

VERBATIM PROCEEDINGS  
DEPARTMENT OF PUBLIC HEALTH

HEALTH INFORMATION TECHNOLOGY  
AND EXCHANGE STRATEGIC PLAN

ROBERT GALVIN, CHAIRMAN

JULY 12, 2010

101 EAST RIVER DRIVE  
EAST HARTFORD, CONNECTICUT

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

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 . . .Verbatim proceedings of a meeting in  
2 the matter of DOIT/HITE, held at 101 East River Drive,  
3 East Hartford, Connecticut, on July 12, 2010 at 12:04 p.m.  
4 . . .

5  
6  
7

8 CHAIRMAN ROBERT GALVIN: -- review of the  
9 minutes until we have a quorum. We're one short of a  
10 quorum, and neither person on the phone is a voter.

11 MS. MEG HOOPER: Correct.

12 CHAIRMAN GALVIN: Okay and we will begin  
13 with on your agenda Item #3. We will begin with some  
14 other item not on your agenda. We'll begin with an item  
15 on Meg Hooper's agenda.

16 MS. HOOPER: Good morning, all. I want to  
17 thank you all for coming today. We have a very busy and  
18 long agenda and wanted to just introduce a few issues. If  
19 we could go around the room and introduce ourselves, first  
20 of all, to make sure that everybody knows everybody?

21 We do have the sign-in sheet. Make sure  
22 that you sign in, both our public guests and our committee  
23 members and our Gartner colleagues.

24 Today, we are looking at the first hour to

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 talk about the subcommittee reports. Back to Commissioner  
2 Galvin on the letter that basically asked how is your  
3 subcommittee going to address the gaps identified in the  
4 need's assessment conducted by the Advisory Committee with  
5 Gartner?

6 In addition, we're looking for certainly  
7 subcommittee comments on how to move forward. Mr.  
8 Wollschlager sent out all of the subcommittee reports to  
9 date, which I think include all the technical committee  
10 has met once, but really didn't have any of those gaps  
11 identified yet, because it really is focusing on the  
12 actual technology, and Deputy CIO Bailey and Peter  
13 Courtway are the co-chairs of that committee.

14 So we will go through for those  
15 subcommittees to present a brief. If we could keep it to  
16 five minutes from each of the subcommittees, summary of  
17 the key points of those recommendations, as to how to fill  
18 the gaps?

19 Warren also sent out to all of you a new  
20 guidance issued by ONC, which is short for PIN, which  
21 stands for Program Information Notice. We forwarded that  
22 to you, and I hope nobody really read it, because it would  
23 have kind of ruined your weekend, but we need you to read  
24 it through carefully.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   It seems a bit confusing, but what we'd  
2                   like to do is simplify it for you. We're going to include  
3                   it in today's presentation from Gartner. ONC has refined  
4                   the guidance for what the states need to do first,  
5                   essentially, and we're trying to boil it down for you.

6                   Each of the subcommittees will need to look  
7                   at the PIN and the specific requirements as we move  
8                   forward through the implementation planning process.  
9                   Gartner is fully aware of this. We're having meetings  
10                  with them to see how we can combine our efforts to meet  
11                  the PIN, the new requirements.

12                  In addition, we're working closely with  
13                  ONC, so I want to bring your attention to the PIN. It  
14                  will be discussed today, in terms of how we're putting it  
15                  together for the implementation plan, but we do need the  
16                  subcommittees to take a look at this.

17                  As an opening point to today, we're going  
18                  to do the subcommittees, then Gartner is going to be  
19                  presenting to us the straw man for the operational plan.  
20                  You know it's due in September. You know it's July 12, so  
21                  we essentially have five weeks to have a final document  
22                  for review by the Commissioner before it is submitted to  
23                  ONC, so we're on a fast track. We've done a remarkable  
24                  job together. Gartner has done a remarkable job of

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 capturing everything.

2 Today's comments from the subcommittees and  
3 the committee at large will be incorporated into the  
4 strategic plan, which will then be forwarded as a partial  
5 draft to ONC for comment. It is also the initial part of  
6 the full strategic and implementation plan due in  
7 September.

8 So I will ask that -- are we going to have  
9 a quorum? I will turn the meeting back over to the  
10 Commissioner for the subcommittee report. Oh, first, any  
11 questions? Any questions on the PIN or where we're at  
12 today for the agenda?

13 We're going to try to keep it under four  
14 hours, because we have a lot to get through. If we could go  
15 through with the introductions to make sure everybody  
16 knows who is who?

17 CHAIRMAN GALVIN: Do we need a vote to  
18 decide whether we're going clockwise or counter clockwise?

19 MS. HOOPER: I don't think so. I think you  
20 have that luxury, sir, as the Chair.

21 CHAIRMAN GALVIN: Okay, well, we'll go  
22 clockwise today. My other important announcement is that  
23 we will serve coffee at 2:00.

24 MS. LYNN TOWNSHEND: Sorry. 2:30.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 CHAIRMAN GALVIN: 2:30.

2 MS. TOWNSHEND: I'm picking it up at 2:15.

3 CHAIRMAN GALVIN: At 2:15, courtesy of Lynn  
4 and myself. I will start the intro. I'm Bob Galvin,  
5 Commissioner of the State Department of Public Health, and  
6 to my left is?

7 MR. FRANK PETRUS: Frank Petrus with  
8 Gartner.

9 MR. ALISTAIR MCKINNON: Alistair McKinnon  
10 with Gartner.

11 MR. JEFF PERKINS: Jeff Perkins with  
12 Gartner.

13 MR. DANIEL CARMODY: Dan Carmody from  
14 Sigma(phonetic).

15 MR. PETER COURTWAY: Peter Courtway,  
16 Danbury Health Systems.

17 MS. LISA BOYLE: Lisa Boyle, Robinson &  
18 Cole.

19 MR. DAVID CASCEILLO: David Casceillo  
20 representing Jamie Mooney.

21 MR. WARREN WOLLSCHLAGER: Warren  
22 Wollschlager, DPH.

23 MR. RICK BAILEY: Rick Bailey, Department  
24 of Information Technology.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MS. BARBARA PARKS-WOLF: Barbara Parks-  
2 Wolf, Office of Policy & Management.

3 MR. MARK MASSELI: Mark Masseli, Community  
4 Health Center.

5 DR. THOMAS AGRESTA: Tom Agresta,  
6 University of Connecticut.

7 DR. KEVIN CARR: Kevin Carr, Internal  
8 Medicine Physician.

9 MS. ANDREA SCHROEDER: Andrea Schroeder,  
10 DSS.

11 MS. MARIANNE HORN: Marianne Horn, DPH.

12 MS. TOWNSHEND: Lynn Townshend, DPH.

13 MS. HOOPER: Meg Hooper, DPH.

14 CHAIRMAN GALVIN: And we do have a quorum  
15 now, so I will raise the issue of the minutes from our  
16 last meeting, the June 21, 2010 meeting, and you should  
17 have a copy of that document in front of you, and please  
18 take a quick look at it.

19 If you have any additions, substitutions,  
20 or deletions, now is the time to bring that up. I'll give  
21 you a couple of minutes to do that.

22 And if there are no changes, I would  
23 entertain a motion to accept the minutes of the June 21,  
24 2010 meeting, as introduced.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 A MALE VOICE: So moved.

2 MS. HOOPER: Okay. We have a motion.

3 CHAIRMAN GALVIN: I need a second for that.

4 Tom Agresta, thank you very much. All in favor? We're  
5 only voting on adopting the minutes on this two-sided  
6 document. All in favor?

7 VOICES: Aye.

8 CHAIRMAN GALVIN: Motion is carried, and  
9 now we'll proceed.

10 MS. HOOPER: Yes, sir.

11 CHAIRMAN GALVIN: Okay. Legal and Policy.  
12 Subcommittee report from Legal and Policy.

13 MS. BOYLE: Our committee, our subcommittee  
14 presented at the last meeting with our consent model.

15 CHAIRMAN GALVIN: Okay.

16 MS. BOYLE: And we also appeared at the LOB  
17 for the open meeting and did a presentation on the consent  
18 model.

19 CHAIRMAN GALVIN: Good.

20 MS. BOYLE: We are meeting on the --  
21 tomorrow. We're meeting tomorrow morning to discuss some  
22 of the issues that have come up in the public forum and at  
23 the last meeting, things that, for example, like the  
24 emergency break the glass option, which came up as a

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 possible add on to our model.

2 Also, probably to talk about some of the  
3 things that have come out of the other subcommittee  
4 meetings that are either different than what we have in  
5 our model or, you know, additional things to think about.

6 Our committee continues to work on the  
7 preemption analysis. That's going, you know, very well.  
8 It's probably close to done, I think, in the next few  
9 weeks, and I think that's pretty much where we stand. I'm  
10 happy to answer questions, but I think that's where we  
11 stand.

12 MS. HOOPER: For those of you that weren't  
13 here for Lisa's presentation at the last Advisory  
14 Committee meeting, we did post that, I believe, on our  
15 website. I'm sorry. I'm going to put you on the spot.  
16 We did put post Lisa's presentation on our website, so if  
17 you didn't see it, but if there are any other questions  
18 for Lisa or Marianne.

19 CHAIRMAN GALVIN: Thank you. Financial.

20 MR. CARMODY: We had a subcommittee meeting  
21 on June 1st. From that meeting, we focused on two things.  
22 We focused on our need to respond to your memo, dated May  
23 28th, and we have responded to your request.

24 We also looked at, as we looked through our

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Charter, the Gartner folks had provided some comments  
2 back, of which we have provided a response.

3 We also spent a good deal of time talking  
4 through what we said were sort of working assumptions. I  
5 think those working assumptions I think we started at the  
6 last meeting, but we actually put them down into our memo  
7 to you, Commissioner, and we laid those out, and I think  
8 that would be something that I would propose that if  
9 others wanted to contribute to it, or we start to keep a  
10 growing list of working assumptions, that keeps everybody  
11 on the same page.

12 Marianne came and gave a presentation to  
13 the subcommittee. The subcommittee is obviously a broader  
14 group than what we have here to make sure everybody was on  
15 the same sort of grounding, and, out of that, we made some  
16 modifications specifically related to the thought that on  
17 our phase one we didn't necessarily need the identified  
18 data set going in.

19 The reality of it was that the Public  
20 Health reporting required a PHI level detail, which was,  
21 again, a good example of getting additional clarification,  
22 so we modified the phase one. Again, phase one could be  
23 worked concurrently. These were in phases that, when you  
24 looked at the plan, were different than what was in the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 plan. There was just more of a phasing type of an issue,  
2 so you could be working on things concurrently.

3 MS. HOOPER: You didn't need one to  
4 complete before you start another?

5 MR. CARMODY: Yeah, you didn't need to do  
6 that, so I think part of it came down to timing, and, so,  
7 we started to create the working assumptions, so that  
8 other subcommittees could either agree, or disagree, or  
9 actually create a dialogue through that.

10 I'd be either happy to go through the  
11 working assumptions, or, if people have looked at them, to  
12 contribute with them, or make comments to them, that say,  
13 hey, wait a minute, we were going off in a different  
14 direction that was otherwise.

15 MS. HOOPER: We didn't post the  
16 subcommittee comments yet on the website, because they're  
17 kind of in draft, and, again, they're advising the  
18 Advisory Committee to advise the Commissioner.

19 We did post the consent option, or it was  
20 presented at that public forum, but if you haven't taken a  
21 look at it. Warren, did you want to speak at how the  
22 Program Information Notice might clarify things on the  
23 Finance Committee?

24 MR. WOLLSCHLAGER: Well to the extent that

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 the committee identified specific processes or products in  
2 various phases, that's going to have to change around a  
3 little bit here, based on the PIN ONC issue.

4 We had talked about Public Health reporting  
5 as really the first process we've got to go after in phase  
6 one as something to be used by the group. That's not the  
7 number one priority for ONC.

8 If you have a chance to look at lab  
9 reporting and describing and CCD. But, as Dan said, these  
10 phases are not really standalone, and, so, I don't think  
11 there will be a significant need for revisions to the  
12 working document here in light of the PIN. I'm not sure  
13 that that's the case with all of the subcommittees,  
14 however.

15 MR. McKINNON: One of the important things  
16 of the finance was actually assessment that needs to be  
17 discussed. I seem to remember, not too long ago, every  
18 possible way of funding this. Somebody would say you  
19 can't do that. You can't do this. You can't do that.  
20 Something's changed if we're going to do an assessment.

21 MR. WOLLSCHLAGER: Dan, do you want to, for  
22 those who haven't had a chance to see the document, do you  
23 want to provide an overview?

24 MR. CARMODY: Actually, I think it's

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 probably more of a migration. It's not just one or the  
2 other. The thought was that, if you haven't read the  
3 notes or the minutes yet, I think I presented this the  
4 last time, I don't think we really substantially changed  
5 what the recommendation was, which was, in the first year  
6 or so, to kick this off the ground, it's going to take a  
7 little while to demonstrate and generate revenue, but the  
8 thought was is that, initially, everybody would  
9 contribute, and when I say everybody, we try to include as  
10 many groups as possible in it, so that, again, everybody  
11 is going to benefit from this.

12 And, so, there was going to be an initial  
13 assessment, but then you had to move away from that. The  
14 thought was is that, you know, when you start looking at  
15 what the services were going to be, you know, the question  
16 is, you know, we've talked before, there was a master  
17 patient index, there was a master provider index, there  
18 was a record locator, so that if it was more in a  
19 federated model, you know, did you actually have to keep a  
20 centralized model or not?

21 But the other thought was, and we talked  
22 about this a little bit, which was could those set of  
23 services be exposed as quickly as possible in the life  
24 cycle of this, so that you could actually sort of

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 commercialize that? And, again, commercializing it with  
2 the appropriate consent, so the example of, you know, did  
3 we really want to take on a personal health record?

4 The conversation went to, gee, that, you  
5 know, personal health record ends up needing a pretty high  
6 level of operating expenses to that associated with, you  
7 know, how are they going to make changes to it? You're  
8 going to have to put a call center in and things like  
9 that, I think things that commercial products or  
10 commercial entities probably already have a foundation to.

11 And, so, if you were to expose those  
12 services, then you could have the likes of whatever,  
13 whether it be a carrier, or a hospital, or physician  
14 group, whoever wanted to provide that the individual  
15 wanted to make access and make available all of their  
16 information, they could say, look, send all of my  
17 information over to whomever they decided and then create  
18 a commercial source of income, so that we could try to get  
19 this so that it's self-sustaining.

20 So that was sort of where we were going,  
21 so, to start off potentially with an assessment across the  
22 board, that would have to be potentially varied by a  
23 constituent.

24 We hadn't gotten to the fact of, you know,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 what that would be for any of the constituents, but we had  
2 thrown some examples out there, and then try to move to a  
3 subscription model as quickly as possible, and the thought  
4 was those generic services could be made available, so  
5 that, again, we try to keep this infrastructure as light  
6 as possible, not have overhead, an operating overhead.

7 MR. WOLLSCHLAGER: Just a couple of points.

8 The committee did move forward with the assumption that  
9 the consumers were not going to be charged at all for  
10 this, so it wasn't going to be the patient or consumer,  
11 and the fee, the standard fee would be sunsetted out at  
12 some point.

13 Maybe there's a period where there's a  
14 hybrid model before we can fully migrate to a sustainable  
15 subscription model.

16 MR. CARMODY: But I think the key to it was  
17 to try to make it so that it was getting it away from the  
18 assessments. It really needs to be on its own two legs,  
19 and the thought was, again, take something that is already  
20 a commercially available project, like a PHR, and it's  
21 offered in a variety of different places today. The State  
22 didn't have to be the one who is going to give you another  
23 venue. Just use those venues and let those people that  
24 are interested expose it, and then try to create that, so

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 that people can create a registry.

2 MS. HOOPER: Any questions for Warren or  
3 for Dan?

4 CHAIRMAN GALVIN: I did get an overture  
5 from the business school about having a summer intern, and  
6 they were interested until they realized that we couldn't  
7 pay him or her, so I think we'll get the same thing in the  
8 fall when we ask.

9 I think this was an undergraduate student,  
10 and I don't know of any mechanism, where we can pay a  
11 graduate student to come in, but we'll -- they're  
12 interested in it, but they, being business school people,  
13 want to get paid for it.

14 MS. HOOPER: Oh, for heaven's sake.

15 MR. WOLLSCHLAGER: The only other point for  
16 the Department is that this would require legislation from  
17 the Department to enact this financial model.

18 CHAIRMAN GALVIN: Yeah. We need to pay  
19 somebody to come in.

20 MR. WOLLSCHLAGER: No, to charge everyone a  
21 fee.

22 CHAIRMAN GALVIN: Of course.

23 MR. MCKINNON: And would there be a  
24 mechanism? Would it use a mechanism that exists or some

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 different mechanism? The method of charging the tax, is  
2 it going to be done on the back of a tax that already  
3 exists, or some new tax?

4 MR. WOLLSCHLAGER: I don't think we've  
5 gotten to all that. I don't think it's going to be  
6 consistent for each provider's type.

7 MR. MCKINNON: -- what can be done --

8 MS. HOOPER: That is one that needs to be  
9 fleshed out during the operational model planning process.  
10 Also, with some legislative leaders.

11 MR. CARMODY: So I guess one of my  
12 questions would be, at some point, when are we able to  
13 access the funding that's been made available, because one  
14 of the things we get into is we need more folks that spend  
15 more dedicated time to this, and, again, having a meeting  
16 every other week for three to four hours is just not going  
17 to get us the uplift. It's just not going to, so --

18 MS. HOOPER: If it --

19 MR. CARMODY: -- come until they approve  
20 the plan.

21 MS. HOOPER: Well, again, if it's part of  
22 the planning process, Dan, then we would, you know, you  
23 could bring it to Warren, and then we would have a  
24 discussion, as to how we could assist with that with the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 existing funds, as long as it's part of the planning  
2 process, but actual implementation funds, funding for  
3 staffing in the new authority, anything that goes forward  
4 from implementation doesn't happen until October on a good  
5 day.

6 If ONC can review our application, I mean  
7 our plan and approve it from September 27th until October  
8 1st, then we're going to have some more funds for  
9 implementation, so we can just continue that.

10 MR. CARMODY: I just only feel that we're  
11 going to be able to -- one of the things we talked about  
12 is we started saying this is what it takes in order to  
13 have somebody go off and get some of this.

14 I know there were certain takeaways that  
15 Warren had had around getting certain types of  
16 information. I just feel that we're just not going to  
17 make enough progress on actually building a model, that in  
18 getting some of those pieces, unless we have somebody  
19 working on it on a regular basis.

20 MS. HOOPER: Alistair, you've got time,  
21 right? How about Warren and the core team will talk about  
22 it at DPH to see what we can do to assist?

23 MR. WOLLSCHLAGER: As I said, there's quite  
24 a bit of information scattered around, but when you start

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 talking about levying a fee on all provider types, that's  
2 a lot of data to pull together.

3 MR. MASSELI: Dan, what are you looking  
4 for?

5 MR. CARMODY: Going back, we were looking  
6 at maybe somebody that had a business degree, somebody who  
7 could actually work and spend some time taking some of  
8 these variables. You know, first, gathering the  
9 information, what are the variables, what are the sources,  
10 looking at sort of the funding mechanisms that we can tap  
11 into.

12 First was just trying to generate what was  
13 the revenue, and just doing some of the just sort of off-  
14 the-cuff calculations of, if you're going to do off of  
15 discharge data, or if you're going to, you know, you're  
16 going to do it off a claims fee.

17 I mean looking at the various constituents,  
18 you know, if you were going to add an assessment onto  
19 physicians. How many physicians are there in the state?  
20 Are you going to vary it? Coming up with those detailed,  
21 you know, variables and calculations, and we're just  
22 trying to do that in a meeting when we need other people  
23 to come and show us, and then go off and do basically  
24 scenarios.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 I mean part of it is, you know, we can  
2 create some of the use cases at a higher level, but it's  
3 then taking those use cases and saying, okay, now go off  
4 and find --

5 CHAIRMAN GALVIN: What would happen if, and  
6 you talked to these people, we need probably about \$10,000  
7 to do this, how would we get that money?

8 MS. HOOPER: It's part of the planning  
9 process. We would speak with ONC about our existing  
10 budget and how that could be utilized for contractual,  
11 whether we would go through, you know, again, Frank and  
12 Alistair has something that Gartner would be in addition,  
13 because it's an existing contract, or we would talk about,  
14 again, getting that funding to somebody would require an  
15 existing vendor agreement with the State of Connecticut,  
16 remembering it's DPH funds.

17 CHAIRMAN GALVIN: Well what if we got the  
18 money in the Department and contracted with the business  
19 school?

20 MS. HOOPER: Well that's why I think that,  
21 you know, we should talk off line about this, but I  
22 appreciate very much your point, that you need a staff  
23 person essentially to be putting this together. You need  
24 a resource to do this.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. CARMODY: The question is what piece of  
2 this has to be done at the planning phase if you're making  
3 a decision that a mechanism is going to be used to have  
4 legislation around a fee, and that's one step, and then,  
5 as part of implementing the operational plan, you take a  
6 look at what vehicle would be used to achieve that fee,  
7 and that might be, so you have to say what goes in the  
8 planning side and what goes in part of the implementation?

9 MS. HOOPER: Understood, but I think -- I  
10 appreciate what you're saying. In order to draw up the  
11 options and actually look at this in order to make some  
12 recommendations in the next month, as to how you want to  
13 move forward on the financing level.

14 MR. CARMODY: I think we have a basic  
15 premise to work off of. What we don't have, though, is if  
16 somebody said, okay, so how much are you going to actually  
17 be able to generate? What do you think you actually need?

18 MS. HOOPER: Correct.

19 CHAIRMAN GALVIN: Okay, so, who do we have  
20 to call for to get Dan some money?

21 MS. HOOPER: We're going to talk about this  
22 back at the shop.

23 MR. MASSELI: Well have you tried like Yale  
24 School of Organization Management? Have we talked to

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 anybody?

2 MS. HOOPER: Right. We could be contacting  
3 other --

4 MR. MASSELI: I mean it's late in their  
5 cycle, obviously. Most of the people I know have got  
6 assignments and are headed around the world.

7 MR. CARMODY: Last meeting, we talked about  
8 maybe somebody at UConn, but we hadn't gone off and done,  
9 you know, we haven't chased them down.

