uphold. So this
4 is not just a clinical picture.

5 MR. PETRUS: Yeah. And it could be de-
6 identified too --

7 MR. COURTWAY: Frank, a quick question.
8 When we -- in each of these models, you know, I can't tell
9 what we're opting out of. In -- in each of these models
10 can the patient opt out of aggregation or are they opting
11 out of release?

12 MR. PETRUS: Release. Aggregation, the de-
13 identified information --

14 MR. COURTWAY: Not the identified?

15 MS. BOYLE: We -- we talked about it at two
16 different levels like you're saying. We talked about it
17 as, you know, going into two different -- (1) the level of
18 going into the EHA and the other is different standards
19 for coming out --

20 MR. COURTWAY: Right --

21 MS. BOYLE: -- so we really have separated
22 that. And on the coming out, we've really done it at a
23 use level --

24 MR. COURTWAY: Mmm-hmm --

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1 MS. BOYLE: -- you know, what kinds of
2 things are -- you know -- and is it always de-identified
3 in circumstances -- in certain circumstances which things
4 -- are they going to be able to get PHI, what -- so we did
5 talk about a two-level kind of a thing. One is, you know,
6 going in, which we're talking about this, and opt out
7 with, you know, just special heightened areas as in opt
8 in. And then we talked about once it's in, how do you get
9 it out, and what are the circumstances in which you get it
10 out. And we broke it down to a use level. We got down to
11 -- there's a long list we went through in a painstaking
12 fashion of all the different ways to get it out and what
13 would the circumstances under which we could take it out.

14 MR. PETRUS: And it seems like you've done
15 a lot of work in this first area.

16 MS. BOYLE: Yes.

17 MR. MCKINNON: Is -- that list that you're
18 talking about is that written down somewhere?

19 MS. BOYLE: Well -- yes --

20 MR. MCKINNON: Actually --

21 MS. BOYLE: Our committee has been -- yes,
22 our committee has been working -- we actually -- we're
23 going to have a meeting this week and we were going to
24 deliver a model, but we punted until after this meeting

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1 because we didn't want to --

2 MR. PETRUS: Well you're -- you're on the
3 right path --

4 MR. MCKINNON: Yeah --

5 MR. PETRUS: -- because these are the three
6 things that we think need to be done.

7 MS. HOOPER: And that model will be vetted
8 with the whole group. Move on -- (laughter) --

9 MR. PETRUS: Anything you say. Technical
10 and business operations domain --

11 MS. HOOPER: And may I ask -- Kevin will
12 share your model with the entire group also?

13 A VOICE: Mmm-hmm.

14 MS. HOOPER: Thank you.

15 MR. PETRUS: Let's -- let's move on to --
16 I'll talk to the next slide. Basically when we look at
17 implementation, we're looking at -- typically we see four
18 variations. Variation No. 1 is a sole -- the authority
19 does it all. The authority will govern, build, maintain,
20 and administer the HIE. Alternative No. 2, you'll govern
21 -- the authority will govern it and source the building
22 and the maintenance, but not the administration and
23 oversight. 2b is something like that where the maintain
24 and operate will be sourced initially until you build the

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1 capacity to run it yourself, which would lead you to
2 Alternative 3, which would be govern, source the building,
3 and you run it and the authority maintains it. And 4 is
4 only the maintenance and operation would go to a third-
5 party for hosting it and running it.

6 These seem to be what we're seeing out
7 there as the major options. And when we took a look at
8 what we heard from you what's going in the state, we
9 really came to two options, which -- go back please --
10 which would be this option, and the next, and the sourcing
11 option, which would be --

12 MR. MASSELLI: Sourcing was No. 2?

13 MR. PETRUS: No. 2.

14 MR. MASSELLI: Yeah.

15 MR. PETRUS: No. 2 and --

16 MR. MASSELLI: Yeah --

17 MR. PETRUS: -- basically No. 2b. Source
18 it initially, get it up, get it running, have someone else
19 maintain and operate it as you go through, you know, the
20 shakedown crews, then take it on. And the other option is
21 basically the authority governs it and administers it, but
22 it's solely sourced to a third-party vendor or vendors
23 because someone could build it --

24 MR. MASSELLI: Sure --

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1 MR. PETRUS: -- and someone else could be
2 hosting it and running it --

3 MS. HOOPER: Frank, can I ask on the pros
4 and cons throughout this entire document, which we all
5 want to spend more time with -- is that pros and cons for
6 Connecticut or pros and cons just generally?