10 MR. MASSELI: There's nothing preventing us  
11 from going out and soliciting like that, where you're not  
12 obligating dollars. The issue will be do you have the  
13 right person to do it? Just because somebody has a  
14 business degree, I'm not convinced that they are  
15 necessarily equipped to work through the set of issues  
16 that you've identified, but you might as well at least  
17 talk to some of the leadership folks in both of those  
18 institutions, Yale and UConn, and say here's the core  
19 competencies that we're looking for, and there's somebody  
20 who fits this bill. Here's the amount of time that we're  
21 looking for, and maybe they're an adjunct to somebody  
22 else. If we end up getting Gartner some more money or  
23 whatever we do, but --

24 MS. HOOPER: They might listen to you

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 versus DPH calling them.

2 DR. AGRESTA: The other part of that is you  
3 build in the potential for long-term, you know, lower  
4 costs, you know, real assessment over time, and it then  
5 becomes part of their curricular activities, etcetera, and  
6 opportunity for people to get engaged long-term, and you  
7 really need that, too.

8 So I think, if you can do that, you're  
9 building in some longer term vestment in the workforce, as  
10 well.

11 MS. HOOPER: We're going to take this.  
12 Five minutes is way over.

13 CHAIRMAN GALVIN: Okay. How about you and  
14 Dan and I do a little conference call about this, so we  
15 get things a little clearer?

16 MS. HOOPER: We will see what we can do.

17 CHAIRMAN GALVIN: We have to do this. What  
18 he's telling you is that if he doesn't get the  
19 sophisticated input, that it's not going to work. You  
20 can't have volunteers doing this. You need somebody to  
21 figure out all those parameters that Dan is speaking  
22 about. They could do it as a business, but sometimes that  
23 operations, not operations manager, but that capstone  
24 thing they do at the business school.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   They'll put teams of students on it, but  
2 they usually want a pound of flesh, meaning a State  
3 university.

4                   MS. HOOPER: I just thought nights and  
5 weekends, Dan.

6                   CHAIRMAN GALVIN: We'll work that out.

7                   MS. HOOPER: Yes, we will.

8                   CHAIRMAN GALVIN: We'll figure a way to do  
9 that, and we've got to draw on the governance.

10                  MS. TOWNSHEND: Governance, on behalf of  
11 Commissioner Galvin, I believe I'm doing the presentation.  
12 There were five gaps that were identified by Gartner that  
13 needed to be addressed. The first was oversight of the  
14 initiative, which right now all of you know is really with  
15 DPH, but mainly with the Advisory Committee, and it will  
16 be moving.

17                  Thankfully, the legislature and the  
18 Governor's office have moved this along, so that there  
19 will be a Board of Directors. There will be a quasi  
20 public entity moving forward. That will be in place  
21 January 1, 2011, and one of the things that we are looking  
22 to make certain that we do is that there is a smooth as  
23 possible a transition from this committee to the new Board  
24 of Directors.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   With respect to specific oversight of HIE  
2                   privacy and security policies, first and foremost working  
3                   very closely with Legal and Policy Committee or  
4                   subcommittee is very important, and certainly the  
5                   maintenance of subcommittees, both now and moving forward  
6                   into the new quasi public agency entity, are very, very  
7                   important.

8                   One other thing under the initiative  
9                   oversight is, and this is an ONC requirement for every  
10                  State territory, is that DPH will maintain the position of  
11                  State government HIT coordinator, and a lot of that  
12                  responsibility is in the PIN, so it would be great, again,  
13                  as Meg mentioned, if the subcommittees and the committees  
14                  can review that very, very carefully, and that's something  
15                  that right now is in Warren's very capable hands.

16                  The second gap that was identified,  
17                  Planning and Operational Oversight, and that really we  
18                  concentrated on what the Board of Directors is to do, and  
19                  that is that they will be establishing protocol by which  
20                  they will hire staff, including, I want to make sure I get  
21                  the right, Chief Executive Officer is actually.

22                  We've been using the term Executive  
23                  Director, but statute does call the head of the authority  
24                  the HITE CT, the Chief Executive Officer, and the Board of

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Directors needs to make certain that they develop the  
2 bylaws that will govern the quasi public agency. That's  
3 an authority that's given to them under Public Act 10 117,  
4 right?

5 The third gap was insuring stakeholder  
6 input and influence. The Board of Directors certainly is  
7 responsible for making sure that the subcommittees,  
8 themselves, have the requisite people on them to advise  
9 the Board and the subcommittees by this document that  
10 we're proposing today would be broken out by each of the  
11 domains, as identified by ONC, along with the one that's  
12 been identified by this group, which is Mark Masseli's  
13 Special Populations subcommittee, which is very, very  
14 important to the Commissioner and to I believe everyone  
15 here.

16 One other area where ONC has been very,  
17 very clear is that we need whoever the SDE, the State  
18 Designated Entity, is. Right now, it's DPH. January 1st,  
19 it will be the HITE CT. He used to work very closely with  
20 CMS entity, which is DSS, and with the REC, which in  
21 Connecticut is the health Connecticut, so we are working  
22 very closely, the 3C3 Committee, which is those three  
23 entities, and it will become a fourth entity.

24 With authority coming in, DPH will still

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 have a role as of January 1st being the holder of the  
2 cooperative agreement to make certain that across all  
3 planning and across all of the efforts that are made that  
4 these efforts go forth very much hand-in-hand with one  
5 another, so that we can leverage any overlap and make  
6 certain that we aren't spending many taxpayer dollars on  
7 the same effort.

8 We want to make sure that's a concerted and  
9 strong front and effort to make sure those dollars are  
10 used appropriately.

11 Another gap was the reporting and success  
12 measures -- oh, wait a minute. With regard to insuring  
13 stakeholder input and influence, we want to make certain,  
14 of course, that everything is transparent, all of our  
15 meetings are open and noticed, and that people who wish to  
16 have public comment or have participation, based upon  
17 their particular area of expertise or interest, are  
18 included.

19 When I went to calculate how many people  
20 were involved, anywhere from simply putting a public  
21 comment to being a member of this entity right here, there  
22 are just about 150 people statewide who are involved and  
23 53 organizations, so we have a great start into making  
24 certain that we have the stakeholders necessary.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   There are probably some out there. We want  
2                   to make sure that anyone who wants to be part of the  
3                   process and has a skill set that they can bring to the  
4                   process is ready, willing and able and comes to the table  
5                   with whatever comments or skill sets they wish to share.

6                   Reporting success measures for  
7                   accountability, this is an AH(phonetic) funded program,  
8                   and AH makes certain that we report on a quarterly basis,  
9                   and they are very stringent reporting guidelines with the  
10                  federal government, and we are meeting those.

11                  Part of it is to make certain that we have  
12                  the stakeholders at the table. Part of it is to make sure  
13                  that we are spending the money, as is outlined in the  
14                  cooperative agreement.

15                  In the document that's been sent to each of  
16                  you, there are several bullet points with regard to that,  
17                  and it measures or tells you what the metrics are for the  
18                  second quarter of 2010, so we are doing that on a very  
19                  regular basis and making that as open and public a process  
20                  as possible.

21                  Also, within the cooperative agreement, we  
22                  are moving forward with an MOA, a Memorandum of Agreement,  
23                  with the University of Connecticut, and it's the Health  
24                  Center, right? University of Connecticut Health Center to

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 assess the process of developing the aspects of the HITE  
2 here in Connecticut.

3 The last gap, public awareness, education  
4 and participation in the plan, again, that's the 3C3  
5 moving forward towards the united goal of a working,  
6 private, secure HIE that is exchanging information that is  
7 relevant to stakeholders to positions and, also, to  
8 patients here in the State of Connecticut.

9 That is the, in a nutshell, those are the  
10 five gaps that we were looking at. Lisa?

11 MS. BOYLE: I just had a question. Can you  
12 just explain what's the MOU with UConn Health Center?

13 MS. TOWNSHEND: That is required by the  
14 cooperative agreement, and that is -- the four-year MOA is  
15 an evaluation, comprehensive evaluation for HITE for the  
16 cooperative agreement, and that is to assess the process  
17 of developing the HITE here in the State of Connecticut.

18 MS. HOOPER: It's essentially a  
19 documentation of everything that we're doing. In fact,  
20 Dr. Tiku(phonetic) is here, our contractor, so that we can  
21 evaluate how our process is going along, so the feds can  
22 use it as a -- of course, we think it's a model for all  
23 the other states, best practice, of course, here in  
24 Connecticut, as opposed to any other state.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   Is that on the record now? And then, also,  
2                   to assist us as we move forward. It isn't just the  
3                   counting of meetings and who is represented, but really  
4                   what is the HIE going to be serving? Are we going to, in  
5                   fact, serve the needs that we identify?

6                   CHAIRMAN GALVIN: At this point, I'm going  
7                   to read into the record that we have been joined by the  
8                   Honorable Michael Fedele, Lieutenant Governor of our fair  
9                   state, and by Dr. Kenneth Dardick, a primary care  
10                  practitioner in the Storrs/Mansfield area, who is in the  
11                  trenches fighting out and stamping out disease.

12                  MS. TOWNSHEND: Any questions with regard  
13                  to the governance?

14                  CHAIRMAN GALVIN: Business and Technical  
15                  Operation.

16                  MS. HOOPER: I don't know how you're going  
17                  to take 23 pages and put it in five minutes, Dr. Agresta,  
18                  but let's give it a shot.

19                  DR. AGRESTA: All I'm going to do is  
20                  summarize.

21                  MS. HOOPER: Thank you, sir.

22                  DR. AGRESTA: The Business and Technical  
23                  Operations subcommittee had quite a number of gaps  
24                  assigned to us. The only way we could effectively deal

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 with that was to split ourselves into three, and that's  
2 what we did.

3 We basically created three sub-groups, gave  
4 them each a set of gaps to address, and then consolidated  
5 them and had them pretty much in what I would consider a  
6 nearly complete draft format to submit back into the  
7 group.

8 The high level issues are we are at task  
9 with defining the process by which collaboration -- one of  
10 them is defining the process by which collaboration with  
11 the other ONC funded agencies in the State are, so, as  
12 Lynn kind of mentioned, there's a coordinating committee  
13 that's sort of formed a little bit, but we got a little  
14 more deeply into what that process might look like,  
15 including describing routine meetings, the types of  
16 communication that might need to go back and forth between  
17 them, the types of information that might need to flow,  
18 and the areas around which we believe collaboration could  
19 occur.

20 Collaboration can occur in areas that  
21 everybody has to address, so one of the areas that  
22 everybody has to address is really meaningful use and  
23 making sure that meaningful use works for each of these  
24 subgroups, and, so, having a group that kind of looked at

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 meaningful use in the HIE in the Regional Extension  
2 Center, in terms of Medicaid was an idea that we thought  
3 about, how they're different, how they're the same, you  
4 know, how can we make sure that one group is not --

5 MS. HOOPER: May we share that with that  
6 committee that we meet with, that coordinating committee?  
7 May we share your document?

8 DR. AGRESTA: Absolutely.

9 MS. HOOPER: Thank you.

10 DR. AGRESTA: Yeah. My intent was actually  
11 to share it with the Regional Extension Center Committee,  
12 as well.

13 MS. HOOPER: Good. Thank you.

14 DR. AGRESTA: So we also, then, recognize  
15 that we had issues around communication and marketing,  
16 essentially, and that was one of the other gaps that was  
17 noted, and the communication marketing issues, the first  
18 critical one that I believe is going to hit us this week,  
19 if I'm reading the tea leaves correctly, is that probably  
20 the meaningful use criteria, the final ones, are going to  
21 be released.

22 Whether that happens this week or next  
23 week, it's going to happen very soon. The rumor has been  
24 tomorrow. I keep hearing it from different places, which

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 makes it more and more likely to be the case.

2 In fact, we were asked, as a Regional  
3 Extension Center, to prepare for, you know, stuff in the  
4 next day or so, so we believe that the meaningful use  
5 criteria is going to hit, though it will hit some to the  
6 extent of even getting out and noted to the newspapers and  
7 things like that, so we've got a real critical need, and  
8 one of the things we want to probably talk about this  
9 afternoon is how do we coordinate amongst those different  
10 groups what's said, who says it, who the spokespeople are,  
11 who the real knowledge and content experts are, and how  
12 can we share that, rather than having lots and lots of  
13 replication of effort.

14 So we threw out a couple of ideas about how  
15 to deal with that, but recognized that that was critical  
16 issue sort of number one, that that was going to happen  
17 this week.

18 MS. TOWNSHEND: Just real quick. My  
19 understanding is that ONC is putting together a packet of  
20 information.

21 DR. AGRESTA: A tool kit.

22 MS. TOWNSHEND: A tool kit.

23 DR. AGRESTA: Yes.

24 MS. TOWNSHEND: That we can be using, and

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 we can use locally. That would be a great way to co-grant  
2 with the REC, CMS and the --

3 DR. AGRESTA: Correct, so, I've been on a  
4 number of -- I'm actually on an Advisory Committee to the  
5 ONC around marketing and outreach and education, and we  
6 give them a number of points of feedback, which they have  
7 adopted most of.

8 I suspect, at most, it's going to be a  
9 marketing type of tool kit at this point and a little bit  
10 of education tool kit, not as much as I believe is  
11 necessary, so there will be a real need, I think, to go  
12 beyond sort of marketing and sort of outreach to actually  
13 think about education.

14 Now, if you think about it, marketing and  
15 outreach is very different to a primary care clinician  
16 than it is to a patient than it is to the general public,  
17 and those things are -- those messaging can be very, very  
18 confusing if they all come not coordinated, so the other  
19 thing that we suggested was that any type of messaging  
20 from the State level from any of these groups be  
21 coordinated and that we develop a coordinated messaging  
22 person, etcetera, or a group across them in some fashion,  
23 and that needs to be considered in the meeting.

24 MS. HOOPER: In fact, today we are meeting

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 from point five, and that's our key agenda.

2 DR. AGRESTA: That's what I understand.

3 MS. HOOPER: Yes, sir.

4 DR. AGRESTA: And, so, that was one of the  
5 issues that we identified as really critical and key, and  
6 it's going to be important this week.

7 MS. HOOPER: Yes, sir.

8 DR. AGRESTA: Then, we also were tasked  
9 with thinking about how to prioritize and figure out who  
10 the actual stakeholders were and how to prioritize what  
11 was happening within the HIE to meet those stakeholders'  
12 needs, and, so, what we did is we listed, you know, the  
13 stakeholders we were aware of.

14 Obviously, Lynn probably has a lot more  
15 information about the stakeholders at this point that  
16 would probably be valuable to our organization.

17 MS. TOWNSHEND: And it's, actually, at  
18 least the organizations are listed in what was sent out to  
19 the committee. I have the list of people.

20 DR. AGRESTA: What I think probably makes  
21 sense is to think about a process of keeping this data up-  
22 to-date routinely available. It's not so much the current  
23 organizations and people.

24 It's probably more how do you maintain it,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 transfer it, etcetera, and there was a recognition that  
2 that needs to be part of the operational plan, and it  
3 needs to be in place as we go forward, so that the process  
4 of maintaining that.

5 Then there is the issue of prioritizing  
6 what actually happened. We recognize that we need to  
7 prioritize the HIE efforts to meet meaningful use, because  
8 that was obviously why we were being funded, and we really  
9 were stuck with, you know, the cart before the horse  
10 issue. We can't do that until we know exactly what  
11 meaningful use is going to look like.

12 I think they gave us this document that was  
13 released on the 6th to Dr. Galvin and DPH kind of I think  
14 told us what's going to be in the meaningful use. It  
15 telegraphed the three critical issues, and I think it will  
16 be very helpful in kind of refining how that occurs, but  
17 the group started to look at, you know, quality reporting.

18  
19 It started to look at Public Health  
20 reporting, it started to look at transfer of data, and it  
21 started to basically say, all right, as a process we can  
22 define the fact that you need to kind of do needs  
23 assessment, you need to develop plan development, you need  
24 to do evaluation, and, basically, rather than get into the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1       specifics of each one of those things, we can first define  
2       a process by which you can continually achieve that,  
3       monitor it and kind of move forward, because we thought  
4       that was a first step type of issue.

5                       So those are the major issues that we  
6       covered in our group.

7                       MS. HOOPER: Thank you very much. If you  
8       all haven't looked at all the committee's work, I just  
9       want you to know that the Commissioner and all of us from  
10      the Department really appreciate all the effort that went  
11      into this.

12                      This is what we all needed, was dedicated  
13      time to this to get that idea, and 23 pages was worth it,  
14      because I actually found it taught me a lot.

15                      CHAIRMAN GALVIN: Special Populations.  
16      Mark?

17                      MR. MASSELI: Sure. While we're not on the  
18      domain of the ONC, in terms of their focus and have less  
19      heavy lifting, other groups have certainly been looking at  
20      trying to articulate out the principles around what  
21      special populations -- how one would define them, and I  
22      think we've come up, with Sarju's help, with a good  
23      committee.

24                      We've met three or four times and have

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 outlined really examples of this. I think there are a lot  
2 of intersections with finance and with communications and  
3 all of those that we are very concerned about and have  
4 articulated out.

5 I'd say, as the initiative moves forward,  
6 Dan, your group will probably want special populations to  
7 be a focus when we move outside ONC to other groups for  
8 funding, because I think it will loom much larger than it  
9 does now in the current arrangement, and, as we go out to  
10 a broader funding source, our focus and concern about  
11 vulnerable populations will be important to keep an eye on  
12 it.

13 It will give us some opportunities, but I  
14 know everyone around the table shares the same sets of  
15 concerns about providers who have an enormous commitment  
16 to special populations, making sure that they're funded  
17 adequately, making sure they're engaged into the  
18 population that we've defined.

19 And recognizing it's a narrative process,  
20 we didn't want to exclude a group that we hadn't been  
21 thinking about, and, so, we've given examples of the types  
22 of statuses that people might have, with the notion that  
23 this will evolve as more people learn about our initiative  
24 and raise issues, so we look forward to being more active

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 in each one of the committees as we move forward.

2 MS. HOOPER: We're also hoping to help the  
3 Reform Act is going to provide some more opportunities,  
4 not just for the --

5 MR. MASSELI: Yup, yup.

6 MS. HOOPER: -- but with addressing the  
7 disparities.

8 CHAIRMAN GALVIN: Thank you. Technical.  
9 Peter?

10 COURT REPORTER: One second.

11 MR. COURTWAY: Okay. First, I'd like to  
12 acknowledge Lynn Townshend and Rick Bailey. They were  
13 instrumental in helping getting the first meeting off the  
14 ground, and I really appreciate it. Thank you very much.

15 The subcommittee did meet last week to  
16 review the questions outlined in the May 28th memo, and we  
17 worked from the bottom up on that, starting with the  
18 impact on the Regional Extension Center, and one of the  
19 things that we will be doing is reaching out to the  
20 Regional Extension Center, e-Health Connecticut, to  
21 determine what the strategy is in regard to the offering  
22 of an electronic health record, if that's part of the  
23 plans of the sustainability of the center, or whether or  
24 not it's really more broad, or a combination of the two,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 in terms of the support for independent EHRs, which is  
2 important, because, as we discussed it at the committee,  
3 the impact of how you connect to the exchange is going to  
4 be an important part of the education program, as well as  
5 whether or not an electronic health record is offered as  
6 part of the domain of the REC.

7 It may mean that that becomes the EHR of  
8 last resort, if you will, that's available to the public  
9 through the overall stimulus funding, or whether or not  
10 the HIE, itself, needs to support an EHR as part of its  
11 list of features, you know, or products that are offered  
12 as part of the Health Information Exchange.

13 So we'll be reaching out this week to try  
14 to gather more information about the strategy of the REC  
15 on that.

16 Moving from there, we went to the standards  
17 and determined that we did not need to set up the Separate  
18 Standards Committee. The feud about Standards is there's  
19 so many of them that we really didn't need another  
20 committee to try to sort through it all, and we'll be  
21 focusing really on two different sets of standards.

22 One is the federal standards, as it relates  
23 to the exchange of information, which are being defined  
24 and redefined, but we're going to hang our hats on the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 federal standards for that, and then moving into the  
2 technical standards of what is available in the technical  
3 domain from a security point of view, from an information  
4 architecture point of view, so that we're marching along  
5 in a very standardized approach in regard to moving  
6 forward.

7 The meaningful use components actually may  
8 help on that, since the meaningful use is a combination of  
9 applications process and security parts event, so we'll  
10 inform against that domain, also, and, at the next  
11 meeting, we'll be going after what some of those high  
12 level standards are, which are very important for us,  
13 where as we move up this chain and get to the procurement  
14 side, to be able to establish what standards the vendors  
15 need to be able to work with it.

16 MS. HOOPER: Are you anticipating having  
17 stricter standards than ONC or recommending stricter  
18 standards than federal?

19 MR. COURTWAY: No, we are not.

20 MS. HOOPER: Good.

21 MR. COURTWAY: Not at this point in time.

22 MS. HOOPER: Thank you.

23 MR. COURTWAY: You're welcome. We were  
24 very fortunate to have Laurie Forcat(phonetic), who is an

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 expert on standards, you know, join the committee, so it's  
2 been very helpful, and she was distributing a fair amount  
3 of information to the committee members.

4 In regard to the collaboration with the  
5 State's Procurement Office developing the Procurement  
6 Strategy, we did talk about that. I guess it depends on  
7 the practice that we want to follow for the procurement.

8 At the time of the procurement, it will  
9 probably already be into, we believe, into this quasi  
10 public, you know, entity, but what we do want to do is to  
11 follow the good practices of what the State currently  
12 does, as well as generally good business practices out  
13 there.

14 So, on the procurement side, it's more  
15 setting up the structure for how we'll do the procurement,  
16 making sure that there is time to inform it of how the  
17 State does its procurement pieces, and then start  
18 structuring the document to move forward.

19 Finally, structuring the document really is  
20 talking about the enterprise architecture and products,  
21 and this is the point where we stopped the committee at  
22 the last session, so that we could gather the rest of the  
23 information from the different other domains about what,  
24 specifically, the HIE was expected to offer.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   So, for example, it's clear in the Program  
2 Information Notice that e-prescribing, structured results  
3 and document exchange are there, but, for example, until  
4 today, when Mr. Carmody said that we don't need to offer a  
5 personal health record as part of it, that means that that  
6 comes out of that.

7                   If there was a desire to offer a personal  
8 health record, it would come into the procurement, so we  
9 need to go through each of the different areas, each of  
10 the different domains and see which ones are actually  
11 segments of a product procurement that we would do and  
12 which ones we do not have to worry about.

13                   MS. HOOPER: Thank you, Peter.

14                   CHAIRMAN GALVIN: Thank you. I think Meg  
15 has one final comment, but I did have a meeting with Dr.  
16 Angelo Carraba, the president of e-Health. He and I did  
17 some talking about the Chief Operating Officer, and it was  
18 our feeling over a breakfast meeting that we need to  
19 consider having one person, one Chief Operating Officer  
20 for both entities for the authority and the REC, the R-E-  
21 C, and I think the Board has, in general, and the  
22 Executive Committee, in particular, we need to think about  
23 what kind of person we want for this job, in terms of if  
24 we get someone who is incompatible with executing the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 desires of the authority, then we're going to push way  
2 back.

3 I'll say it another way. We don't want to  
4 have to start all over again after six months and say, oh,  
5 gees, we hired the wrong kind of person, so there's a lot  
6 of philosophy involved, and the kind of person we want to  
7 be managing the agencies, and would that person require an  
8 architect, a systems architect, as well, or do we look for  
9 somebody who had both architectural skills and executive  
10 skills?

11 Knowing one of those people very well,  
12 they're pretty hard to find, and, so, we may want to -- we  
13 need to clarify our thinking on that point. I think  
14 there's also a question of are we going to look  
15 regionally, or are we going to look nationally. Looking  
16 nationally means we have to get into issues about are you  
17 going to pay me to fly out here for the interview or not,  
18 for the second interview, and what we hear is of course  
19 you're going to help me.

20 So you're going to buy my house, and help  
21 me find a house here. You know the issues. I come from  
22 Iowa, and a \$400,000 house here is a \$200,000 house there.

23 There are a lot of issues that we need to think about,  
24 and there's a lot bigger price tag if you have to move

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 somebody from Dubuque, Iowa, or from Portland, Oregon to  
2 Connecticut and probably some guarantees, in terms of  
3 employability, in terms of a contract that might be a  
4 little different if it were somebody who was regional.  
5 More about that later. Ms. Hooper?

6 MS. HOOPER: Why wouldn't anybody pay us to  
7 come to Connecticut to work with us? Anyway, I wanted to  
8 say on the reports, I wanted to say, with all the reports  
9 again, thank you all very much. You see the  
10 interrelationship. We can't have financing, unless we  
11 know what the product is. We're not going to have  
12 governance, unless we know what we're actually going  
13 after, so you're all working together on this stuff.

14 I wanted to also bring up an issue that has  
15 come to DPH. There are some vendors, not only here around  
16 the table, possibly, but also some that want to join or  
17 are already members of your subcommittees.

18 If you could just be aware that, as that  
19 goes forward, any vendor or any consultant that might be a  
20 part of or interested in part of the funding that may come  
21 later may be at risk for being a part of this process.

22 Marianne is going to put some notes  
23 together, but we just want to be clear on that upfront,  
24 that there may be some funding opportunities that may be

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 at risk for some of the consultants and/or current vendors  
2 participating with us, however, we want all of those  
3 comments, including Gartner, certainly, that we need to  
4 gather as much information as we can, so just, with that,  
5 we are going to be putting something together, but as the  
6 subcommittees go back and take a look at the Program  
7 Information Notice, we want as much input and inclusive as  
8 possible, but also recognizing that some of your  
9 colleagues that may be in business to try and apply for  
10 some future HITE funding from the State may be in a  
11 certain risk benefit needs to be reviewed.

12                   Anyway, I think that we're ready. My God,  
13 we did it in an hour.

14                   MR. MASSELI: Where are we on the  
15 appointment of the authority right now?

16                   MS. HOOPER: Well letters are going out to  
17 the legislators, who are going to be putting this together  
18 with a note about make sure to do your appointing.

19                   Some of the legislators have already  
20 contacted us, saying that they would like to either  
21 appoint existing members. Do you want to announce it,  
22 then? We do know that each of the legislators are going  
23 to be approached not only in writing, but, also,  
24 personally from DPH representatives.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   As we've said before, and let's put it on  
2 the record again, if any of you want to serve on the Board  
3 of Directors, please let your appointers know that you are  
4 interested.

5                   If you have someone who you would like to  
6 recommend, please let the appointing authority know that.  
7 We are going to have two additional members, as you all  
8 recall, one being a consumer representative. Right now,  
9 Dr. Dardick is our only consumer representative  
10 officially. I'd like to think that all of us are consumer  
11 representatives actually around the table.

12                   So, with that, I'm sorry, Mark, but we  
13 don't have that. It does have to be named by October 1st  
14 meeting before November 1st. Warren?

15                   MR. WOLLSCHLAGER: Thank you, Meg. I just  
16 had two quick questions regarding next steps. Now I  
17 understand trying to get some specialized expertise for  
18 the Finance Committee, but, at this point, the  
19 subcommittees have put out recommendations or assumptions  
20 that are at the subcommittee level that not necessarily  
21 been adopted in any formal, the issue, for instance, of  
22 the personal record, personal health record.

23                   That's a recommendation of the Finance  
24 Committee. It makes a big difference to the work of a lot

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 of other committees. How do we process those  
2 recommendations?

3 MS. HOOPER: I'm sorry.

4 MR. WOLLSCHLAGER: They're sort of just  
5 sitting out there.

6 MS. HOOPER: No. Thank you. And it is, if  
7 we move on, it is just sitting out there. Are there  
8 committee members -- again, we're providing input to the  
9 full Advisory Committee to the Commissioner. Are there  
10 comments on particularly what the questions that were  
11 raised from the Technical Committee? I think, Mark,  
12 you're open to investigating as this goes forward, but  
13 Financing and Technical are really looking for some  
14 feedback. Comments or questions? Kevin?

15 DR. CARR: No. I think I would just add,  
16 you know, with the Department of Information's guidance,  
17 the one thing that's really, really important for us to do  
18 is to make sure that they understand what's the right  
19 thing for Connecticut, right?

20 MS. HOOPER: Correct. Specifically, to us.

21 DR. CARR: Specifically, to us. So if  
22 there's a service or something that's prioritized or not  
23 prioritized, then, given the stakeholders that we have  
24 here, if Public Health reporting or quality reporting or

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 something else is really important to us and there's a  
2 sustainable business model behind it, then we keep it in.  
3 If not, then we get rid of it.

4 I mean that's one thing that I would just  
5 kind of throw out there, reprioritizing.

6 MS. HOOPER: We appreciate that from the  
7 Department of Public Health.

8 DR. AGRESTA: Reprioritizing and kind of --  
9 I think we have to meet three basic things, and I think  
10 that we're going to discover we're off cycle a little bit.

11 DR. CARR: We have to address them in some  
12 way.

13 MS. HOOPER: One component of each of  
14 those.

15 DR. CARR: Right, so, like lab results  
16 routing, for example. We didn't find anybody that wanted  
17 to pay for that at the State level, and if we could  
18 address it by saying it's one to be handled through some  
19 other channel.

20 MS. HOOPER: And it's being offered  
21 currently through some of the existing Health Information  
22 Exchanges.

23 DR. CARR: Yeah, so, just as long as --  
24 that's my only concern about the PIN, is that we look at

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 it absent any other conversations.

2 MS. HOOPER: Thank you very much. Does  
3 everybody understand? Again, the PIN is identifying where  
4 information notice. It is not a mandate, as to whether we  
5 are risking any future funding. It is trying to say a  
6 consistent measure across all 50 states, as we're supposed  
7 to be interacting with other states and as you travel and  
8 move and all that.

9 And I appreciate very much what Kevin is  
10 also pointing out. It does state that Public Health --  
11 part of physicians' practices hospitals' Public Health not  
12 necessarily, but it's kind of relegating Public Health and  
13 the basis that we kind of lay it as a foundation for our  
14 efforts behind.

15 MR. COURTWAY: This is Peter Courtway.  
16 Just a little point of clarification. The PIN is quite  
17 specific in its definition of should and shall.

18 MS. HOOPER: Correct.

19 MR. COURTWAY: Should is the recommendation  
20 piece. Shall is it will.

21 MS. HOOPER: And it varies throughout, so  
22 that's why we need you to take a look at this very  
23 carefully where those should and shalls are.

24 MR. COURTWAY: And to clarify the point,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 there is a shall in the words that proceed the products  
2 that are to be offered, which include e-prescribing, the  
3 exchange of data, discreet data and the exchange of the --

4 MS. HOOPER: But it says a component of. It  
5 doesn't say a full set by each state.

6 MR. WOLLSCHLAGER: I think it says one  
7 methodology to achieve each of the three.

8 DR. CARR: But there will just be a lot of  
9 confusion, as any document, right? There is currently an  
10 RFI out that's for multiple states that are looking for an  
11 e-prescribing module and routing engine that doesn't  
12 necessarily exist outside of Surescripts right now. And,  
13 so, we just have to make sure that if there is something  
14 that's supported by Surescripts and everybody is already  
15 kind of linked into it, that we don't recreate that, is  
16 one example.

17 Then, also, for other services, that we are  
18 able to prioritize them if we think that they're  
19 important.

20 MS. HOOPER: And this is where the  
21 subcommittees are back at the table again with it. But to  
22 Warren's point prior, so that we could move on, the  
23 recommendations, let's not set aside the PIN, but  
24 recognizing that's going to affect how we move forward in

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 kind some of our context, but, right now, what's come from  
2 the subcommittees has come before this Advisory Committee.

3 We are asking this Advisory Committee to  
4 give either some consensus or support for some of or all  
5 of those recommendations, because we need to include that  
6 in the strategic plan section, so is there opposition or  
7 confusion to any of the subcommittee recommendations to  
8 date? I'm going to go to Tom first, because his hand was  
9 up quick.

10 DR. AGRESTA: Well I think the issue is  
11 maybe not opposition or confusion. I think the issue is  
12 there were -- we've provided them in different kinds of  
13 detail and different kinds of format, with different kinds  
14 of, so they're not standardized, okay?

15 MS. HOOPER: I know. We're not worried.

16 DR. AGRESTA: But it matters. It matters,  
17 because it's hard to even know if somebody else's  
18 recommendations are coherent with yours, or in conflict,  
19 or complimentary to yours, so that's a goal that might  
20 need to be taken on.

21 We've submitted them. Maybe somebody now -  
22 - maybe now it needs to be reviewed and a cross-mapping of  
23 stuff, along with questions about, all right, well, what  
24 do you mean by this, or there's potential overlap or

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 conflict, etcetera, noted in these three areas, so the  
2 subgroups can then go back and kind of address that.

3 MS. HOOPER: Frank, I assume that's  
4 something that you'll be doing.

5 MR. PETRUS: That's just what I was saying  
6 to Alistair. One of the things that we have to do is  
7 harmonize of all that you've brought to us and put it into  
8 the strategic plan and move forward with the operational  
9 plan.

10 When we highlight that there's disharmony,  
11 because, you're right, they're in different formats and  
12 different little wordsmithing that's been presented. For  
13 example, the personal health record, excluding the  
14 personal health record.

15 Well does that mean you're going to exclude  
16 the HIE being able to leverage and use products that are  
17 already out there, Microsoft or Google, others have, using  
18 with appropriate rules and rights of the Health  
19 Information Exchange, or does that mean you don't want  
20 them to be there at all? I'm assuming it's not the  
21 latter. It's just you're not taking responsibility for  
22 creating a separate personal health record from the  
23 products that exist.

24 So we will take all of that information

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 that you've documented, put it into the street, revise the  
2 strategic plan and operational plan, and then highlight  
3 for you where there's disharmony or conflict to say we're  
4 not the decision makers here. Here's what we see as the  
5 conflict or disharmony. We may make a recommendation for  
6 your consideration that you can accept or not, but that's  
7 how we would do that.

8 MR. CARMODY: So what's the timing of that,  
9 only just because I think it is a good input to sort of  
10 like the next leg of.

11 MS. HOOPER: We've asked -- unreasonably  
12 so, but we have asked Gartner to put these kind of  
13 comments and suggestions into the revised draft this week.  
14 Is that still a doable thing, Alistair?

15 MR. MCKINNON: Yes.

16 MS. HOOPER: Yes? See, it's not too  
17 unreasonable.

18 MR. CARMODY: Yes, it is.

19 MS. HOOPER: But it's a 24-hour day,  
20 Alistair. Anyway, we're hoping to see you hopefully a  
21 week from now, let's say, that there will be a revised  
22 draft of that strategic plan. We're also going to forward  
23 it on to Washington to get their input, but, regardless,  
24 as we develop the implementation plan, it's going to drive

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 how some of that actually can come through.

2 Again, your working assumptions are going  
3 to be tested now as we move forward with the  
4 implementation plan. I think that that process is going  
5 to help. Marianne?

6 MS. HORN: Just to clarify, we have a Legal  
7 and Policy Subcommittee meeting tomorrow, and we'll take  
8 the PIN and look at our recommendations and see if we need  
9 to make any changes.

10 In terms of any changes that we might  
11 recommend, what's the deadline in the process for getting  
12 it back to this committee?

13 MS. HOOPER: What would your recommendation  
14 be, Attorney Horn?

15 MS. HORN: Well, I mean, our meeting  
16 schedules are different. We can probably work very  
17 quickly on that, and probably, by the end of the week, we  
18 can have something. I don't know, the other  
19 subcommittees, when they have a scheduled meeting.

20 MR. PETRUS: We have a meeting on the 19th  
21 internally to discuss our and your interpretation.

22 MS. HORN: Okay.

23 MR. PETRUS: I think there was also a call  
24 last week that also provided a little bit more ambiguity.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MS. HORN: So that would be a week from  
2 today?

3 MS. HOOPER: Yes. A week from today, we're  
4 going to be meeting. DPH staff are going to meet with  
5 Gartner to go through, line-by-line, on the Product  
6 Information Notice and determine where there might be some  
7 issues that we need to address together. We would  
8 appreciate your input and your thoughts on the PIN. You  
9 can send information to Warren, as the committee liaison,  
10 who is remarkably not speaking much and at the other end  
11 of the table, but that's his choice. Yes, Lisa?

12 MS. BOYLE: I guess, you know, I'm  
13 struggling a little bit with our committee, you know, did  
14 a fairly, I think, detailed consent model.

15 MS. HOOPER: Very.

16 MS. BOYLE: And then we had the last  
17 meeting, and a lot of people weren't here, and then we had  
18 the public meeting, and I think we had like a handful of  
19 people show up, but yet there's a, and I don't think I'm  
20 telling a tale out of school, there's a blog that has  
21 opposed the model.

22 MR. CARMODY: Really?

23 MS. BOYLE: Yes.

24 MS. HOOPER: They did post our response

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 from the Department of Public Health to Dr. Galvin.

2 MS. BOYLE: So, you know, we've been sort  
3 of going forward. I guess, you know, I haven't heard  
4 anyone really say anything that was really contrary today  
5 to our model, other than I notice the finance piece has,  
6 and it's not contrary to, we just haven't gotten there,  
7 they have as a recommendation the break the glass  
8 functionality, and then there's a recommendation that we  
9 actually require all providers to participate, instead of  
10 having a provider actually opt in.

11 I was going to talk about that tomorrow.  
12 That may have legal complications, you know? In order to  
13 try to get someone, we may have to adopt legislation, but  
14 what I've been just kind of going forward is that, as a  
15 committee, I'm going to poke at our committee a little  
16 bit.

17 Actually, we revisited the model at our  
18 last committee meeting and actually said should we go to a  
19 total opt in? I mean that fundamental a conversation.  
20 And, so far, our committee continues to charge forward.

21 I'm a little, just to be honest, I'm a  
22 little concerned that I want to make sure we have a gauge  
23 of the consumer piece.

24 MS. HOOPER: Okay.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MS. BOYLE: Because I don't want us to keep  
2 going down this road and having all these meetings and  
3 then have it all the sudden us to say that it's not going  
4 to be supported by, you know, the community of Connecticut  
5 at large, and then have everything be kind of, you know,  
6 wasted, all of the effort.

7 MS. HOOPER: Understood. I think that one  
8 of the issues that came up is, and, Dr. Dardick, we're  
9 going to put you on the spot, I'm sorry, was that there  
10 wasn't enough consumer input. There were other efforts  
11 that looked at consent models throughout the state.

12 Again, that's just one example. I'm  
13 surprised that we haven't actually heard from some of the  
14 other disagreements with how either this process or some  
15 of our output might be.

16 From the strategic plan comments that we've  
17 solicited from everybody, there is no negative nor request  
18 for clarification. I believe that you got approval from  
19 this, or not approval, support from this Advisory  
20 Committee to move forward with the consent option, as you  
21 presented to us, which is what you did at the leadership  
22 forum, I mean at the public forum.

23 There was a comment that there wasn't  
24 enough public consumer input. Unfortunately, again,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 there's only one assigned consumer representative here,  
2 but, as I said earlier, I would assume that all of us are  
3 representing not only ourselves, but our constituency.

4 Dr. Dardick, did you have any comments on  
5 the consent model that you needed to make clear that  
6 perhaps we didn't hear?

7 DR. KENNETH DARDICK: No. As a member of  
8 the Legal and Policy Committee, I certainly participated  
9 in that.

10 MS. HOOPER: Yes, you did, sir, and we did  
11 make note of that. Kevin and Tom, you had a question?

12 DR. CARR: I would just add that --

13 MS. HOOPER: You know, we were on time. I  
14 blew it.

15 DR. CARR: One thing that really worked  
16 well when e-Health Connecticut was developing its policy  
17 was to partner with the ERB(phonetic) and the Connecticut  
18 Health Policy Project to do a joint consumer event, and  
19 that might be one way to bring in those that we, as this  
20 committee, don't necessarily have direct access to,  
21 because they have e-mail alerts that they can send out  
22 through their existing channels, and a lot of the consumer  
23 advocacy groups trust those two groups, and, so, it  
24 automatically, if they do feel that they're on the same

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 page as you are, you'd have that, you know, sit down with  
2 them, and they'll create an event, a communication event,  
3 and, if there are differences, you kind of hammer those  
4 out prior to the event, and if they're on the same page,  
5 they communicate it.

6 MR. PETRUS: That's a very good point, and  
7 what other states have found is very successful in  
8 partnering with their RECs. In fact, that's the number  
9 one leadership role that a lot of the RECs have taken, is  
10 really around consumer awareness, so you really don't get  
11 into the myths about how this is going to infringe on the  
12 sanctity of your personal health records, because it  
13 doesn't.

14 You have a lot of responsibilities and  
15 rights that go along with that. That's part of education,  
16 which, with the timelines you all have had, you haven't  
17 had much time in the public to do education. You've been  
18 providing the information out there without the context of  
19 them being aware, really have any chance to understand, so  
20 they can meaningfully participate, so a lot of the  
21 participation you get is realistic fears about how will  
22 their rights be protected.

23 MS. HOOPER: Correct.

24 MR. PETRUS: You have all that awareness

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 and understanding stuff that needs to be done, and I think  
2 partnering with the RECs at some of those leadership  
3 groups --

4 MS. HOOPER: Well, to answer your question,  
5 because I do want to move on, that, in fact, the Advisory  
6 Committee appreciates what the subcommittee is doing. The  
7 Department is listening to all the advice and/or support  
8 from the Advisory Committee. You are not wasting time.  
9 The experts around this table have said that they support  
10 that consent option.

11 How it's going to be finalized, we'll go  
12 through a number of public forums. That was the purpose  
13 for that forum, was to draw comments that we didn't  
14 receive. We don't take offense at all at negative  
15 comments, but I think that your issue and your question  
16 was are we getting enough input?

17 Those public forums are one way that we are  
18 continuing to do that and have Dr. Dardick's excellent  
19 representation. Remember that the new Board is also going  
20 to have two dedicated consumer reps, but, again, if we all  
21 aren't representing ourselves and our constituencies,  
22 which include all consumers, which are patients, doctors,  
23 hospitals, then we ought to re-think how we're moving  
24 forward.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 DR. AGRESTA: It's interesting, because  
2 there's already a suit in Rhode Island.

3 MS. HOOPER: Is there?

4 DR. AGRESTA: Yeah. The ACLU, so maybe you  
5 ought to think about the ACLU as a -- what happened in  
6 Rhode Island.

7 MS. BOYLE: The Rhode Island case, right?

8 MS. HOOPER: Yeah.

9 DR. AGRESTA: In Rhode Island, there's a  
10 suit against their HIE already this last week. (Multiple  
11 conversations). Nonetheless, it probably is a key issue.

12 I think the other thing to kind of be  
13 cognizant of is the other group of stakeholders that you  
14 need to get to is really getting into the practitioner's  
15 office and seeing the functional capacity of the software  
16 systems and the people involved to actually carry out that  
17 consent process, and that's the concern I raised, is  
18 whether that's really functionally capable of occurring.

19 Even if you set it up as a consent model,  
20 can it actually occur, because of the way that people  
21 store data, etcetera. And I know you've had some  
22 discussions about that, but I think that probably needs to  
23 be bubble tested.

24 MS. HOOPER: And I think that's where we're

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 going to go with this. We've set some strategies, some  
2 goals, some of those high-level working assumptions to  
3 move forward, so let's take that where we are going on the  
4 actual implementation plan. We may have to backtrack or  
5 re-determine some of our strategies.

6 CHAIRMAN GALVIN: But let me just interrupt  
7 you to say, you know, the public forum people don't go to.  
8 We're relocating our medical lab from where it is on  
9 Clinton Street to Rocky Hill. We had two public forums in  
10 Rocky Hill. Nobody, not one person, showed up at either  
11 of them.

12 When it came time to get the last of the  
13 bonding money, some concerned citizens that didn't know  
14 anything about this, somebody was putting a lab in their  
15 town, they were going to have Marburg viruses and all  
16 kinds of terrible things that were going to come boiling  
17 out of the lab and kill all the Veterans and all of the  
18 citizens.

19 And the State rep. and the State senator  
20 involved basically got it knocked off the bonding agenda,  
21 because there was such an outpour of I didn't know about  
22 this, you're not telling me, so the things, where you put  
23 it in the Connecticut Law Journal, nobody goes to those.

24 DR. CARR: And that's the reason I think

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 that partnering with those that have a way to draw in  
2 consumers that really can draw them in, that's what you've  
3 got to do.

4 MS. HOOPER: And that's what we're going to  
5 do with the three ONC efforts. Deputy CIO Bailey, thank  
6 you very much. There is ice cold water available to our  
7 team, and coffee will be coming at 2:30, so if you like a  
8 little hot and cold.

9 Frank, don't forget that people will need a  
10 break, but you all know where the ladies and men's rooms  
11 are. Please use the appropriate one.

12 MR. PETRUS: You want to take a quick break  
13 now?

14 MS. HOOPER: Would you like to, Frank?

15 MR. PETRUS: Why don't we take a quick  
16 break now?

17 MS. HOOPER: Why don't we take a quick  
18 seven-minute break?

19 MR. PETRUS: That sounds perfect.

20 MS. HOOPER: Please come back, so that we  
21 can actually get into the operational planning. Don't  
22 leave. The best part is yet to come, or we're going to  
23 make decisions without you. Let's put it that way.

24 (Off the record)

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: We really want to go through  
2 the rigor and the context at a high level of how we're  
3 approaching the operational plan built off of the  
4 strategic plan.