7 MR. PETRUS: Pros and cons generally, but
8 with a Connecticut spin.

9 MS. HOOPER: So -- right --

10 MR. PETRUS: Yeah --

11 MS. HOOPER: -- so when you heard from
12 somebody that it won't work --

13 MR. PETRUS: Exactly --

14 MS. HOOPER: -- for whatever reason, you
15 put in --

16 MR. PETRUS: Again -- you got it. So -- so
17 there's a hybrid here because there are some -- what we've
18 seen in trends --

19 MS. HOOPER: Yes --

20 MR. PETRUS: -- as well as what we've heard
21 -- that's for example why we brought up the issue about
22 the value of proposition because we heard -- where in
23 other states it was clear, here the folks had some
24 questions about it --

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1 MS. HOOPER: Which we appreciate. Okay.
2 And then you've got some good sourcing examples there --
3 MR. PETRUS: Yeah.
4 MS. HOOPER: Where's -- general thoughts
5 right off the bat on the sourcing? 2 and 2b or not --
6 MR. MASSELLI: Source --
7 MS. HOOPER: -- 2b --
8 MR. MASSELLI: Source it --
9 MS. HOOPER: Right. I mean 2 is --
10 MR. MASSELLI: 2 --
11 MS. HOOPER: 2?
12 MR. MASSELLI: 2 --
13 MS. HOOPER: Okay -- from your perspective.
14 Any others -- is anybody outside of the 2's here?
15 DR. AGRESTA: Yeah, I don't think -- I
16 don't think you'd have to -- the thing about -- the beauty
17 about it, I'm not sure you'd need to say 2a or 2b --
18 MR. MASSELLI: That's --
19 DR. AGRESTA: -- because --
20 MR. MASSELLI: -- yeah --
21 DR. AGRESTA: -- because you'd just have a
22 contract that expires at a certain time --
23 MR. MASSELLI: That's right --
24 DR. AGRESTA: -- and if your group matures

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1 enough --

2 A VOICE: Right --

3 DR. AGRESTA: -- then you assume that role
4 when you figure out what it is -- but we're not ready to
5 do anything but source --

6 MR. MASSELLI: Source it --

7 DR. AGRESTA: -- source it initially.

8 MR. MASSELLI: Source it.

9 MR. MCKINNON: Yeah, that was -- that was
10 just put in there in case somebody said no we really want
11 to take this over ourselves. You -- you can do that as
12 well.

13 DR. AGRESTA: Sure --

14 MS. HOOPER: Obviously, right --

15 DR. AGRESTA: -- but that's not a decision
16 we need to even make now I would think --

17 MS. HOOPER: No --

18 DR. AGRESTA: -- because I mean it doesn't
19 really impact our business model

20 MR. COURTWAY: Well it does impact you in
21 contracting, you know. And so depending on what type of
22 contract -- if your contract is a volume based contract --

23 MR. PETRUS: Transaction --

24 MR. COURTWAY: -- contracting it on a

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1 subscription basis --

2 A VOICE: Yeah --

3 MR. COURTWAY: -- to hedge your bets on how
4 fast the adoption is. At some point you want a ceiling to
5 that or say here's the cap and then have the option of
6 bringing in -- but again it's just a contract term.