5 Today's discussion is really going to focus  
6 on -- in spite of what you think, we haven't already  
7 written the operational plan. It's in the safe, and we'll  
8 bring it out.

9 We have an approach to the operational  
10 plan. We're starting to put pieces to the operational  
11 plan together, based upon the strategic plan, and, so, we  
12 really want to talk about how we have structured this, the  
13 assumptions, the key components, the discipline process  
14 that's in place.

15 We want to talk to you about the approach  
16 and the assumption and get your input. Are we missing  
17 anything regarding the assumptions for developing the  
18 different components of the plan?

19 We are also going to take a look at what we  
20 see at each of the five domains, going forward with the  
21 operational plan, what we think are the high-risk areas  
22 that we need to have a discussion around. How do we put  
23 in the right actions, the key activities to mitigate these  
24 risks?

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   At the end of the day, what we're trying to  
2 say to ONC is that the State of Connecticut has  
3 demonstrated significant thought, rigor and discipline in  
4 putting an operational plan together that's aligned with  
5 the guidelines that have been promulgated by ONC,  
6 including the PIN that came out July 6th, considering that  
7 four other states have already gone forward with their  
8 cooperative agreement before the PIN, so that's  
9 interesting structure, and who knows what PIN will come  
10 out before we submit this. We really want to say --

11                   MS. HOOPER: -- positive support there.

12                   MR. PETRUS: I'm sorry.

13                   MS. HOOPER: It's okay.

14                   MR. PETRUS: It might provide more clarity,  
15 understanding that what you need to be doing with ONC is  
16 giving them confidence that you've really walked around  
17 this elephant and you have come up with a reasonable  
18 discipline plan that you're going to modify as you go  
19 forward.

20                   I think the one thing, as we walk through  
21 this, is to understand that this is a cooperative  
22 agreement, and at each key milestone, you renegotiate with  
23 ONC what you're going to be doing, and you will be  
24 changing this plan.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   You also will be moving forward with the  
2 plan, and you will have lessons learned, opportunities  
3 that will pop up, barriers that you didn't anticipate,  
4 changes in administration on the Federal or State level  
5 that will have an impact, and, so, we're not looking to  
6 say the operational plan that you submit will be the final  
7 plan for the full life of this project. It is the  
8 operational plan that provides a foundation to go forward  
9 with the release of the dollars that you have a right to  
10 to move forward with the HIE.

11                   What we want to talk about today, this is  
12 the foundational framework that we're using to build your  
13 plan. Is it rigorous enough? Is it discipline enough?  
14 Does it make sense to you? Are the assumptions correct?  
15 Are there any gaps? And then let's take a look at some  
16 risk, so that we could hear from you how you want to  
17 mitigate those risks, so they can be captured in the  
18 operational plan. Does that make sense?

19                   MS. HOOPER: Um-hum. I'm sorry. Does it  
20 make sense? I mean are we in agreement that we need to  
21 move forward? We're not going to let the PIN or anything  
22 else restrict us right now. We need to see what fits for  
23 Connecticut.

24                   MR. PETRUS: Okay. Rules of the road are

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 the same rules that we've always had. Let's not spend  
2 time on wordsmithing. Let's keep focused on what we need  
3 to be doing. If there are things that we can't resolve  
4 today, we're going to punt them, and we'll work them  
5 through, so that we can resolve them and address the  
6 questions that you have.

7 Where we are today, if you go back to that  
8 picture, because that's a really good place to be, we are  
9 at the end of this site. I think that's a lot of work,  
10 and you all should be very proud of the work and the rigor  
11 that you've put into this, and we're into the 13th to the  
12 15th week for the strategic planning process.

13 This is the methodology that we use,  
14 building up and starting with making sure that we were  
15 Connecticut-specific regarding the domains, and even some  
16 of the conversations that you had today were how will this  
17 work in Connecticut? What are some of the challenges in  
18 Connecticut, which is really important regarding the  
19 domains that ONC has set out.

20 I want to stop here, because Meg said it  
21 earlier, and I think it's important for us to keep our eye  
22 on this now that ONC has said they want the strategic and  
23 operational plan together.

24 What we're looking at is that the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 operational finalized plan needs to be going in, and the  
2 final working session we're looking at is August 6th.

3 MS. HOOPER: That's just two weeks away.

4 MR. PETRUS: And we are now at July 12th.

5 MS. HOOPER: Okay. What was I thinking?  
6 Plenty of time. Dan, plenty of time to get that analysis  
7 done.

8 MR. PETRUS: Right, and outside of Bastille  
9 Day, no holiday.

10 DR. CARR: It's all your fault, Dan.

11 MR. PETRUS: So we're set. Then we move on  
12 to the comprehensive operational plan, which is August  
13 13th, so lock down the strategic plan on the 6th. Lock  
14 down the operational plan on the 13th.

15 Let's look at the assumptions for the  
16 operational plan. We've got a very Project Management  
17 Institute, PMI, project management professional approach  
18 to this. We did a hierarchical decomposition of the work  
19 breakdown structure. We went from the parent, to the  
20 child, to the grandchild, to the great-grandchild of each  
21 one of the tasks and identifying where we saw that there  
22 was real critical dependencies and identified those  
23 interdependency and gave rough estimates of duration.

24 And I would like to underline, stroke in

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 gold the rough estimates. When we look at that from  
2 Gartner's perspective, we do research in this area. We  
3 have the largest global benchmarking database around IT  
4 development.

5 They're rough estimates, but they're rough  
6 estimates based upon some reality out there in the  
7 industry, but, also, this isn't the industry. This is the  
8 State of Connecticut, going through election period, and  
9 the Office of National Coordinator with PINs coming out  
10 very late in the process.

11 And we created a Charter around this, and  
12 we will flesh out the narrative around that. That's our  
13 approach. Any thoughts about the approach? You'll get  
14 more details in a minute.

15 MS. HOOPER: We're good.

16 MR. PETRUS: Assumptions, big assumption.  
17 Talk about the elephant in the middle of the room if we  
18 were doing a therapy session. Big assumption.

19 The work so far, the strategic plan work  
20 and the work that we have put in up to July 6th on the  
21 strategic and operational plan does not include achieving  
22 the capabilities in 2011 that were identified in the July  
23 6th ONC PIN, and that is the sharing of structured  
24 information, lab findings, etcetera, e-prescribing and

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 what we would call in Connecticut a continuity care  
2 document for eligible providers, and eligible providers in  
3 the ONC language is physicians and midwife and nurses,  
4 physician assistants and dentists.

5 And then, when you think about some of the  
6 things they're looking at, I'm not sure that dentists  
7 would need all of that, but there's question about that.

8 We need to work with you all as we go  
9 forward in harmonizing the strategic plan and moving  
10 forward with the operational plan to really get more  
11 guidance from ONC, and we have a meeting on the 19th to  
12 really go through every word, all the definitions in that  
13 PIN, because what's confusing to us at Gartner that have  
14 worked with other states around this, who their strategic  
15 plans have already been approved, they have drawn down  
16 more money. Their operational plan had been approved.

17 And, in those days, which was like three  
18 months ago, the emphasis wasn't on these three things.  
19 The emphasis was on regional exchange and the nationwide  
20 health information network to make sure you were spending  
21 your money for those books.

22 Three months later, now they're looking for  
23 the incentive dollars for the adoption of EHR. I'm not  
24 saying it's wrong, but there's been a little change there,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 and the question that we have to raise, and we'll talk  
2 more about this as we move forward with you, what do they  
3 mean by that component of each, and are they looking for  
4 the investments of dollars, so by the end of 2011 there is  
5 significant progress going forward with the appropriate  
6 components, or a hybrid model, where some of that sharing  
7 is already happening, as it does happen in DSS right now  
8 with e-prescribing in the Medicaid.

9                   What are they looking for? What would be  
10 enough for them to bless your operational plan and let  
11 those dollars start flowing? As we move forward, we  
12 really have to think about what do we accelerate in the  
13 strategic plan and in the operational plan to provide them  
14 that level of confidence?

15                   The operational plan is focusing on the  
16 planning and budget purposes that discipline around  
17 realistic plan, and, later, Jeff is going to talk to you  
18 about how we started to look at the framework for making  
19 estimates around budget for the HIE that we will need to  
20 work with you to finalize as projections moving forward  
21 both on the cost side and on the revenue side.

22                   MS. HOOPER: This is where PIN looks for 33  
23 million a year for 24 staff. We got seven million out of  
24 the cooperative agreement.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: Yeah, and that's something  
2 that there was a call last week with ONC, and they  
3 actually said there's not enough money for you to do  
4 everything we're asking you to do, so that makes me feel -  
5 -

6 MS. HOOPER: -- priority for Connecticut.

7 MR. PETRUS: What they want is how we use  
8 the money that we give you to move to fulfill these three  
9 capabilities.

10 MS. HOOPER: Correct.

11 MR. PETRUS: And, in the past, three months  
12 ago, they said how are you going to use the ONC money to  
13 demonstrate your ability to connect with other states in  
14 the Nationwide Health Information Network. Now they're  
15 saying how are you going to use that money to do this, I  
16 think is what's going on, but I could be wrong.

17 MS. HOOPER: Oh, no, that would be better.

18 MR. PETRUS: Well I'm not God, but we'll  
19 see. The last bullet is the most important one. This is  
20 how you move forward to get the approval to draw down the  
21 dollars, remembering that this is a cooperative agreement,  
22 and, as you learn things and as ONC learns things, that  
23 this strategic operational plan will change.

24 And ONC is new at this, as well, so they're

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 doing some ready, fire, aim, and they are overwhelmed, so  
2 I really counsel that you think about putting in a  
3 rigorous discipline operational plan, understanding it's  
4 going to change, and I probably will say this three or  
5 four times as we go through.

6 MS. HOOPER: That's fair.

7 MR. PETRUS: Anything else about the  
8 approach or assumptions for the operational plan?

9 MR. COURTWAY: Do you believe that the PIN  
10 replaces the other components of attaching to the NHIN?

11 MR. PETRUS: Oh, I think they want it all.  
12 If you look at their guidance, you have, ultimately, if  
13 you look at their business case, you know, connecting to  
14 the NHIN is still a priority. The other key priority is  
15 that you're supporting your Public Health agenda.

16 The other key priority is you're supporting  
17 your Medicaid agenda, so there are many priorities that  
18 they'll want to see in your operational plan and vision  
19 and direction that they want to see in your strategic plan  
20 that you're talking about those, but now, with this new  
21 PIN, I think they want to see their dollars invested in  
22 the meaningful use capabilities.

23 MR. COURTWAY: Since the PIN is coming out  
24 from the ONC, does that mean that when they just loosely

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 use the e-prescribing word, that they're talking about the  
2 meaningful use definition of e-prescribing in each of  
3 these?

4 MR. PETRUS: That would be my  
5 interpretation.

6 MS. HOOPER: We don't know a lot of those  
7 details yet, which will drive how we're doing this.

8 MR. PETRUS: That would be Frank Petrus'  
9 interpretation, because they really have put this around  
10 the term meaningful use.

11 MR. MCKINNON: Also, when they talk about  
12 eligible providers they actually mean as qualified by the  
13 meaningful use rules, which is not everybody else's  
14 definition of what would be an eligible provider.

15 MS. HOOPER: As you all raise these  
16 questions, we will be working with ONC to get  
17 clarification on them.

18 COURT REPORTER: One second.

19 MR. PETRUS: I think that the key words are  
20 meaningful use and eligible providers, which says to me  
21 this is around Medicaid/Medicare.

22 Stage one of meaningful use, which will be  
23 released at 10:30 tomorrow morning, released from the ONC  
24 press release that came out, and it's these three

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 capabilities.

2 In your current strategic plan draft, we  
3 place emphasis based upon your input on leveraging  
4 commercially available services, and when you think about  
5 the concept of e-prescribing, it would already exist out  
6 there, these services are available now, and achieving  
7 that component probably could happen by the end of 2011,  
8 considering your Board is going to kick off January 2011.  
9 They get their structure, their bylaws, the CEO and all  
10 those things in place, do the procurement process,  
11 etcetera. I think you can see that.

12 Currently, due to the lack of common  
13 approaches across all of those auxiliary services that  
14 provide structured information, labs, etcetera, we did not  
15 see this from your input coming into a phase two or  
16 release two, which would not be in 2011, so this would  
17 have to be accelerated.

18 If we look at the other compliance  
19 regarding the continuity of care, or patient care summary,  
20 as ONC talks about it, it could be accelerated, but, as it  
21 is now in the high-level plan, we're looking at 2012.

22 MS. HOOPER: Right. Good. We can't  
23 accelerate that. I'm sorry. Does anybody here have a way  
24 that we could accelerate that before 2012? Okay.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: And that's why we need further  
2 guidance for ONC to make sure we are understanding what  
3 they're saying here and what they want to see with the  
4 investment of their dollars around these three  
5 capabilities in 2011.

6 Any thoughts and ideas that you all have? I  
7 know that Legal and Policy is going to be looking at this.  
8 We're going to be meeting on it next week, Monday. We  
9 will be going back to Molly, who is the program associate  
10 for you all with ONC, to get further clarification.

11 I also would counsel that you reach out to  
12 some of your peers, other states that are in this  
13 position, and how are they approaching this, you know, if  
14 they found some kind of magic formula.

15 MS. HOOPER: Can I just remind everyone  
16 this is really -- we very much appreciate that Frank is  
17 presenting this to us, but this is where they're also  
18 looking for some feedback, so if you have any concerns  
19 right off, although I respect that you'll probably address  
20 some of our issues later on in the presentation, but, Tom,  
21 I can see you itching.

22 DR. AGRESTA: Well I was just wondering,  
23 you know, I mean as you get clarification from them, the  
24 issue around providing sort of statewide services for

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 certain things versus access to a service that, you know,  
2 might actually be available by somebody else, there are a  
3 number of ways to get statewide services available.

4 I'm not sure that it's not achievable for  
5 the types of things they're talking about. I remember now  
6 that the rules, meaningful use rules, as interpreted by  
7 the eligible provider side, is that they're only required  
8 to kind of meet those things if the local, or regional, or  
9 state has the capacity to deliver that.

10 We can't control for whether one hospital  
11 can produce its labs in a format that is standardized, but  
12 you might well be able to control for having the standards  
13 defined and having those things there and for some places  
14 up and running, and, therefore, you know, you meet the  
15 criteria, and the individual provider is still able to get  
16 their dollars, because their local place is not ready to  
17 do it, but we've documented that for them.

18 MS. HOOPER: Correct.

19 DR. AGRESTA: So I don't know that they're  
20 incompatible.

21 MR. COURTWAY: There was a letter sent in  
22 from the Hospital Association on behalf of the hospitals  
23 that was we were concerned that the transfer of detail,  
24 discreet lab data in phase two was too late. There was a

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 concern on the quality and data reporting side and the  
2 CHA, you know, one of the Board subcommittees, that they  
3 wanted to get into e-prescribing, so I think that, with  
4 the PIN, it's actually in alignment with where the  
5 hospitals would like to -- I think we'll get a tremendous  
6 amount of support from the hospitals on the linkage.

7           Having said that, I will tell you that not  
8 many hospitals are prepared, not only themselves nor their  
9 vendors, and that, specifically, is a lot around the CCD  
10 aspects that everybody seems to be struggling with.

11           MS. HOOPER: And that's also for the  
12 private practices, also.

13           DR. AGRESTA: The providers will have to  
14 demonstrate or the hospitals will demonstrate in this  
15 first round that they have the capacity to receive and  
16 send, not that they are actually doing it, and I think  
17 that, you know, you may, as an HIE, be looking at, you  
18 know, creating capacity as a conduit, as opposed to  
19 capacity of the --

20           MS. HOOPER: -- part of our evaluation, is  
21 what are we actually measuring here, capacity, capability,  
22 or actual implementation?

23           DR. AGRESTA: Right, and I think tomorrow  
24 you're going to have a whole lot more clarity.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: I think the difference between  
2 capabilities and capacity, if I was ONC, I'd say to you  
3 where are you investing your dollars currently?

4 MS. HOOPER: Correct.

5 DR. AGRESTA: Right.

6 MR. PETRUS: To leverage that existing  
7 capacity that will lead some day to the HIE having the  
8 capabilities, because if you're just, you know, depending  
9 on the kindness of strangers, the question is how do you  
10 invest those dollars to make that happen, I think is got  
11 to be part of your thinking.

12 MS. HOOPER: That, actually, should be part  
13 of the implementation plan.

14 MR. PETRUS: Now this is the roadmap from  
15 the strategic plan, and you've got it in front of you, as  
16 well, and I just want to talk to this a little bit,  
17 because, right now, the work breakdown structure that we  
18 have developed at the high level before the July 6th pit  
19 was really built around what you had identified through  
20 your subcommittees regarding different releases that were  
21 tied to policy, was tied to technical, business and  
22 technical operation and finance.

23 So kickoff in the, again, we use state --  
24 there's a calendar in the yellow, and then state fiscal

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 years in the manila color, basically kickoff the HITE  
2 board. All the legal preemption enforcement mechanism  
3 consent model, the bylaws for the Board of Directors, all  
4 of the setting the stuff up begins in January 2011.

5 Core team establishment and on boarding  
6 coming in in Q-3 in fiscal year '10/'11, business  
7 strategy, product portfolio development in the same time  
8 period, and the value of proposition finalization and  
9 financial sustainability plan. That's what I was talking  
10 about a little bit earlier.

11 What do you need to do now to look at the  
12 options for the financial stability plan, and then what  
13 pieces would you be doing here to really dive down to  
14 build that and create that into a reality?

15 Education and Outreach Services begins soon  
16 after the Board has established itself. Right at the  
17 beginning, you begin the enterprise architecture  
18 development, based upon what's coming out of the strategic  
19 plan.

20 You do the detailed functional technical  
21 performance requirements, the specification document, you  
22 develop your procurement strategy, and we're envisioning,  
23 from what we heard from you, in quarter four of 2010/2011  
24 fiscal year in the middle of 2011 the RFI and RFP

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 developing an associate award.

2 The vendor comes on and begins in Q-1 of  
3 the fiscal year 2011/2012 the DDI process, with deployment  
4 and rollout happening somewhere around Q-3 of 2011/2012.  
5 User education and training going on, release two or phase  
6 two, coming in at the beginning of 2012, Q-3 of 2011/12.  
7 Phase three, as you can see, comes in at about 2013, the  
8 beginning of that year, and then, throughout the HR  
9 adoption readiness support, HIE education and outreach.

10 This was the vision before the PIN, and you  
11 see that the continuity of care, e-prescribing and  
12 structured information and sharing was really looking and  
13 release two and three.

14 So are we on the same page at how we were  
15 thinking about this, and, obviously, some restructuring is  
16 going to be needed in some areas and other areas. As Meg  
17 said and you confirmed, it may not be possible to have it  
18 all by 2011.

19 MS. HOOPER: Correct.

20 MR. PETRUS: Let's look at the work  
21 breakdown structure, and I want to spend some time here.  
22 We'll go into the parent. These are the parents. We'll  
23 go into children and grandchildren and great-grandchildren  
24 in a second, but how we structured this was planning, HIE

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 (coughing) development and funds acquisition, one, two and  
2 three, and interdependent.

3 You've got to have planning in place, the  
4 authority and the infrastructure for the authority, the  
5 funds acquisition moving forward, then we go to 4.0, the  
6 solution architecture. You have to have that in place  
7 before you can go with your procurement strategy, your  
8 procurement process to bring on the contractor at task  
9 5.0.

10 Standards adoption and setting comes out of  
11 the architecture parallel with your procurement process,  
12 because you have to be setting some standards and  
13 direction and specifications for your vendor.

14 The HIE standup in 7.0, after contractor on  
15 board, standards in place, and once the infrastructure is  
16 set up, you go to release one, continuity of care  
17 document, public health reporting, release two, quality  
18 reporting, release three, integration and personal health  
19 records, capabilities, all of it driven by the solution,  
20 architecture and the standards that have been adopted, and  
21 then customer service for ongoing support, enhancements,  
22 modifications.

23 MR. CARMODY: So the, and I know, again, we  
24 talked about this before, so the personal health record,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 again, was that us offering it, or offering up the  
2 capability that somebody could provide a personal health  
3 record?

4 MR. PETRUS: The latter.

5 MR. CARMODY: So that somebody could come  
6 in using the HIE as a base to say I'm going to deliver.  
7 And do we think that, or at least is your --

8 MR. PETRUS: -- yeah.

9 DR. CARR: Because we use a different term,  
10 I think. It wasn't personal health record. It's like  
11 enablement.

12 MR. PETRUS: Good point.

13 MR. CARMODY: So it's enabling. And the  
14 other question would be is there anything that  
15 precludes us from doing this in parallel with one another.

16 Again, if we had the infrastructure in place, if we were  
17 doing the continuity of care document, the public health  
18 reporting and that infrastructure was PHR related, that  
19 you can enable those PHRs sooner, rather than later.

20 MR. PETRUS: Yeah. As you can see, there  
21 are overlaps in the phases.

22 MR. CARMODY: Okay.

23 MR. PETRUS: So there could be parallel  
24 development, and then you could move pieces of these

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 milestones.

2 MR. MCKINNON: Well there's a complexity  
3 thing as well. There's an assumption that I would make, is  
4 that in each of these different releases, you actually  
5 talked about many multiple phases happening and I feel in  
6 a parallel utility -- because you try to roll this out to  
7 a lot of constituents. It's not like you're going to set  
8 up a (indiscernible) and only provide it to a small number  
9 -- they are trying to get this out to a critical mass  
10 really fast, so trying to parallel these things more is  
11 going to be complicated.

12 MR. CARMODY: Well Peter is really good, so  
13 I'm sure he'll be able to structure this thing, such that  
14 he can enable that. That was the thing that we sort of  
15 were going back and forth. Again, part of this is to get  
16 the funding perspective to try to get it, so that if you  
17 want to pick your PHR vendor of choice, whoever that may  
18 be, if we had the right infrastructure, you could say to  
19 them look at the infrastructure set, here's the (multiple  
20 voices).

21 MR. MCKINNON: So you think services --

22 MR. CARMODY: Yeah. Again, this is all  
23 contingent upon the individual enabling, saying I want to  
24 do this, but if you can do it in a way that says, you

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 know, here's my service model, here's my API, that you're  
2 going to come in and you can draw from it, I'll give you  
3 the schematic, then if you were able to forecast or  
4 foreshadow that ahead of time, to let people know that  
5 that's what you're going to be enabling, then those  
6 organizations who could hopefully come in and say, yes, we  
7 want to use your services could start building ahead of  
8 time, realizing that, you know -- that was the thought  
9 process.

10 DR. AGRESTA: So that's going to run in  
11 parallel to what's going to happen with the vendor  
12 community working on EHRs. They're going to have to be  
13 certified to meet meaningful use, so the question really  
14 becomes where is the right place to put that service?

15 And I think we're going to find, and I  
16 don't think any of us have any answers to that yet, and  
17 that's probably why it's sort of out there a little way,  
18 maybe step two, step three, probably more in the --  
19 (multiple conversations).

20 MS. BOYLE: Can we --

21 MR. PETRUS: Also, in the specifications  
22 you start developing, the enterprise architecture and the  
23 functional implementation and performance specs you really  
24 have to have that upfront.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 DR. AGRESTA: Yeah.

2 MR. PETRUS: And there are issues and  
3 concerns that you have for parallel functional  
4 development, which we have some of, roll out challenges of  
5 multiple capabilities or existing products that you wanted  
6 to leverage and enable, so that you can sell space to  
7 them, we would have to know about, because that would  
8 really go into the thinking and the planning for the  
9 architecture and the functional technical requirements.

10 DR. AGRESTA: But it also is going to  
11 happen at the same time in parallel, and the question of  
12 2013's meaningful use criteria may really drive it such  
13 that it comes out of EMR products, and the HIE is going to  
14 be, you know, so I'd be very careful.

15 I think we're going to get a lot more  
16 guidance perhaps in the next day or so about where things  
17 are sort of tending to go.

18 MS. HOOPER: So are we going to be the  
19 facilitator or the creator? Is that kind of where we're  
20 leaning, is one or the other?

21 DR. AGRESTA: I think you'd probably need  
22 to get -- I mean this is one of those scenarios. There's  
23 quite a bit of difference between sort of everybody's  
24 definition of our personal health record, and all those

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 kind of things is how it's used, etcetera, so this is one  
2 of those areas where there's still a lot of ambiguity.

3 At least in EMRs, there's less ambiguity,  
4 although there's movement towards more ambiguity now with  
5 service oriented architecture.

6 MS. HOOPER: One of the responsibilities of  
7 the new high-tech and of the DPH right now is  
8 RIO(phonetic), is to set those standards for Connecticut  
9 at a level that Connecticut can reach, so do we let the  
10 ambiguity remain here, but we take the bull by the horns  
11 and actually make something in January that sticks?

12 DR. AGRESTA: Well this is where, you know,  
13 you probably want to collaborate very heavily with what's  
14 happening at the Regional Extension Center.

15 MS. HOOPER: Absolutely.

16 DR. AGRESTA: Their model is, at the  
17 moment, is sort of more to create a window, where products  
18 are vetted and carefully reviewed, and permit, you know,  
19 the customer to sort of go to that window and see what's  
20 there, then kind of directly get the services.

21 MS. HOOPER: If they all meet the minimum  
22 standard set by the RIO, then we wouldn't have an issue,  
23 and I don't know that we would.

24 MR. GORDON: Just a brief comment, that

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 it's likely that the services that you can offer will be  
2 dictated by practically what people are going to want to  
3 adopt. EMR is going to be the place that the data will  
4 get generated for the personal health records. Until EMR  
5 adoption, personal health records aren't going to really  
6 take off, and EMR is going to be dependent on being able  
7 to feed them the lab data, so it may be that that's the  
8 kind of rollout of different kinds of things that will  
9 happen in order to be able to get the services that you  
10 want in place.

11 MR. COURTWAY: I think, from a personal  
12 health record point of view, even as my hospital had on as  
13 a hospital provider, you know, we have steered away from  
14 offering a personal health record, but know that we have  
15 to provide transport to in a standardized fashion for  
16 discreet data by 2000 and X, and I think that the reason  
17 why we took that approach is that there are so many other  
18 competing providers of it, whether or not it's the  
19 insurance carrier, who is trying to do medical management  
20 of the patient population and would like to have that in  
21 there, whether or not it's, you know, just general Google,  
22 or general Microsoft, or a DHR that's in a physician  
23 practice.

24 I think that it's probably a more trusted

HEARING RE: DOIT/HITE  
JULY 12, 2010

1       entity for a person in the community to get it from than a  
2       state entity, but we do have to provide the capabilities  
3       at the state level to be able to provide some level of  
4       exchange of that, but the practical reality of it is, the  
5       moment you make a decision not to offer a personal health  
6       record as part of the exchange, it simplifies a tremendous  
7       amount of it.

8                   MR. CARMODY: There is an X-12 standard for  
9       PHR interoperability, so, I mean, you have a, I mean, it's  
10      pretty extensive. It's laid out there. It says this is  
11      what is the PHR. (Multiple conversations)

12                   MS. HOOPER: Frank, move us all along.

13                   MR. PETRUS: Okay. Any thoughts, other  
14      thoughts, about staging and the check of the process that  
15      we have in place now, pending further clarification on the  
16      PIN?

17                   MS. HOOPER: Right.

18                   MR. PETRUS: And, right now, we're looking  
19      release one is the continuity of care document and public  
20      health reporting, quality reporting and more functionality  
21      tied to the EHR, EMR, and then last would be the  
22      enablement for personal health records.

23                   MS. HOOPER: Okay.

24                   MR. PETRUS: I'm going to go quickly

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 through the individual breakdown of the parent and child,  
2 grandchild and great-grandchild of the work breakdown  
3 structure. You have this as a takeaway.

4 As we always have done in these workshops,  
5 any comments, any thoughts about how the work breakdown  
6 structure had been put together, or any major gaps that  
7 you see and are thinking about how to plan moving forward  
8 with this, understanding that the PIN is going to have  
9 some impact on the sequencing, and, also, once it's  
10 approved by ONC, there will be changes.

11 So the first we're looking at is the  
12 planning phase, and the planning phase is to, as you kick  
13 anything off, you would go back and revise, based upon the  
14 cooperative agreement, the approval of ONC, where they're  
15 going to give you comments of things that they'll want you  
16 to change, so we built that in, finalizing the value of  
17 proposition to support the market analysis, the employment  
18 planning, and business development and the market and  
19 communication and all the marketing campaigns that are  
20 necessary.

21 The second piece is, in parallel, is the  
22 HITE Connecticut Authority Development, the governance  
23 structure, and this is the establishment of the Board,  
24 which would include the development of the bylaws for the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Board, the operating structure, consistent with the  
2 legislation that has been approved, and mechanisms for  
3 stakeholder input, how the organization will be managed,  
4 and how the organization will coordinate with the  
5 Department of Public Health, the Department of Social  
6 Services, the Regional Extension Center, the Medicaid  
7 Health Information Technology Incentive Program.

8 MS. HOOPER: Yeah. We're hoping that we  
9 can come to you with some recommendations on that for how,  
10 as the Advisory Committee, you're going to help establish  
11 what the Board is going to do, so a little tricky.

12 The Board will then have the right to say  
13 on November 1st, no, we're going to do this instead.

14 MR. PETRUS: Staff acquisition, the Board  
15 will have the responsibility to identify with the core  
16 team, based upon what's in the, obviously, the operational  
17 plan as recommendation, and we have a straw person  
18 organizational chart to share with you.

19 MS. HOOPER: Correct.

20 MR. PETRUS: The skill sets that will be  
21 required, the recruitment and selection, and how do you do  
22 this? What part is actual staff that are assigned to the  
23 authority? What is staff augmentation, or vendor or  
24 consultant staff and/or state staff that will be used?

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   Continuing with the authority development  
2                   will be all the reporting requirements, the measurement  
3                   metric capacity of the organization to meet all of the  
4                   requirements that ONC has, that ARRA has, and that you  
5                   have to each other, as you've identified, measures with  
6                   UConn necessary to make sure that you are meaningfully  
7                   yourself moving forward.

8                   DR. AGRESTA: There is one stakeholder that  
9                   is ONC-funded that would probably be difficult put in  
10                  there, and we need to explicitly reach out and get engaged  
11                  and cognizant of it, is the Capital Community College,  
12                  based on funding for workforce development around HMT.

13                  MS. HOOPER: And the training, waiting on  
14                  the curriculum. I think Warren is in contact with them,  
15                  and perhaps they would be, maybe for the outreach and  
16                  communications, or, also, the business and technical --

17                  DR. AGRESTA: Yeah. They need to get put  
18                  into all of our (indiscernible).

19                  MR. PETRUS: So I'd rather these be the  
20                  workforce development. Be more specific about that.

21                  MS. HOOPER: Perhaps we could, because,  
22                  again, they're also waiting on the curricula that we  
23                  developed by -- who got that award for the curricula  
24                  development? Harvard?

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 DR. AGRESTA: It's only just use the  
2 organization.

3 MS. HOOPER: Right, but there were a number  
4 of grants available before HIT.

5 DR. AGRESTA: Five to develop the  
6 curriculum, which is supposed to come out in a couple of  
7 weeks.

8 MS. HOOPER: Right.

9 DR. AGRESTA: I don't know how they're  
10 going to do that, and then a number of regions with a  
11 whole host of other community colleges.

12 MS. HOOPER: Correct.

13 MR. PETRUS: Policies and processes, policy  
14 framework, operational policy, personnel policies, as you  
15 would have with any entity, finance, human resources,  
16 procurement.

17 MS. HOOPER: Again, folks, what DPH is  
18 proposing in this we're going to submit what, again, we're  
19 going to recommend something for you to consider,  
20 understanding this is going in as a plan prior to the  
21 establishment of the actual Board of Directors.

22 We will be making recommendations to the  
23 Board of Directors on how to assist with the transition.  
24 Just like anything else that Frank has been saying, the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 operational plan will be subject to change.

2 MR. PETRUS: And the key here is you're  
3 saying to ONC we have thought about all the nits and nats.  
4 We have crossed the Ts and dotted the Is. What's going  
5 to be necessary for a sustainable organization moving  
6 forward, and a sustainable organization has to have these  
7 core components.

8 MS. HOOPER: And there are some guidelines,  
9 sorry, for the quasi governmental agency, quasi public  
10 agency that it will be, so we'll make sure that we're in  
11 compliance with what State requirements are.

12 MR. PETRUS: Continuing with the authority  
13 development is the data use and consent infrastructure,  
14 building upon all the work that's already been done, the  
15 principles, and then how there will be oversight necessary  
16 to insure compliance with and fulfillment, and if there  
17 are associated sanctions.

18 Security standards, privacy policies and  
19 setting the standards, adoption and customer service to be  
20 able to educate, maintain and respond.

21 Step three is fund acquisition. Consistent  
22 with what will be refined in the strategic plan is the  
23 processes and operation required to obtain and maintain  
24 and document and have audit trails and mechanisms for

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 appeals regarding the fees, funding, subscriptions that  
2 will be necessary for the future sustainability of the  
3 Connecticut HIE, how fees are assessed, how they are  
4 collected, how there's an audit process and trail, and  
5 what kind of appeals process will be in place.

6 And, again, this is critical for us to  
7 spell out in the operational plan consistent with the  
8 strategic plan what the rigor is to move in this direction  
9 and how, then, the authority will operationalize this,  
10 implement this.

11 MR. MASSELI: What was the annual yearly  
12 budget that you're projecting right now?

13 MR. CARMODY: We haven't done that yet, but  
14 that's actually some of the stuff -- we started to collect  
15 some of the -- part of it starts to get into -- I mean we  
16 have the variables, so the short answer is we do not have  
17 an annual budget.

18 So the answer is we have not, to Mark's  
19 point. We had talked about the variables that would go  
20 into it, and then we started talking about what do we need  
21 to have people starting to chase stuff down. I'd be  
22 interested to hear how the conversation develops, because  
23 one of the things that -- again, I think we have to  
24 finalize, again, what is in and out after we digest those

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 services, and I want Peter to tell me, as well as the  
2 operational folks, what do you guys think you need?

3 So I think we've thought about how you can  
4 make that happen. I think we need the operation's piece  
5 and what is it actually going to take both pre and post-  
6 implementation to then talk about what do we think are the  
7 most sensitive pieces to whatever we propose.

8 MR. MCKINNON: This is going to be a high-  
9 level budget as part of the operational going to get  
10 submitted -- will your finance committee continue to  
11 evolve a more detailed budget?

12 MR. CARMODY: Yes. Is that in here?

13 MR. PETRUS: We're going to give you the  
14 rules of thumb that we're using and the metrics that were  
15 used, and we're going to give you examples of what other  
16 states have done, and then we're going to give you the  
17 framework --

18 MR. MASSELI: -- we're going to get their  
19 rough ballpark is?

20 MR. PERKINS: We're not going to get that  
21 today. We're going to talk about how we're going to get  
22 the right budget for Connecticut.

23 MR. CARMODY: We had talked about it once.  
24 We really didn't explore it any further, was had anybody

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 talked about tax credits? I mean we talked about there  
2 was something before with the green technology. That  
3 wasn't going to work.

4 MS. HOOPER: Yeah, it wasn't going to work,  
5 apparently, now.

6 MR. CARMODY: Now, but we haven't really  
7 factored it in. We sort of -- I'm not saying we didn't  
8 spend much time on it, but we really didn't do much more  
9 than what was out there wasn't going to work, but are  
10 other states using tax credits?

11 I mean it is something, as opposed to the  
12 assessment, that we really didn't explore, and if we were  
13 to get somebody to come in and help crank through a model,  
14 are other people using them, or do you know? You don't  
15 have to answer me today.

16 MR. PETRUS: I don't know.

17 MR. CARMODY: I don't think I've seen it on  
18 the table.

19 MR. PETRUS: I haven't seen it.

20 MS. HOOPER: That's where, again, the  
21 legislature, which is also --

22 MR. CARMODY: That's okay, but it's a  
23 different ask. I mean it's going in and asking I want you  
24 to make an additional assessment versus I want you to take

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 an assessment and a tax credit, not knowing if it's -- I  
2 haven't seen anything out there that use tax credit.

3 MR. PETRUS: Anything else on the work  
4 breakdown structure to funds acquisition and management?

5 DR. CARR: My biggest concern is, you know,  
6 look at the overall project plan, and this is where so  
7 many HIEs get stuck, right, as in the turning over the  
8 funding, so, you know, whenever we are working through the  
9 architecture, we're trying to figure out, you know, we  
10 have funded services that we give to an architect, and we  
11 say these are the things that you need to build us an  
12 architecture for these particular services, and that's  
13 really easy once they know what the heck we're going to  
14 provide and who is going to fund it and where the money is  
15 going to come from.

16 It feels like we need a checkpoint in here  
17 somewhere before we go into the architecture that says  
18 these are the services, and this is the funding for it,  
19 and who is going to pay, and the commitment, and somebody  
20 signed something that says they're going to pay for it,  
21 and I don't know where all that comes from, you know, when  
22 all that happens, because some of it is going to require  
23 legislation.

24 MS. HOOPER: Which will require pre-setting

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 up.

2 DR. CARR: Do you know what I mean?

3 MR. MASSELI: Has anybody sat down with  
4 DSS? Has somebody talked to Mike over there and said, you  
5 know, it's not a bread basket, you know, it's this, and  
6 what are you all thinking strategically at the Department  
7 around these types of resources?

8 MS. HOOPER: Andrew is here for Marsha,  
9 but, yeah, I think there's a Commissioner's meeting with  
10 Commissioner Starkowski(phonetic) Wednesday.

11 And I do think that, again, not only from a  
12 leadership, but, also, executive level and staff level all  
13 have to be on the same page.

14 MR. PETRUS: I think the point of check  
15 points is really well taken.

16 DR. CARR: Yeah, because I look --

17 MR. PETRUS: Check point number one would  
18 have to be, obviously, once the strategic operational  
19 planner approved and you have the questions and response  
20 and then the authority comes to life in January and one of  
21 the things they're going to have to do is revise and  
22 validate the operational plan and the value proposition  
23 and business case, because the business case is going to  
24 have within it the financial sustainability model and has

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 to do some reality test there, because, at that point, the  
2 plan could be changed, depending on what you can or cannot  
3 get through the new administration as you move forward  
4 with the legislation that might be necessary, or what  
5 happens at DSS, or what happened in Public Health,  
6 depending what the senate is going to do to provide some  
7 relief for the states that currently themselves in budget  
8 crisis, because the ONC dollars are really those seed  
9 dollars that you are to match to really get the enterprise  
10 architecture in place and start to build the capabilities  
11 while you build up your fees and your subscription  
12 service, so checkpoint number one is here.

13 Checkpoint number two comes here, where you  
14 start to say, all right, we had this model, and we were  
15 able to get this model through the legislature, we're  
16 moving forward with it, it looks good. Like when you set  
17 up the authority, you kept moving as if it was going to  
18 pass, and it did pass.

19 The checkpoint here is where is it at,  
20 because you're going to bill assessment fee, subscription,  
21 whatever this model is going to be, and, so, at this point  
22 in your plan, you have to have a checkpoint, is this real,  
23 and are we going forward?

24 MS. HOOPER: And can we clarify that the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 checkpoints aren't just informally for us, but, in fact,  
2 maybe it should be a formal process for not only the Board  
3 of Directors and staff, but, also, all of the agencies  
4 involved, including DPH, DSS, e-Health, all the rest of  
5 you.

6 DR. CARR: Because there's so many people  
7 that are involved, I think we don't have those.

8 MS. HOOPER: We're with Gartner right now  
9 to kind of do a checkpoint of where we're all at around  
10 this table, but we have to kind of stand on our own two  
11 feet without Gartner after awhile.

12 MR. PETRUS: And that's a very good point.  
13 You have to formalize these checkpoints, and they need to  
14 be in the plan that basically say go, no go, or go, but go  
15 blue and not yellow.

16 DR. CARR: Because all of these look  
17 equally important right now, but they're not.

18 MR. PETRUS: No. You got it. Now, as we  
19 move forward, if the checkpoints that we've had to date  
20 says this is the pool of money that we're going to be able  
21 to leverage along with ONC to move forward and this is our  
22 -- we drove down and did the business case analysis of  
23 what the potential is out there, subscription potential,  
24 the number of docs, the number of hospitals, or however

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 you develop that model, that will be available, then we go  
2 to the next, is the solution architecture.

3 And with, going to the next point, multi-  
4 stakeholder involvement, the entities that are involved,  
5 so that would part of your technical subcommittee of the  
6 authority would be starting to take a look at, with the  
7 dollars that we have and see available in the future and  
8 our agreement with ONC, that we will be able to connect to  
9 other states in the nationwide health information network  
10 and fulfill these three capabilities and their components  
11 as much as possible within 2011 or whatever the  
12 interpretation is, what can we build to do that? What's  
13 going to work?

14 And we have to look at the business  
15 architecture, the information architecture, the technical  
16 architecture and the solution architecture, and we'll look  
17 at trends and enterprises and go through these steps to  
18 come up with a general system design with the appropriate  
19 specifications of what this architecture will be, as the  
20 drawing that was so well done by Kevin for us earlier on,  
21 that this is what the future looks like, and agree and  
22 sign off on the common requirements vision and the process  
23 to govern it as you move forward. That becomes another  
24 checkpoint.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   Then we look at the procurement process,  
2                   and this really starts with looking at what's out in the  
3                   marketplace by the time you get there, and there may be  
4                   things in the marketplace that are there today, and there  
5                   may be some new things in the marketplace, because you've  
6                   got 50 states, plus the territories, that are having  
7                   billions of dollars invested by ONC, by CMS for EHR  
8                   adoption, Health Information Exchange, ICD-9 to ICD-10, to  
9                   HIPAA 250-10, and all these other things that are going on  
10                  out there, I'm seeing the marketplace every day change.

11                  We did some work in another state on  
12                  behavioral health case management system, and we just did  
13                  one two years ago, a year and a half ago, and there wasn't  
14                  in the marketplace then what there is now, because now  
15                  there's going to be meaningful use dollars for behavioral  
16                  health EMRs, EHRs, and, so now the vendors are responding  
17                  to it, and it's expanded by another two.

18                  MS. HOOPER: And don't forget health parity  
19                  for mental health.

20                  MR. PETRUS: There you go.

21                  MR. MASSELI: So how many states will roll  
22                  out starting next year?

23                  MR. PETRUS: Roll out HIEs?

24                  MR. MASSELI: Yeah.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: All of them are supposed to  
2 have approved cooperative agreements as far as the  
3 operational plan by October of this year, all of them.

4 MS. HOOPER: And the territories.

5 MR. MASSELI: And there will be ONC funding  
6 for all of them?

7 MR. PETRUS: Yes.

8 MS. HOOPER: Yes.

9 MR. PETRUS: Everyone has got their  
10 planning dollars. Some have already gotten their  
11 operational dollars, but then comes the concept of what  
12 you have out there. What will the procurement strategy  
13 be? Understanding what you're putting in the strategic  
14 and operational plan is a vision that you all have come up  
15 with, but we haven't really talked about a procurement  
16 strategy, with the exception of used products that are  
17 already available or capable in the marketplace, as  
18 opposed to (indiscernible).

19 MS. HOOPER: Can we actually identify those  
20 products, or assume products?

21 MR. PETRUS: I think that we've already  
22 assumed products in our strategic plan.

23 MS. HOOPER: Correct.

24 MR. PETRUS: We assume that they'll be

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 there. I'm thinking here, as part of your work breakdown  
2 structure, there has to be a formalized procurement  
3 strategy in how you're going to go forward.

4 MS. HOOPER: Okay.

5 MR. PERKINS: Just to clarify, Frank,  
6 you're saying that the marketplace has products that we  
7 can leverage, not that you've decided on products?

8 MR. PETRUS: Yeah. I think that when your  
9 strategic plan, what we heard from you is there's a lot  
10 out there. Let's not build something from the ground up.

11 MR. MASSELI: Does DOIT serve us on the  
12 procurement side? I mean who is the authority --

13 MS. HOOPER: The authority is it.

14 MR. MASSELI: Is it? Well, but I can use  
15 the State's buying list, because I'm a not-for-profit.

16 MS. HOOPER: Oh, I'm sorry. The quasi  
17 government.

18 MR. MASSELI: Quasi government can pick up  
19 the procurement.

20 MR. BAILEY: We had that discussion within  
21 our work group, and it may be that the State procurement  
22 process they could probably utilize the State procurement  
23 process, but when you get down to where you're finalizing  
24 Ts and Cs, it could be a lengthy process.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   The fact that they're going to be a quasi  
2 public entity they may have more latitude in a procurement  
3 process that provides more latitude and not having to deal  
4 with such a stringent structure that we have, and,  
5 therefore, they could probably do it in a more expeditious  
6 manner than we could probably get it done.

7                   MS. HOOPER: But I think, Mark, from your  
8 perspective and, Commissioner, from like our ability to  
9 get Gartner, thanks to your agreement with them, those  
10 kind of advantages I don't know that we couldn't take  
11 advantage of.