7 MR. MASSELLI: There's two -- two ways it
8 would go -- and in your business model it talked that
9 people were doing this, right, thinking about the --

10 MR. PETRUS: But there's also two --

11 A VOICE: Talk to Peter and Peter will tell
12 us --

13 MR. MASSELLI: No -- well -- (laughter) --

14 MR. COURTWAY: My contract is --

15 (Multiple voices overlapping and laughter -
16 indiscernible)

17 MR. PETRUS: As you -- as you think about
18 this, it's not all one or the other. You can actually go
19 to one vendor or a group of vendors --

20 MR. MASSELLI: Sure --

21 MR. PETRUS: -- to build it for you,
22 they'll design it. And then you could go to another
23 vendor who would host it for you and run it based upon a
24 fixed contract or a transactional piece --

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1 MS. HOOPER: Understood --

2 MR. PETRUS: -- zero, zero, two cents for
3 every -- so you -- or you could go out there and bid it
4 out to one vendor who actually designs it, builds it, and
5 would operate it for you --

6 MR. MCKINNON: That's most common --

7 MR. PETRUS: -- so you -- so --

8 MS. HOOPER: Okay. And that would be
9 fleshed out. Are we -- does anybody want 1, 3, or 4? I
10 don't think we're viable for any of those other options.

11 A VOICE: Good point.

12 MR. MASSELLI: No.

13 MS. HOOPER: Okay, good.

14 MR. PETRUS: And the next steps, we I think
15 already identified some of that. Keep going. We will --
16 based upon your information today -- before we get to
17 public comment, understand as we've done with every one of
18 these workshops, take a look at this and that, take a look
19 at the environmental scan and SWAT analysis. Any comments
20 goes to Lynn. That would then come to us and be
21 incorporated as we finalize this alternative analysis that
22 would lead into the strategic plan, understanding you have
23 another bite at the apple right now, and responding to all
24 you heard today. And as you leave here, you think, uh, I

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1 wish we had looked at this or we think this should be in
2 the model, let us know --

3 MS. HOOPER: Yes --

4 MR. PETRUS: -- and then you'll have the
5 second bite of the apple as we draft the strategic plan to
6 also vet it. So there's going to be a lot of
7 opportunities to have input on this. And we'll follow up
8 in the next steps regarding meeting around the finance
9 model.

10 MR. MASSELLI: Frank, nice job.

11 MS. HOOPER: Very nice.

12 A VOICE: Nice.

13 MR. PETRUS: And Kevin, thank you --

14 MS. HOOPER: Thanks, Kevin --

15 MR. PETRUS: -- for the extra effort. And
16 for all of you with your frankness and your ideas to make
17 this a discussion and not a presentation.

18 MS. HOOPER: And -- well -- and Frank, can
19 we assume that the comments made here today have been
20 grabbed by your staff --

21 MR. PETRUS: Yep.

22 MR. MCKINNON: Yeah.

23 A VOICE: Public comments we're going to do
24 --

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1 MS. HOOPER: And then now -- well, I just
2 wanted to make sure that we had everything --

3 COMMISSIONER GALVIN: Let me -- let me make
4 one comment --

5 MS. HOOPER: Okay.

6 COMMISSIONER GALVIN: I just want to tell
7 you something -- and this -- this is from my personal
8 experience. As most of you know most small businesses
9 fail within a year and -- like 85 percent. And the reason
10 they fail is lots of times, most of the times they're
11 under-funded. If you go into this under-funded or without
12 sustainable funding and depend on projections of money
13 that may come in, just are not reasonable. The whole
14 effort will fail and fall apart.

15 MS. HOOPER: Thank you --

16 COMMISSIONER GALVIN: And I'm sorry if that
17 happens.

18 MS. HOOPER: You made two -- are there any
19 public comments? Would anyone like to come forward? Sir,
20 any other comments before we adjourn?

21 COMMISSIONER GALVIN: That's it.

22 MS. HOOPER: Any other comments? Thank you
23 all very very much.

24 (Whereupon, the meeting adjourned at 3:55

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1 p.m.)