12                   MR. BAILEY: They could, and that's one of  
13 the things that we're looking at. For instance, are there  
14 existing procurement mechanisms in place that we could  
15 leverage, and, if that's the case, then we have a whole  
16 different set of dynamics, you know, from a time frame  
17 perspective.

18                   MS. HOOPER: Similarly, with all of the  
19 other partners around the table, you know, UConn might  
20 have a process that can also be leveraged. I think we all  
21 have different procurement processes.

22                   MR. MASSELI: What type of irregularity are  
23 you looking for?

24                   MS. HOOPER: I don't know.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: I think this is what the Board  
2 would be responsible to do, is take a look at what are the  
3 varied procurement strategies that we could use and maybe  
4 a hybrid procurement strategy for how we want to do it.

5 MS. HOOPER: Right, because it moves around  
6 the table.

7 MR. PETRUS: Exactly.

8 MS. HOOPER: They are a finance committee,  
9 right, sir? Plus, you have a large insurer on your back.

10 MR. MASSELI: In his pocket.

11 DR. AGRESTA: I think the question is the  
12 granularity of the operational plan. That's going to be  
13 very helpful for us as we start to think about how do we  
14 actually kind of help provide details around that, or even  
15 brainstorm around that, understanding how granular the  
16 operational plan should be versus where do they get in our  
17 way to be granular, because it may actually get in our way  
18 to get too granular, because we may start to kind of even  
19 push us in a direction that isn't the right direction to  
20 ultimately move in.

21 We'll waste our time. We'll waste our  
22 time.

23 MS. HOOPER: Well and that's the thing. In  
24 a six-week time period, when a lot of people are on

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 vacation, how granular?

2 MR. PETRUS: We think down to the great-  
3 grandchild is as far as we should be going.

4 MS. HOOPER: Okay, so, basically, the  
5 requirements, as recommended under this current advisory  
6 structure, about what's going to be happening come  
7 January?

8 MR. PETRUS: I would get too, for example,  
9 with a procurement. You'd want to make sure that in your  
10 operational plan that you spell out that there will be a  
11 detailed procurement process that will include these  
12 steps. There will be a procurement strategy and  
13 procurement process that will be driven by these  
14 requirements.

15 I wouldn't get to the specificity that we  
16 will use this vehicle, or that vehicle, or this vehicle.

17 MR. MASSELI: You say that they're  
18 available to us less -- we're in on the selection -- but  
19 just give some confidence that we have the ability to use  
20 it if we choose to do it.

21 MR. MCKINNON: What I thought is the actual  
22 activities in a hugely detailed one that (indiscernible)  
23 thing is going to be in the operational fund, so  
24 underneath policies and processes, we've got procurement

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 processes as part of that, as identified what can be used  
2 in the state, so those activities are there. The other  
3 part we were looking at the processes, regardless of what  
4 you pick up this is all the companies have to happen if  
5 somebody goes through procurement, so we're really getting  
6 into that -- this is going to happen, and that's going to  
7 happen, that's going to happen.

8 Yes, we should have something in the  
9 narrative that also says and we'll take best advantage of  
10 procurements available.

11 MS. HOOPER: And, quite frankly, Gartner is  
12 going to be listing all this out, as they are in this, but  
13 where we can actually apply, and I would ask that the  
14 Legal Committee consider, since you're done with the  
15 consent option, that you consider, for example --

16 MR. MASSELI: Drafting those procurement  
17 documents.

18 MS. HOOPER: In the quasi government  
19 (multiple conversations). In the quasi governmental  
20 agency, what are going to be the legal requirements as  
21 they move forward for staffing, purchasing, authorizing,  
22 you know, that kind of thing, right? Wouldn't that be up  
23 to the Legal and Policy subcommittee?

24 MS. HORN: It would be helpful to have

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 their input, although I'm not sure that they're going to  
2 be able to do all of the heavy lifting on that.

3 MS. HOOPER: No, but I mean just from a  
4 review of the legislation for, you know, how does  
5 CRRRA(phonetic) operate?

6 MR. PETRUS: And I think the key that also  
7 would be something that the authority would have to really  
8 guide down to when they look at the options, because what  
9 I think we want to say in the operational plan is that it  
10 is the goal of the authority, the state in this  
11 operational plan and the authority, to do an expedited  
12 procurement process to meet the ONC requirements and  
13 capabilities and to be driven by very detailed  
14 requirements, and that the discipline is really going to  
15 be placed on the requirements and then take a look at what  
16 vehicles are available to provide for an expedited  
17 procurement process.

18 MR. GORDON: I would reiterate that, if you  
19 want to go live in 2011, then procurement is on the  
20 critical path. We're working with another client, who  
21 have two products from two of their partners in place, and  
22 the advisement of the legal counsel was it would probably  
23 be good to talk to the vendors in case you tank the  
24 procurement process, so you should know very soon about

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 what you can do prior to the procurement process.

2 MS. HORN: We were just talking about that  
3 today.

4 MS. HOOPER: Correct.

5 COURT REPORTER: One second.

6 MR. PERKINS: -- back to this term  
7 expedited, but just note that that doesn't mean low  
8 quality.

9 MS. HOOPER: No, no, not at all.

10 MR. PETRUS: We're looking at meeting the  
11 ONC guidelines and timelines, as well. Anything outside?  
12 Let's go back. I haven't finished one thing that I think  
13 is important, is that the procurement strategy should be  
14 obviously driven by the safest and as free from risk as  
15 possible expedited process and driven by key requirements,  
16 and what we have found out within the straw person for the  
17 operational plan is architecture requirements, which was  
18 developed earlier, the functional requirements, what's the  
19 capabilities, the security requirements, the technology  
20 requirements, implementation requirements, how it's going  
21 to be staged and rolled out.

22 The performance and operational  
23 requirements, what is the 24/7, what are the security,  
24 what are the kinds of performance and service levels that

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 your consumers, who are paying subscriptions or fees, have  
2 a right to and can expect to the service level and support  
3 requirements that they're going to get.

4 So these are the key requirements that we  
5 typically see when we move forward in supporting entities  
6 with their procurements. Go ahead.

7 MR. GORDON: That point also sparks another  
8 question from our prior experience, and that is that if  
9 you're going to be doing 24/7, which is required for an  
10 EHR, data center is going to be a big issue, so the  
11 procurement needs to include both the products and also  
12 how you're going to run it, in which data center.

13 MR. PETRUS: And that goes to the  
14 procurement strategy as you lay out all these  
15 requirements. Is it going to be a hosted solution, or  
16 will the authority host it, and then have to build the  
17 facility or lease a facility with heating and cooling,  
18 etcetera.

19 MR. GORDON: I'm going to put it on Peter's  
20 laptop.

21 MS. HOOPER: Real simple, Frank.

22 MR. PETRUS: Procurement process, the RFP,  
23 I won't go through all the steps, but, again, we wanted to  
24 very much flesh out for ONC that Connecticut has dotted

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 the Is and crossed the Ts, that procurement is not just  
2 putting an RFP on the street.

3 MS. HOOPER: No.

4 MR. PETRUS: You have to have an evaluation  
5 model, you have to issue it, you have to have a Q & A, you  
6 have to establish and train the evaluation team, you have  
7 to have evaluation selection. You want to build in a  
8 baffle. You want to move over contract negotiation with  
9 contract award.

10 And the other thing that the authority  
11 would have to look at in a strategy do they decouple the  
12 procurement, they look for a systems integrator to do it  
13 all, or do they do one procurement with multiple lots, and  
14 a vendor can bid on lot one, two, or three, or bid on all  
15 lots. Those kinds of things would really have to be  
16 worked out.

17 In the narrative, we'll talk about the  
18 flexibility to insure quality procurement at the fastest  
19 time possible driven by requirements. Anything on the  
20 procurement?

21 Then we move to Standards Adoption and  
22 Setting. Again, this is the parallel process and the  
23 standards that would be necessary and the operability,  
24 data management standards and governance structure

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 necessary. Define the required standards. Develop  
2 standard proposals and obtain approval via the governance  
3 process for all of the key standards regarding  
4 interoperability, master data, public health, patient  
5 care, lab and auxiliary and personal health records.

6 MS. HOOPER: And this is within the plan,  
7 actually the standards to be laid out, or compliance with  
8 federal standards? Could that be the sentence?

9 MR. PETRUS: The standards that you would  
10 need to develop to be compliant with national standards  
11 and, also, to meet the standards that are unique to  
12 Connecticut.

13 MS. HOOPER: Understood.

14 MR. MCKINNON: So this was adopting  
15 standards for Connecticut? In some cases, it's great. In  
16 some cases, I don't think.

17 MS. HOOPER: Correct, and I think that's  
18 where, again, sorry, but Legal and Policy, we're going to  
19 need some advice, Business and Technical, you know, not  
20 only in setting standards specific to Connecticut, but how  
21 to actually adopt whether legislatively legislature needs  
22 to be involved.

23 In our case, perhaps some of the regulatory  
24 functions, Public Health Code. I don't know what else.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Licensure of facilities? You know, how deep are we going  
2 to go with this, as far as we know now?

3 MR. PETRUS: And that's a good thing.  
4 Someone talked about the Rhode Island lawsuit, and we're  
5 looking into it ourselves at this time. From my  
6 understanding of it, it's not that they're really suing  
7 the HIE for the sharing of information. They're suing the  
8 state, because the state didn't follow their own  
9 regulations, that they weren't compliant with their own  
10 regulatory policies. Very interesting.

11 So if you're going to have standards and  
12 policies, then you have to make sure that they're  
13 compliant and you're not setting up a policy here for the  
14 HIE, which is not compliant with an already state law or  
15 regulation, which is important.

16 And then the communication and the  
17 education and the support and outreach regarding  
18 standards, so all involved, all the stakeholders and the  
19 standards, part of the work breakout structure.

20 Initial HIE Standup, and this is vendor  
21 planning and foundation service created to enable the HIE  
22 and the subsequent releases of functionality, the vendor  
23 operational plan, the vendor prep, finalizing and design,  
24 implementing the infrastructure, and then the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 configuration. Master provider, master patient indexes,  
2 record locator, service and messaging.

3 The cardiovascular system, the HIE,  
4 regardless of the capabilities that you're going to have  
5 now and into the future, must be in place and standing up  
6 the HIE, and it must be tested, piloted and implemented.

7 Release one, continuity of care document  
8 and Public Health reporting is what we have now, and this  
9 is roughly between Q-1 and Q-3 of state fiscal year  
10 2011/2012. The plan, continuity of care documents and the  
11 integrated Public Health reporting is currently the  
12 sequence, again, pending the interpretation of the ONC  
13 PIN.

14 MR. MCKINNON: And this is a checkpoint?

15 MR. PETRUS: Good point. Yes. Why don't  
16 you talk to that?

17 MR. MCKINNON: Well each of the way that  
18 the releases are broken down, the first part of that is  
19 effectively a checkpoint to say do we really want to go  
20 ahead with the services for this release. We ought to  
21 have a Board approval, so it's based on what we discussed  
22 earlier. We're going to do a few other checkpoints, and  
23 this is a similar formal checkpoint at the beginning of  
24 each release.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: The other thing I probably  
2 should have said earlier, for each of these key task,  
3 parent task, the work breakdown structure, you will  
4 communicating to ONC as part of your requirements for  
5 reporting of the cooperative agreement to get their input,  
6 their feedback.

7 MR. CARMODY: Can I ask a question? On the  
8 sequencing, to the steps that require legislative approval  
9 or action, how does that sync up with some of the things  
10 that we've laid out? We have a part-time legislature, and  
11 they do things periodically during the winter months, and  
12 then I know everything sort of starts to gear up, and  
13 eventually they may pass a budget or not in that June time  
14 frame, but like how does the sequencing --

15 MS. HOOPER: -- shorten the long sessions.  
16 We're coming up on a long session, but Joe Canfield from  
17 our Office of Government Relations, who is liaising with  
18 the other agencies with their legislative directors and  
19 basically talking with them.

20 Certainly, it's absolutely correct that  
21 legislation would have to be waiting for a full session  
22 for a vote. Regulatory functions are done at different  
23 time tables with a regulatory review, so, yes, all of the  
24 syncing up would have to be anticipated, and that's why

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 I'm doing the plan. We do a government relations involved  
2 from DPH.

3 MR. CARMODY: So when we look at this plan,  
4 has that been synced up?

5 MS. HOOPER: Not yet, but when we do this  
6 plan, we have to put that into consideration, so correct.  
7 If you do have a financing model that you want the State  
8 to have a budget line item for HITE, then you could start  
9 right now soliciting your legislative representatives.

10 MR. MCKINNON: Should it have started last  
11 year?

12 MS. HOOPER: Well we have, but we're going  
13 to continue to support that.

14 DR. CARR: So should we build in some  
15 assumptions, I guess, you know, like that there would be  
16 some type of a legislation that would require funding into  
17 the plan, just in case that came.

18 MR. WOLLSCHLAGER: Kevin, that was included  
19 in the document that we submitted.

20 MR. MCKINNON: These proposals are going to  
21 be absorbed. A lot of this was done before.

22 DR. CARR: But there would be maybe one  
23 piece of legislation that may require funding and then one  
24 piece that requires some policies.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MS. HOOPER: We would need to make some  
2 distinctions between those, recognizing, again, the  
3 Commissioner --

4 DR. CARR: So that we scare legislators  
5 today.

6 MS. HOOPER: As an executive agency, the  
7 Department of Public Health has been made fully aware that  
8 the Governor is not entertaining a budget item that's  
9 going to negatively effect our existing deficit, but  
10 certainly policy decisions the Commissioner has been very  
11 vocal at the Capitol about support for not only public  
12 health, but Health Information Exchange, but we would have  
13 to have some distinct recommendations.

14 MR. PETRUS: That's very important as you  
15 go through.

16 MS. HOOPER: Because, again, it's DPH for  
17 now.

18 MR. PETRUS: As you go through the  
19 operational plan diversion that we will draft and present  
20 to the Department of Public Health, is you need to take a  
21 look at the steps of that plan and identify where there is  
22 legislative enablement that may be policy issues and/or  
23 legislative appropriations, so that could be built into  
24 our communication and plan to ONC, as well, that

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Connecticut understands this and will seek legislation to  
2 enable us to do X, Y, Z, or to harmonize policies in this  
3 arena and/or appropriations or ability to exercise fees,  
4 or subscriptions, or whatever.

5 MS. HOOPER: And, again, recognizing that  
6 what the Department and all of us have been able to do in  
7 two years is some significant legislation, first going  
8 this way, and now going, you know, the correct way.

9 Jill, you will be assisting in the syncing,  
10 as in S-Y-N-C-I-N-G.

11 MR. PERKINS: I have another comment. I  
12 think another way to address it is, you know, this has now  
13 become a very complex program. A lot of us are starting  
14 to see it in the operational plans.

15 Understanding the risks and prioritizing on  
16 those risks that really represent the biggest impact on  
17 the success of the program, clearly, you know, legislative  
18 approval for additional funding would be one of those  
19 items, and being very proactive and focused on mitigating  
20 those risks early on is another way, in addition to just  
21 executing the plan that you would address that.

22 CHAIRMAN GALVIN: Let me just interject how  
23 the process works. Towards the end of August, the first  
24 part of September, we get together a list of things that

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 we would like to get legislative approval on.

2 Now we have to submit -- that list goes to  
3 the Office of Policy and Management, and they don't always  
4 endorse everything that we want, so we may send up 18  
5 items, and the Office of Policy and Management may decide  
6 that they will only endorse eight.

7 If that happens, we have the ability to  
8 point out to the administration that four of the ones that  
9 were not approved by the Office of Policy and Management  
10 are really critical, but being an executive agency, if the  
11 Office of Policy and Management and the Governor decide  
12 that they do not want to put forth the legislation that we  
13 would like to see, then that's it.

14 We work for the Governor through the Office  
15 of Policy and Management, so if it doesn't get in that  
16 way, it's got to come from people, from sitting  
17 representatives and senators, and, so, once again, it's  
18 very important, particularly during this year, if people  
19 come to you and say, hey, Dan, can I have some money for  
20 my campaign, or would you host a party for me, I think the  
21 question, if you're dedicated, is that I understand your  
22 getting elected is very important to you. Getting health  
23 informatics and HITE funded is very important to me. You  
24 can make yourself very clear that way.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   If you want to go to the Carmody house for  
2                   a little get together and the fundraiser, that's fine, but  
3                   you would expect that, when the legislature comes into  
4                   session, that that individual would get behind the things  
5                   that you want done, and there are key people, and, so,  
6                   there's more than a single approach.

7                   Sometimes people come to us and say you  
8                   didn't put this bill forward, or, once again, we put the  
9                   bills that we want to see move forward go to the Office of  
10                  Policy and Management. At that point, it's out of our  
11                  hands. If they decide they're not going to put something  
12                  forward, then it's got to go off to the people sitting in  
13                  the legislative building.

14                 MR. PETRUS: Good point, Commissioner.  
15                 That August/September timeline does good with what's going  
16                 on with the development of the operational plan, so if  
17                 things pop out that need legislative review and  
18                 enablement, we can build that in. Let's go on to release  
19                 two.

20                 MR. COURTWAY: Just a quick question before  
21                 we move on. I guess, Meg, it's a question for you. If  
22                 the connection and the integration with public health  
23                 reporting is promoted with DPH and there are emerging  
24                 standards for doing that exchange of information, do we

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 have a time table from a state level of funding that says  
2 that this is when DPH will actually be prepared and which  
3 standards you're going to adopt? You do?

4 MS. HOOPER: We're, right now, compiling  
5 what our requirements are from the federal agencies. Some  
6 are funded. Some are unfunded mandates, so the time lines  
7 will be varying upon what is required to upgrade systems  
8 and what funding mechanisms would be in place. Some will  
9 not be in place, but, again, health care reform is coming  
10 out with some of the quality measure improvements, the  
11 actual analysis, researched it.

12 There's some health care reform funds that  
13 are seemingly going to be made available to upgrade  
14 systems from the public health reporting. Not much is  
15 electronic right now that hasn't been supported with  
16 preparedness funds, so that is our component to bring to  
17 all of you, and we have a team that's beginning to tally  
18 it up.

19 MR. PETRUS: And the CDC has lent some  
20 money to some states for modernization of registries and  
21 Health Information Technology readiness.

22 MR. COURTWAY: Thank you.

23 MR. PETRUS: Nothing here. All right,  
24 moving on to release two.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MS. HOOPER: If you could talk to them,  
2 that would be great, Frank.

3 MR. PETRUS: Well I would be glad to, if  
4 they'll listen to me. Release two is like the release one  
5 plan. Get Board approval, and then quality reporting  
6 definition, and, at that time, too, checkpoint, are we  
7 ready for it? Are we moving forward with a participant  
8 implementation support and sign off and moving forward  
9 with the auxiliary service orders results? Again, we have  
10 to review this, in light of the PIN.

11 Release three, plan, Board approval, and  
12 this, again, is the enablement of the HIE for EHR. It is  
13 not developed as PHR interface and integration design and  
14 implementation.

15 Task 11, Customer Service, and this is the  
16 infrastructure necessary for the ongoing support,  
17 sustainability, flexibility, adaptability for the HIE,  
18 vendor customer service function and infrastructure, and  
19 then, three, customer services releases tied to the three  
20 release of it.

21 Operation and ramp up, user education and  
22 training and support through the help and problem support  
23 infrastructure that would be put in place.

24 Let's take a look at -- just stop there.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 As you can see now, the detail that we're going through,  
2 again, you have not seen the narrative, you didn't see the  
3 Microsoft project work plan. What we want to do is make  
4 sure that we walked through and got your response to how  
5 we're building the work breakdown structure around which  
6 the narrative for the operational plan linked to the  
7 strategic plan will be developed.

8 MR. CARMODY: Maybe it's implicit, but  
9 there's something that, as we look at sort of the  
10 releases, is there a spot in there where, because we're an  
11 enabling service, that we're going to be coordinating with  
12 the people who are going to be the consumers of this  
13 information, and do we need to have an explicit line item?

14 Usually, I'm an enabler, and I'm going to  
15 do this. Like when are we collecting that feedback from  
16 those people who are going to use our service, where we  
17 can say let's just make sure that we're on the same page?  
18 Is that sort of implicit in that?

19 MR. PETRUS: We see that, for example, if  
20 you take a look at release one, the participant  
21 implementation and sign off, participant readiness check.

22 MR. CARMODY: That's where you have that.

23 MR. PETRUS: And then, earlier on, if you  
24 go back, Alistair, to --

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. McKINNON: I think this was done  
2 already, but we may want to add several things as well,  
3 but when you're talking about the organization you would  
4 see actual management something to lead to the --

5 MR. PETRUS: We begin with the multi-  
6 stakeholder architecture team that would include the  
7 participant entities, and then, for each release, we had  
8 the participants' involvement and sign off.

9 MR. CARMODY: Okay.

10 MR. PETRUS: But, in the narrative, we can  
11 flesh --

12 MR. CARMODY: You may just want to flesh it  
13 out.

14 MR. McKINNON: I actually think we should  
15 write this to the (indiscernible) relationship management  
16 -- that organization will say that. That that function  
17 will be doing things, in addition to this stuff, as well.

18 MR. CARMODY: When we envisioned it in the  
19 business, I mean that was one of the things that we said,  
20 is really there should be a dedicated -- it should be  
21 dedicated to someone with these skill sets, who is going  
22 to actually carry this out, is motivated and analyzed on  
23 that.

24 MR. PETRUS: Anything else? Staffing and

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 organization skill, staffing and organization assumption  
2 and approach. Approaches that we looked at, other HIE  
3 organizations, we looked at best practices. We drew from  
4 Gartner's research and, also, from standards, the  
5 information technology infrastructure library of what is  
6 necessary for effective service management and application  
7 management and COFIT as well, and then looked at  
8 developing a functional model aligned with the work  
9 breakdown structure, and the assumption is that the bulk  
10 of the project work will be completed by partners and  
11 vendors.

12 We're not hearing you say you wanted to  
13 build a very robust infrastructure of 252 people, 24/7,  
14 with a tier four data center.

15 MS. HOOPER: I'm sorry. I don't think that  
16 we've heard that, but, also, I don't think we're in the  
17 position of having the capital nor investment funds to  
18 even pursue that, correct?

19 MR. CARMODY: I've never heard us say that,  
20 but one of the things I would imagine that whatever we  
21 were going to do, as Peter leads the contracting  
22 conversations, is that we can pick up and move. It's the  
23 state's information and the resources, but we can then go  
24 someplace else, so that, you know, it's easily

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 transferable.

2 MR. COURTWAY: Like I said, to the data  
3 ownership --

4 MR. CARMODY: Yeah.

5 MR. COURTWAY: -- and being prepared to  
6 exit a contract before you enter a contract. You just  
7 basically have to have all that.

8 MR. MCKINNON: We may not have  
9 (indiscernible) we discussed that as part of the  
10 alternatives analysis, looking at the procurement models,  
11 and it was pretty clear there was no real support for  
12 building our own thing, our own data center  
13 (indiscernible) purchased. There's going to be things  
14 that are purchased, unless it's a core competency that  
15 really is demanded of the authority, itself, and ownership  
16 management is an example of that.

17 You really need people who understand the  
18 subset of customers.

19 MR. PETRUS: And I think the key is,  
20 although it's going to be a lean and mean organization as  
21 an authority, it needs to have a very high level of  
22 sophistication and skills and experienced capabilities to  
23 manage the complexity of the HIE, the service level  
24 oversight, whoever is going to be providing those

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 services, the security that's going to be necessary, the  
2 vendors that are going to be involved, so the management  
3 infrastructure has to be extremely sophisticated.

4 MS. HOOPER: Correct.

5 MR. PETRUS: And, so, when you look at the  
6 staffing necessary, the skills necessary and a small, lean  
7 organization, and we're looking at a, I forgot, 23, 24  
8 staff, roughly, they are highly sophisticated  
9 professionals that you're going to have working on your  
10 behalf.

11 This is that functional model. Again, this  
12 is a functional model, not necessarily an individual  
13 model. You have the leadership of the authority. You  
14 have an HIE strategy, a project management office,  
15 obviously, and then broken down to technology production,  
16 legal policies, participant engagement and relationship  
17 management. We can change that to administration.

18 Under technology, the functional oversight  
19 of architecture standards integration and data provision.  
20 Production, maintenance, training and support, legal and  
21 policy, health records, privacy and overall policies,  
22 participant engagement, ARRA coordination and the  
23 coordination of all the entities that are involved in HIT  
24 in Connecticut, and with your training partners in other

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 states in the National Health Information, nationwide  
2 National Health Information Network, marketing and  
3 reporting and administration, the overall finances, human  
4 resources, is roughly how we --

5 MS. HOOPER: Right. I mean that might be  
6 laid out, but the specifics we're not going to be able to  
7 lay -- again, keeping in mind that the Board will set the  
8 final directions.

9 DR. AGRESTA: Right. Right.

10 MS. HOOPER: But we're going to give  
11 recommendations for what could work, funding, space, you  
12 know, the logistics of it.

13 DR. AGRESTA: One of the areas that I don't  
14 see in there in this structure somehow as a sort of  
15 clinician, you know, and thinking about the actual  
16 clinical data and the ability to use it from a quality  
17 perspective and from, you know, how do you put that in  
18 this structure in the leadership, because if you're going  
19 to be moving in that direction, that's been part of our  
20 strategic plan, is to think about using this quality  
21 reporting and other things like that, but I don't see  
22 anybody in those roles.

23 MR. PETRUS: Would that be under  
24 participant management and clinical --

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 DR. AGRESTA: Well I don't know. Isn't it  
2 a lead? Isn't it a lead function to allow for those other  
3 things to flow?

4 MS. HOOPER: I don't know, because of the  
5 constituency of the Board of Directors, is going to  
6 include a number of those. Board of Directors have actual  
7 voting and directive authority.

8 DR. AGRESTA: Will they have enough time  
9 and effort to put in?

10 MS. HOOPER: You know, the Board is going  
11 to be given an estimate of how much of the current  
12 cooperative agreement funding can be offered for the first  
13 four years, or two years of operations, and it would be up  
14 to the Board to determine your staffing responsibility.

15 MR. PETRUS: It may be helpful to go  
16 through the next slides and then come back here. What we  
17 tried to do in the next slides are take a look at high  
18 level, what we see as the major prerogatives, or  
19 perspectives, or role of each of the key functional areas.

20 Leadership, strategic roadmap, the overall  
21 business plan, project approval, multi-year budget  
22 development and approval, major project oversight and  
23 accountability, the integration and culture, standards  
24 approval, score card satisfaction, quality and value

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 review and accountability and Board relationship, Board  
2 participant, Board management relationship.

3 MS. HOOPER: And to address Tom, to address  
4 to your point on the accountability issue, I think that's  
5 where our accountability, as the Commissioner has directed  
6 us, is, look, I'm serving 3.5 million people.

7 The goal here is to improve health outcomes  
8 with a more efficient system, so I wonder if that's where  
9 we might want to build in some of those performance  
10 measures and Dr. Tiku(phonetic) for part of the  
11 evaluations. Are we really meeting our expectation, not  
12 just to play with a new toy, but can we actually improve  
13 health status, health outcomes?

14 MR. PETRUS: And we also see that in the  
15 HIT strategy function.

16 MS. HOOPER: Correct.

17 MR. PETRUS: Which is the clinical  
18 informatics leadership.

19 MS. HOOPER: Yes.

20 MR. PETRUS: Which could be, again, a staff  
21 or a team that looks at the business plan, the  
22 requirements, the roadmap, the informatics for the  
23 nationwide health information network, clinical  
24 informatics, performance, satisfaction survey, evaluation,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 benefit demonstration, standard process develop impact on  
2 outcomes, in that arena.

3 MR. GORDON: And that was also where we  
4 thought a new part of the evaluation benefits  
5 demonstration would be the clinical benefits demonstration  
6 related to the requirements that you wanted to achieve.

7 MS. HOOPER: And we are working, again,  
8 with UConn on -- well, actually, without a contract, but  
9 with the promise of a contract and some money. That maybe  
10 can be contributed to this plan, barring any confusions to  
11 the contracting process.

12 MR. PETRUS: Does that help a little bit?

13 DR. AGRESTA: Yeah. I think that going  
14 back to that prior slide, you know, and making sure that  
15 it's implicit, I mean, these don't necessarily all --  
16 these aren't all people, necessarily.

17 MR. PETRUS: No, it's not.

18 DR. AGRESTA: But I would want to make sure  
19 that captured in this is really sort of the quality and  
20 health care improvement, and that it requires thinking  
21 that way.

22 MS. HOOPER: Absolutely agree.

23 MR. PETRUS: We could call that HIE  
24 strategy and clinical quality improvement or something.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 DR. AGRESTA: Yeah. Something that really  
2 kind of categorizes.

3 MR. PETRUS: Okay. We'll follow-up on  
4 that, and, also, in the narrative spell that out as it's  
5 identified here under that function.

6 Next is the PMO, the Project Management --  
7 that's the project portfolio management, project portfolio  
8 oversight, because there's going to be a lot of projects  
9 going on at one time even within a major project, so we  
10 have to have a strong, robust PMO that follows, you know,  
11 industry best practices, PMI best practices around project  
12 management reporting, risk mitigation, identification and  
13 mitigation, contract management, vendor management, to  
14 make sure the project is on time, within budget, and that  
15 change orders and schedule slippages are minimized.

16 Technology, the application architecture  
17 development, this is where you may want to -- someone had  
18 talked about -- I think the Commissioner talked about when  
19 you have the Chief Executive Officer may want to have a  
20 right hand person around application architecture, or  
21 enterprise architecture, or a combination of enterprise  
22 and business architecture, because the application  
23 architecture, data architecture and procurement, interface  
24 and integration design, which is really critical.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   Your interface mapping, your interface  
2                   planning is going to be critically important, because the  
3                   number one thing that you are is a utility that is  
4                   allowing for the interface and multiple providers  
5                   information within clear standards. IT security and a  
6                   security officer kind of role is going to be critical, and  
7                   standards development and approval.

8                   Production, implementation, change  
9                   management, data, quality management, maintenance  
10                  interface, maintenance participant support, participant  
11                  training, service request.

12                  MR. GORDON: I have just a question.  
13                  You're using the term "participant" to mean the people who  
14                  actually use the utility. We banded around subscriber or  
15                  other kinds of terms. Is there a preferred term to have?

16                  MS. HOOPER: Well we get to that user  
17                  consumer issue, because all of us are both users,  
18                  consumers, as both patients, providers, funders,  
19                  regulators. You know, there's going to be a lot of hands,  
20                  again, depending on who is using the information for what  
21                  purpose.

22                  We're looking at it beyond a personal  
23                  health record. From a public health perspective and,  
24                  also, in measuring that health outcome, we're going to be

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 looking at aggregate, so the users of the system is --

2 MR. GORDON: From a production support  
3 function perspective (multiple conversations) and you have  
4 your help desk number.

5 MS. HOOPER: Right. And, as we discussed,  
6 that hybrid model, where you had said earlier, Dan, they  
7 would just kind of go to where perhaps that network or  
8 software system offers it, or are we all going to have one  
9 central HIE customer service center?

10 MR. MCKINNON: That's an assumption --

11 MS. HOOPER: Correct.

12 MR. MCKINNON: It's best practice for  
13 saving money.

14 MR. PETRUS: One-stop shopping. No wrong  
15 door; that even if you go to the, you know, this tier one  
16 help desk and even if someone else will be handling it,  
17 there's one number they go to, one place they go to, and  
18 then it can be triaged and managed, would be a best  
19 practice, and, as Alistair said, probably the most  
20 efficient way to run it.

21 MR. MCKINNON: (Indiscernible)

22 MR. PETRUS: Maybe in New London.

23 MR. COURTWAY: We refer to it more like  
24 client services.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: Well when we say "client  
2 services," that could be patient services, would be my  
3 concern, because, remember, this is a public document and  
4 a public -- it's not within a health system, or a payer  
5 system. There's going to be a lot of lay folks involved,  
6 so my counsel is I'm not sure.

7 MR. CARMODY: But going back to Peter's  
8 point, I think the fact of the matter is is that we don't  
9 have a direct -- at least the model that we have is we're  
10 not going direct out to the patients or the taxpayers.  
11 There are intermediaries. This is an enablement service,  
12 so the people that are engaging with the HIE are really  
13 our clients, as you will find in a customer service model.

14 MR. PETRUS: I'm not disagreeing. I'm just  
15 looking at that term to a layperson and how they would  
16 perceive that in a document that will be public, so we'll  
17 have to have a glossary and start defining those terms.  
18 Okay?

19 Legal and Policy, our legal officer and  
20 Chief Privacy Officer, consistent with the requirements  
21 that we've defined for HIPAA, health records, contracting,  
22 external policy and regulatory development and  
23 coordination, enterprise risk management, participant  
24 engagement. Again, we're talking about the entities that

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 would be hooking in, pushing and pulling through the HIE,  
2 marketing outreach, coordination with all the other ONC  
3 ARRA, HIT initiatives that are underway, communication.

4 MR. GORDON: So this one could be the  
5 broader participants, not just the clients you are  
6 supporting, but anybody else you want to touch, possibly  
7 the public, because you have communications and education.

8 DR. AGRESTA: Well you definitely have the  
9 public.

10 MS. HOOPER: Yeah.

11 DR. AGRESTA: I mean despite the fact that  
12 we don't think they may have an interface with the  
13 particular HIE, which they might over time, you know, in  
14 some fashion, we don't really know where we're going, but  
15 they have to sign a consent, so, at some point or another,  
16 they have to understand this, and the consent process may,  
17 in fact, end up being something they do on line, so there  
18 may be a sort of public facing, but we haven't decided any  
19 of that. (Multiple conversations)

20 MR. CARMODY: We had a working assumption  
21 that we were not doing any on-line consents, that  
22 everything was being done through the physician.

23 DR. AGRESTA: Well, then, you're going to  
24 find -- I mean the providers, you may want to actually

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 provide on-line consent that it gets done in a provider  
2 office. I don't know that I would have that pre-scripted  
3 upfront, because it may be that, you know, when you get  
4 together all the HIEs and they say, you know, gee, let's  
5 get a region of us and get an on-line, you know, consent  
6 form, and your form might be different than ours, well,  
7 let's collaborate on getting the --

8 MS. HOOPER: Right. Maybe we shouldn't say  
9 one or the other, but not restricted.

10 MR. PETRUS: I think what we need to do is  
11 we need to --

12 MR. CARMODY: -- gets back to the  
13 complexity. I think this goes back to these working  
14 assumptions that we have to get through, because one of  
15 the reasons why we said don't build an on-line consent was  
16 that we didn't want the administration to use it as --

17 DR. CARR: Well at least one of our  
18 assumptions is that it can't be a consent process that  
19 requires additional administrative support from the HIE,  
20 and then that would dictate.

21 MR. PETRUS: If I could push a little bit  
22 on this, you're getting into the functional requirements  
23 and capabilities. Tom asked earlier how granular, what  
24 level of granulation do you get to?

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MS. HOOPER: Are we too granular right now?

2 MR. PETRUS: I think you're too granular.

3 MS. HOOPER: Are we extra-fine sugar?

4 MR. PETRUS: I think you're powder. You're  
5 at the Tom Collins level. Unless you want to say to the  
6 Board and you want to say to ONC that we will not have an  
7 on-line, or we will have an on-line, or we have a  
8 combination, I don't know if that has to be decided.

9 DR. AGRESTA: Right. I was trying to say  
10 I'm not sure that we know, and, so, therefore, I would  
11 keep the language of, you know, the client, you know, keep  
12 our stakeholders broad, like, you know, this does need to  
13 be thought of as something that might (multiple  
14 conversations).

15 MR. CARMODY: It's not so much yes or no,  
16 but there was, again, it goes back to the working  
17 principles around keeping the administrative layer, so,  
18 then, if that's a guiding principle, then we'd go into  
19 that as issues around, again, which is a more granular  
20 issue, but it was administratively we didn't want to have  
21 an outward face to --

22 MS. HOOPER: To go with the list.

23 MR. CARMODY: To the patients.

24 MS. HOOPER: Again, we're moving -- all the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 committees need to, again, kind of review this and keep  
2 working.

3 MR. PETRUS: Because one of the things that  
4 could happen from the Board is that they'd want to have a  
5 patient portal, which would add a complexity.

6 One thing I'm hearing, I think it's  
7 important for us, and we will take it as an action item,  
8 we have to define participant, client, public, consumer,  
9 patient, because there's some areas where it definitely is  
10 client services to those that are pushing, pulling data  
11 through the HIE, and they have a right, and they are  
12 paying for a level of service, security and controls that  
13 you have to communicate to and work with and make sure  
14 it's there, and then there's another piece that you have  
15 to work about, is helping consumers, patients understand  
16 how you're protecting their personal health information  
17 and the right for confidentiality and privacy consistent  
18 with HIPAA.

19 MS. HOOPER: Thank you. We're talking with  
20 ONC to see if we can get some clarifications on those  
21 definitions, but we have to set them for our own  
22 discussion, set them in the plan, and set them as part of  
23 our communication strategies, or else we're all -- we  
24 might be saying things and implying another.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: And the last functional area  
2 is administration, long-term sustainability model, finance  
3 management, ongoing procurement for human resources,  
4 overall operation administration of the authority.

5 We anticipate 23, it could be 20, it could  
6 be 25, but as we look at this functional model and do some  
7 guesstimate, 23 full-time equivalent we see as necessary  
8 overall. Some of these can be resourced by partners that  
9 you might work with, State partners, private partners.

10 Others can be staff augmentation. We think  
11 that there should be a strong core of nine FTEs to insure  
12 the continuity and alignment for the strategic direction  
13 as you move out.

14 MS. HOOPER: There's the seven million.

15 MR. WOLLSCHLAGER: There's a lot more than  
16 seven million.

17 MS. HOOPER: Well we only have seven  
18 million dollars. That includes implementation funds,  
19 unless an insurance company maybe wants to lend staff.  
20 (Multiple conversations)

21 MR. PERKINS: Just to do a time check,  
22 Frank, I think you needed --

23 MS. HOOPER: We need 20 minutes for public  
24 comment.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PERKINS: Okay.

2 CHAIRMAN GALVIN: Is there going to be any  
3 public comment? Let's ask. Let's ask the public. Is  
4 there going to be any public comment?

5 MS. HOOPER: So far.

6 CHAIRMAN GALVIN: Also, the people who  
7 might comment are probably sitting in the audience.

8 MS. HOOPER: Oh, but I mean if they hear  
9 anything else that they'd like to comment on after this.

10 CHAIRMAN GALVIN: Yeah. If somebody wants  
11 to make a comment, let us know, otherwise, we'll go to  
12 4:00.

13 MS. HOOPER: There you go. Thank you, sir.

14 CHAIRMAN GALVIN: Okay? Let me give you.  
15 If you under staff this, you're done. If you dissociate  
16 yourself -- let me make something crystal clear.

17 This program is for the benefit of three  
18 and a half million people, so that they will get better  
19 health care, and the people who could tell you who gets  
20 good health care or don't get good health care they're  
21 guys that have M.D. after their name and not  
22 administrators and not guys with MBAs, or however the hell  
23 you want to call, but the guys, like Ken Dardick, like Tom  
24 and Kevin, who are physicians. They can tell you that, so

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 if you dissociate that part, it's going to fail.

2 I can tell you exactly what you get. If  
3 you went over to the State Capitol today and asked for an  
4 item, what would you get? Hot water. That's the game.

5 MS. HOOPER: And I understand, and I think  
6 that, again, we need to look at, back to the Finance  
7 Committee, sorry that I'm picking on you, but it's so  
8 easy, but the issue there is not you, the issue being that  
9 when we talk about the financing committee, in fact, just  
10 for everybody, we have the 7.2 million dollars in the  
11 cooperative agreement. There is the RHC funds. There's  
12 the reimbursement fund for the physicians. There's the  
13 self-sustainability model. There's the State legislature.  
14 There's other federal funding opportunities.

15 All of those together right now, what we  
16 have in hand to both staff and implement, staff a RIO or  
17 an agency and implement an actual Health Information  
18 Exchange is seven million dollars, unless we're going to  
19 talk more on the RHC funds and how we can leverage  
20 existing resources being dedicated to HIT.

21 But back to the Financing Committee, you  
22 know, if we're going to staff this great agency with some  
23 really good people, then we don't have a product to  
24 develop, but a product to support that might be off the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 shelf, you know, again, and how that happens.

2 CHAIRMAN GALVIN: So let me interject one  
3 remark, which will make me hugely unpopular.

4 MS. HOOPER: I doubt that.

5 CHAIRMAN GALVIN: That's all right. The  
6 authority is going to meet first on the first of November.

7 MS. HOOPER: Yes, sir.

8 CHAIRMAN GALVIN: Guess what's going to  
9 happen shortly after the first of November?

10 MS. HOOPER: I think there's an election  
11 right after that.

12 CHAIRMAN GALVIN: Yeah, and then you're  
13 going to have a whole bunch of people, who want to change  
14 everything, so we need to have our heads screwed on tight,  
15 and we need to say, if we decide, you know, we've got  
16 great consultants here, if we decide nine people and  
17 somebody says can't you do it with four, no, we can't.

18 MS. HOOPER: Actually, DPH's cooperative  
19 agreement with ONC legislation would have authority, but,  
20 again, that's why they did have that the Board would be  
21 named before the appointing bodies were excused, possibly,  
22 but, anyway.

23 CHAIRMAN GALVIN: Okay. Excuse me. There  
24 will also, making himself more unpopular, be a fair amount

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 of job hunting at that time, or job giving at that time,  
2 and we may not want to accept everyone we're given,  
3 particularly people who don't have subject expertise, so  
4 we need to straighten this out and figure out what we want  
5 and what kind of people we want, so we don't get  
6 somebody's nephew.

7 MS. HOOPER: You could have just rolled on  
8 with the next agenda item.

9 CHAIRMAN GALVIN: Everybody is somebody's  
10 nephew, but you know what I mean.

11 COURT REPORTER: One second.

12 MR. PERKINS: So this section, actually, we  
13 want to talk about how do we move toward really locking  
14 down what we think this HIE will cost for the State of  
15 Connecticut, so in terms of the approach how we're going  
16 to talk about doing this, obviously, it would be based on  
17 the vision and priorities and the phases set forth in the  
18 strategic plan, agreed to by leadership here today.

19 We move to represent a total cost view, so  
20 not just the software costs, or not just implementation  
21 costs, but really a holistic view of what it's going to  
22 cost, and we want to get at that total cost view with any  
23 kind of multiple approaches for input, so there's some  
24 rules of thumb.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1           You probably have heard some, you know, a  
2           dollar for a participating physician, and there's a whole  
3           range of things, but the fact is the HIE marketplace is  
4           still very much forming, and those rules of thumb go out  
5           of date quite quickly, so we can't rely on that.

6           When you take a look at what's going on in  
7           other states and looking at what they've submitted, in  
8           terms of their strategic and operational plans and try to  
9           make some sense of that in comparison to Connecticut, you  
10          know, relative to where that state is versus where  
11          Connecticut is in the evolution --

12          MS. HOOPER: Alistair, stop doing that.

13          MR. PERKINS: I'm just doing an overview.

14          MR. MCKINNON: You're not doing it --

15          MS. HOOPER: I know, but, Alistair, you're  
16          making me crazy. (Multiple conversations) I'm going to  
17          hit you next, Alistair.

18          MR. PERKINS: So in addition to looking at  
19          what other states are doing, we're going to actually get  
20          some input from the HIE vendor community.

21          We certainly want to do that in a way that  
22          will not preclude anyone's participation. I think that's  
23          a good role for Gartner to play in this engagement, so the  
24          vendor community would not know we're talking about

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Connecticut.

2 We've described the characteristics and the  
3 working assumptions. We want to get them to provide us  
4 some guidance on what they would suggest to put in place,  
5 in terms of budgets at this point in time.

6 And then there's just some high-level  
7 estimates that we can do around the organizational policy,  
8 that sort of thing, so costs will be spread out over  
9 multiple years, but really the key thing is, once we have  
10 a good understanding of what we think it's going to cost,  
11 that's where you're going to have, you know, relative to  
12 the money you have today. I think you said seven point  
13 something.

14 MS. HOOPER: What we do have, right, that  
15 we can begin to work with.

16 MR. PERKINS: Right, so, 7 point something  
17 million, plus some additional and matching funds, and then  
18 kind of lay that all out, and, so, what's available and  
19 the difference with what it's going to cost, that's where  
20 you have to focus really what goes in the strategic plan,  
21 is what are the funding caps.

22 We talked about proposed assessment. We'll  
23 kind of lay that out as we move forward. So a couple of  
24 assumptions. We've already talked about these somewhat,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 but really the focus for the HITE Connecticut staff is  
2 around leadership, governance, management, some operations  
3 from the participant perspective, but the real detailed  
4 implementation effort, the technical operation of an HIE  
5 really would be performed by a third party.

6 The cost should take into account really  
7 what's going to be required, in terms of a reporting  
8 capability around gap, around ONB(phonetic) reporting,  
9 around our funding reporting back to ONC.

10 Frank mentioned earlier that the  
11 operational plan is, you know, it's not going to be  
12 finished in August and stamped and staffed (coughing) over  
13 time, and correspondingly, you know, as that plan evolves  
14 and the strategy evolves over time or the details really  
15 of implementation involved, so may the cost evolve over  
16 time, so this is a starting point, and you have to  
17 remember, you know, as you get into the procurement phase,  
18 you're going to refine these cost budgets when you get  
19 more detailed input from vendors.

20 We talked about this earlier, as well. No  
21 decision had been made on the specific solution of an HIE,  
22 so, you know, if you could talk kind of pre-solutions on  
23 kind of the software licensing side to the solutions that  
24 are maybe talking to the spectrum, so we're not worried

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 about a specific technical solution at this point in time.

2

3 We're just going to talk about costs from a  
4 little high-level broad perspective, so it would be  
5 looking more like a market average cost, based on the  
6 specific needs of Connecticut.

7 And then, so, we're not addressing funding  
8 and how you're going to fund this thing in this document,  
9 not the operational plan section of the document. That  
10 would really look back to the strategic plan, so just to  
11 clarify.

12 Okay, so, what is ONC really asking, in  
13 terms of what's included from a financing perspective?  
14 The focus is around the detailed cost estimate, so that's  
15 where we've got to really focus our effort. I'm going to  
16 talk about what is a total cost view of an HIE in just a  
17 moment.

18 There's some other things that they want  
19 that cost estimate to take into account that will also be  
20 reflected in other areas of the operational plan, but  
21 (coughing) Frank just talked about, dependency, specific  
22 time frames, what are the specific implementation tasks,  
23 what are the major risks. We talked about that, in terms  
24 of having ways to have -- some of the key things that have

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 got to happen for the program to be successful, staffing  
2 plan and reporting.

3 MR. COURTWAY: Excuse me. For the  
4 reporting side, Meg, is there a requirement to provide  
5 quarterly or yearly reporting to the state legislature,  
6 also?

7 MS. HOOPER: Yes. From the authority,  
8 itself, yes.

9 MR. COURTWAY: From the authority, itself?

10 MS. HOOPER: Yes, and it's not only on  
11 activities, but, also, for the budget.

12 MR. COURTWAY: So even though it's not  
13 required, we have at least for the state requirements,  
14 also.

15 MS. HOOPER: That's a good point. Thank  
16 you.

17 MR. PERKINS: Next slide?

18 MR. CARMODY: Can I ask you? So this has  
19 to be detailed out by when? It says key components need  
20 to be included in the operational plans.

21 MS. HOOPER: Right, which is what we're  
22 going to submit in September, and we're guessing, Dan,  
23 based on, again, if we consider what we've learned today,  
24 it's a lot of information, and what Gartner has laid out

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 for us and is before you is some working assumptions  
2 leading up to this point, and then they're going to  
3 present what some of the numbers are in other states, and  
4 then challenge us to see how would we calculate some of  
5 those numbers, based on, you know, everything is leading  
6 up to this.

7 MR. PERKINS: And we're going to help by  
8 reaching out to some vendors that we think would be a most  
9 appropriate fit for your working assumptions, and, again,  
10 not saying, hey, we need some total cost estimates for  
11 Connecticut, but say here's a state that's going to be  
12 going through this, now can you provide us an input back  
13 around what you would expect to see, in terms of budgetary  
14 estimates?

15 MS. HOOPER: Again, we'll be setting what  
16 the budgets are going to be submitted as.

17 MR. COURTWAY: And we have done some of  
18 this for other states that have worked on this initiative,  
19 and we've done some market scan, and we've also done some  
20 work for ONC around components that go into an HIE, so we  
21 have that data that we can bring forward to do some check.

22 MS. HOOPER: That's why we hired you,  
23 Frank.

24 MR. PETRUS: I thought it was because of

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Alistair.

2 MS. HOOPER: Well that's why I wanted you.

3 MR. PERKINS: So what do we mean when we  
4 say kind of a holistic view of cost or total cost? It's  
5 really the cost of the organization, kind of those very  
6 direct costs associated with people and staff, salaries  
7 and benefits. It holds a whole bunch of other indirect  
8 costs, like the space that they use, office equipment.

9 Budget for outreach and communication,  
10 obviously a big part of HITE in Connecticut. Travel,  
11 legal, a whole bunch of other miscellaneous stuff, but  
12 stuff that can get locked in indirect, and then we have  
13 really the HIE, and I'll just use the word infrastructure,  
14 but the HIE solution, itself, and there's some one-time  
15 costs associated with that around the software, hardware,  
16 master patient provider indexing solution, the  
17 implementation or kind of configuration that solution can  
18 actually work for them in the Connecticut environment.

19 Development of interfaces to the various  
20 points and probably management and oversight during this  
21 kind of critical phase of implementation, so, again, what  
22 we want to do is kind of take your working assumptions and  
23 the characteristics of Connecticut, take that to the  
24 vendor community and say come back and let us know what

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 you think this is going to cost.

2 What you've got implemented are a whole  
3 bunch of ongoing costs, kind of annual reoccurring costs  
4 around supporting corroborating the solution of the  
5 platform providing help desk, user training, vendor  
6 support maintenance, platform enhancements, improvements  
7 into the solution over time.

8 We talk about holistic view of cost or  
9 total cost of ownership, that this is really what we're  
10 focused on.

11 MR. PETRUS: So maintenance includes  
12 licensing or server licensing and other licenses that  
13 might need annual fees?

14 MR. PERKINS: Yeah.

15 DR. AGRESTA: Can I just ask? I think it's  
16 great that you're going to do all that, kind of gather  
17 some of that from the vendor community to help in this  
18 process, but what's the timing on that?

19 MR. PERKINS: We want to get to the vendor  
20 community this week, and I expect around a week turnaround  
21 time, maybe 10 days, something like that, but this is not,  
22 you know, we're not looking to address every line item in  
23 great detail.

24 I mean we're looking at taking kind of five

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 to seven high-level buckets and the characteristics of the  
2 Connecticut and need that you have and have them come back  
3 and have an example of what something like that may look  
4 like.

5 MR. PETRUS: The ONC requires you to update  
6 that budget at different milestones as part of the  
7 cooperative agreement, because you start here at an  
8 estimate. You'll get there at each one of those  
9 checkpoints.

10 MR. PERKINS: So, again, we're going to --  
11 it's a complicated enough area around estimating this  
12 cost, as pointed out, and I think this team has  
13 experience, so we're going to use multiple approaches,  
14 rules of thumb, what other states are doing, vendor input,  
15 and then our own high-level cost estimate, so we'll be  
16 working with Dan and the team.

17 MR. CARMODY: Question for you. Are the  
18 assumptions, the working assumptions that you're going to  
19 go through in the next that we talked about, you guys were  
20 going to take a week and go through, is that going to be  
21 synced up with this vendor evaluation meeting?

22 Is there anything that when you scan the  
23 information that we came back that we need to talk about,  
24 or, geez, that took you guys off in a different direction,

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 or is it nothing that you're concerned?

2 MR. PERKINS: Not at this point in time.  
3 Some of the working assumptions may be too low-level  
4 detailed that would really change the vendor's answer back  
5 to you in one shape or another.

6 MR. CARMODY: Understood. I agree with  
7 that, because some of them were very specific, but is  
8 there anything in the working assumptions that when you  
9 look at it and you say, okay, that's a low-level  
10 assumption, however, it actually raises a bigger issue  
11 that we need to be concerned with that would drive us into  
12 a different direction?

13 MR. PERKINS: I think we need a little time  
14 this week, like the earlier part of this week, to kind of  
15 fully sort through that, certainly given all the input  
16 from the other areas. If there is, we will look at it.

17 MR. PETRUS: In a minute, before we leave  
18 today, we want to look at some risks, and some of those  
19 higher risk areas may have some implications, but when we  
20 take a look at what the range of costs are for certain  
21 components and then what we can tell from our  
22 benchmarking, where we have average cost for  
23 (indiscernible), average staff for application power and  
24 so forth, that's pretty good data that I'm not concerned

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 about.

2 But as some of the complexity of some of  
3 the risks that you're facing that will have an impact on  
4 cost, because of time, that's something we can look at.

5 MR. PERKINS: I'm going to skip through  
6 these next few. I talked about rules of thumb. Here are  
7 some of the details. Like I said, this is not something  
8 that you want to use to really drive your cost estimates  
9 in the operational plan, just kind of are we in the rough  
10 ballpark?

11 MR. PETRUS: This is sanity check.

12 MR. PERKINS: Sanity check.

13 MR. PETRUS: When we get it, then we'll  
14 count up the number of patients, and we'll do some sanity  
15 check to say is this really inflated, or is it really  
16 short?

17 MR. PERKINS: So when we looked at what the  
18 other states had submitted, just kind of summarize that  
19 here, over four years, 32 millions dollars from now, they  
20 seem to be in kind of a similar situation. They haven't  
21 really started implementing HIE within the state.

22 They're expecting to get 10 million in  
23 state funds actually to support the HIE initiative, and  
24 this was coming through, actually, someone here may be

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 more familiar with it than I am, but I think it was a rate  
2 setting program, so I assume that they will be charging  
3 more for rates for the underinsured, people not covered,  
4 and then recovering that to actually fund the HIE.

5 MR. PETRUS: The key here to look at is the  
6 population numbers, docs numbers, hospital numbers to give  
7 you some comparison for Connecticut.

8 MS. HOOPER: Yes, but, if you look at the  
9 next one on Utah, I mean it's half the population, but,  
10 you know, a fifth of the price, so --

11 MR. PERKINS: Right. That's why we can't  
12 use these and just kind of map it to Connecticut, of  
13 course. They're much further along in the events of the  
14 HIE initiatives. In fact, started with the clinical  
15 exchange information as early as 2004.

16 MS. HOOPER: Right.

17 MR. PERKINS: So their focus now is on  
18 expanding that to include some additional capability,  
19 actually some of it around e-prescribing and lab ordering  
20 and delivery. Same with the PIN update, but much lower  
21 cost for sure.

22 DR. CARR: In Utah, just as a little  
23 background, they also have administrative exchange going  
24 through --

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PERKINS: Yes. Exactly.

2 DR. CARR: So that's paying for a lot of  
3 staff.

4 MR. PERKINS: Absolutely.

5 MS. HOOPER: Correct. No, because I do  
6 want to stick with the 33 million. Really, that is a good  
7 operational number.

8 MR. PETRUS: -- Utah is like one health  
9 system here in Connecticut.

10 DR. CARR: Yes.

11 MS. HOOPER: Correct.

12 DR. AGRESTA: And they also have a huge  
13 amount of informatics support to set it up, which really  
14 funded a lot of it was through grants and, you know, sort  
15 of other stuff.

16 MS. HOOPER: But it is interesting for us  
17 to see the operational cost for Utah that hopefully some  
18 day we can get to.

19 DR. AGRESTA: Yeah. You might well.

20 MR. PERKINS: Okay, so, I'm not going to go  
21 through these for the sake of time, but they're here.  
22 We'll take that into account. Maine was also an example.

23 In terms of when we go to the vendor  
24 community for input, this is kind of the level of detail

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 that we're going to ask them for. Obviously, the kind of  
2 organization cost would be taken out, but what's the  
3 software cost, what should we budget for hardware, what  
4 should we expect for implementation and interfaces given  
5 the working assumptions and characteristics about  
6 Connecticut?

7 What do we expect for an ongoing operations  
8 vendor support maintenance, etcetera?

9 MR. CARMODY: So can I ask? So what are  
10 you using for the input to that? So you said the  
11 characteristics. What are you giving?

12 MR. PERKINS: We haven't put it together,  
13 but there will be some summary of the strategic plan, what  
14 are the priorities? We need to dig into your working  
15 assumptions a little more, but whatever that we think, you  
16 know, at the HIE you know --

17 MR. CARMODY: So do you already have some  
18 of these pieces, or is that what you're going to end up  
19 getting?

20 MR. PERKINS: The metrics, we can get that,  
21 yeah, easily. Yeah. But I'm thinking more than just  
22 numbers. I'm thinking the characteristics of what you  
23 want to accomplish in HIE in Connecticut.

24 CHAIRMAN GALVIN: And who goes to the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 vendors? You said we go to the vendors.

2 MR. PERKINS: We'll help facilitate that,  
3 yeah. Again, because I think that's a good role for us to  
4 play, because they don't need to know it's Connecticut.

5 MR. MCKINNON: Well, actually it's not  
6 Connecticut so much, but it's got nothing to do with  
7 Connecticut, so this is disconnected from any sort of  
8 procurement process with us.

9 CHAIRMAN GALVIN: Okay.

10 MR. PETRUS: We've already done some of  
11 this for other clients, and we've already done some of  
12 this for ONC, so we're trying to expand on the database  
13 that we've already developed around capacity, and we will  
14 talk about the functionality you want, but we'll also talk  
15 about low, mid and large jurisdictions. Obviously,  
16 Connecticut would fit in there, I believe, as we do this,  
17 so that's something that's in process for us now.

18 MR. PERKINS: Okay, so, again, we're not  
19 talking about reams of data back from the vendor, but some  
20 high-level guidance over some key categories for multiple  
21 years. So how does this translate or relate back to  
22 funding?

23 This is your seven point, you know, nearly  
24 three million available, plus matching funds. We've got

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 federal matching fund requirements, so, you know, for  
2 input back to the strategic plan, we need to really  
3 understand what we have available, what are the costs in  
4 key categories, and how does that map out over the years,  
5 and then kind of on an annual basis, what are the  
6 additional funds that's really needed? Warren?

7 MR. WOLLSCHLAGER: It may not make any  
8 difference, but, again, Connecticut is using in kind, not  
9 matching dollars.

10 MR. PERKINS: Correct. Yes. Thank you.

11 MR. PETRUS: We're not defining how you use  
12 the dollars.

13 MR. WOLLSCHLAGER: I figured that, but I  
14 just want to make sure that that's the assumption.

15 MR. PERKINS: And that did include the in  
16 kind bond, 8.4. It does.

17 MS. HOOPER: Okay.

18 MR. PERKINS: So, again, not to get into  
19 the details here, because this is really about the  
20 funding, but to help kind of set up and facilitate that  
21 funding discussion. Some of this was in a strategic plan  
22 already, a whole bunch of sources, and your purpose is  
23 really to focus on how do we get at the short-term and  
24 longer term needs of this.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   Once we've got an understanding of what  
2                   those additional funds required are, we can start to map  
3                   it back to where we plan to get the funds. And I think,  
4                   for the purpose of the September/October submission to  
5                   ONC, this is the level of detail that we need for the  
6                   strategic and operational plan, along with kind of your  
7                   thoughts around the kind of ongoing sustainability, so  
8                   some of this is securing, you know, near-term funds  
9                   through whatever means assessment, or whatever is decided  
10                  on, and then some high-level, you know, vision of how you  
11                  want to actually charge for those services corresponding  
12                  to the value they deliver.

13                               MS. HOOPER: Okay. Thank you.

14                               MR. PETRUS: We're going to talk about  
15                               risk, but before we talk about risk, are there any public  
16                               comments on anything that has come up regarding the work  
17                               breakdown structure and the approach to the operation of  
18                               the plan?

19                               MS. HOOPER: And if we have any comments,  
20                               if you could come up to one of the microphones, please?  
21                               Thank you. Frank?

22                               MR. PETRUS: You got it. Let's talk about  
23                               risk analysis and where we would like to end today. If we  
24                               can get your input in the 20 minutes that we have left?

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MS. HOOPER: I'm sorry. For the record,  
2 there being no public comments, Frank, continue.

3 MR. PETRUS: We classified the risk based  
4 upon industry standards around COFIT, which is Control  
5 Objectives for Information and Technology Management.  
6 ITIL, which is Information Technology Infrastructure  
7 Library, which has to deal with the management and  
8 services provided to oversee the complexity of an IT shop,  
9 such as with HIE, and we tried to map these risks back to  
10 the ONC domain, so we could say to ONC Connecticut has  
11 reviewed this operational plan and really looked at  
12 prioritizing the risk that we were faced. We're not  
13 naïve. We're not thinking that we're not going to face  
14 any risks or barriers, and we have come up with mitigation  
15 strategies to address these risks with building them into  
16 our operational plan.

17 We're not going to be Pollyannic about  
18 this, so what we need from you is some sanity check on  
19 whether or not we're accurate about the risk, and what we  
20 have is risk framework is the core business hazards, non-  
21 participation by providers. What if you gave award and  
22 nobody came? What if you develop the HIE and no one  
23 comes, or your value proposition isn't clear?

24 Governance, the governance structure is not

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 represented. Finance, we all have the start up financing  
2 as secure as we need it. Financial sustainability, the  
3 future funding of this and sustainability of this is not  
4 viable.

5 HIE functionality is complex. A lot of  
6 push and pull, and Connecticut is very rich with the  
7 technology capabilities of its participant entities and,  
8 also, very challenged on the doc side with the majority of  
9 docs are in two, or three, or less practices.

10 Adaptability to what happens in the future,  
11 business and technical operation is timely solution  
12 delivery. People have great concerns that the State of  
13 Connecticut can't get out of its own way and make this  
14 real. We heard that from stakeholders.

15 MS. HOOPER: Yup.

16 MR. PETRUS: You've heard that from  
17 stakeholders.

18 MS. HOOPER: Of course.

19 MR. PETRUS: Vendor risk, vendors over  
20 promise, under deliver. Staggered implementation not well  
21 coordinated, and then legal policy, breaches and security  
22 or confidentiality, and, so, we've weighted these are very  
23 high-risk for what we see now. This is Gartner's take on  
24 it.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1                   The yellow, medium risk and the donut  
2                   green, low priority, so let's go through these and get  
3                   your sense of the analysis. Thank you, Alistair. We  
4                   think it's a very high risk is the participation of  
5                   providers from some of the feedback that has happened,  
6                   some of what we've heard, and Q care hospitals may choose  
7                   to implement community sharing initiative in their service  
8                   area and bypass the HIE, and our payers may choose to  
9                   implement share initiatives for their own provider network  
10                  separate from the Connecticut HIE. We see that as a high  
11                  risk.

12                                 MS. HOOPER: Yes.

13                                 MR. COURTWAY: Could you put an HIN direct  
14                   as a high risk in its category?

15                                 MR. PETRUS: Yup. One of our research  
16                   analysts, Wes Richel(phonetic), has already written about  
17                   that, because, basically, there's two messages going out  
18                   to the community through your statewide HIE, through HIE  
19                   director at HIN direct. We will add that.

20                                 MS. HOOPER: Yeah, please. Thank you,  
21                   Peter.

22                                 MR. PETRUS: So no disagreement on that?

23                                 MR. CARMODY: Where did you come up with  
24                   the payers may choose to implement the data sharing just

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 for their own private network?

2 MR. PETRUS: From you.

3 MR. CARMODY: We have heard that comment  
4 here and elsewhere.

5 CHAIRMAN GALVIN: So what you're saying is  
6 Lawrence & Memorial has a network with their  
7 practitioners, and they may say we don't care what happens  
8 in Torrington. We're all set up, and we're not going to  
9 participate in any other organization.

10 MR. CARMODY: I guess, as representing the  
11 payers, I just don't necessarily know. I don't think that  
12 there's been a value proposition put in front of them to  
13 say why you wouldn't. I mean for a lack of not having it,  
14 I think you'd say, yeah, I mean I'm going to continue  
15 along with medical and other things that are within my  
16 network, but if given the opportunity to be able to share  
17 and get more information to understand how you (coughing)  
18 services.

19 MR. PETRUS: So you would remove that  
20 second?

21 MS. HOOPER: Yeah.

22 MR. CARMODY: Anyone disagree with that?

23 DR. CARR: I think, if you just say  
24 "payers," it says it's payers, but if you said all of the

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 participants, really, I mean that's a risk.

2 MR. CARMODY: Yeah. I would say I think  
3 it's broader than payers.

4 DR. CARR: Yeah. I think the issue of even  
5 patients, right, not messaged correctly, may choose to  
6 sort of consent, not consent.

7 DR. AGRESTA: You said participants may  
8 choose.

9 MR. CARMODY: Right.

10 MR. PETRUS: We'll work on that. We'll  
11 work on that.

12 DR. AGRESTA: And it may represent, you  
13 know, critical mass fast enough, as opposed to eventual --

14 MR. PETRUS: Good point. I like that. I  
15 think that is a good point, having the critical mass  
16 sufficient to initiate and then sustain.

17 DR. AGRESTA: We see the value proposition  
18 as not that much a risk. We think a lot of work has gone  
19 into that. I think that there's a lot of consensus that  
20 there is a value proposition. Whether or not it be  
21 fulfilled by the HIE has got to be challenged, but we  
22 don't see that as a major risk.

23 MR. CARMODY: I think there's an issue  
24 around the ability to measure. I think the value

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 proposition is one thing. I think everybody sort of says,  
2 yeah, it seems about right. The ability to measure it is  
3 the issue when it gets into how do you measure?

4 MR. PETRUS: Okay. Good. Good.

5 Governance, governance structure is not representative of  
6 all stakeholder interest. We see that as a moderate risk,  
7 because we think that it's been addressed in the  
8 authority. There's subcommittees, there's public  
9 participation, and we think, with the regional extension  
10 centers, that there's more movement in that direction, so  
11 we don't see that as a high risk. Consensus on that? I  
12 see nodding. I know it's getting late.

13 Finance start-up funding availability,  
14 short-term start-up funding cannot be secured. We think  
15 that the start-up funds are there. When you really think  
16 of building the infrastructure, getting the Board on its  
17 feet, you've got, with in kind services, about eight  
18 million dollars.

19 You get the approval from ONC, that should  
20 be enough that, you know, create the house of cards.  
21 Sustainability, is it a house of cards, or is it, you  
22 know, two by fours or metal framing with concrete floor  
23 and infrastructure re-bars that will go forward? We think  
24 that that's a real risk for a variety of reasons.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 Political reasons, I think the Commissioner  
2 was quite articulate about we've got an election coming  
3 up. There are going to be new players. The commitment  
4 and the urgency to support this going forward I think is  
5 more political, and then we talked about the value  
6 proposition and participants participating and becoming  
7 subscribers. We see this as a major risk to be mitigated  
8 and talked about mitigation in the operational plan.

9 DR. CARR: Do you mind if we break out the  
10 start-up funding for governance and oversight out from the  
11 start-up funding of technical infrastructure?

12 MR. PETRUS: No, not at all. It's your  
13 plan.

14 DR. CARR: I think that's where the concern  
15 is here, and the State of Connecticut will have enough  
16 money to start up and the governance and meeting  
17 facilitation, etcetera, but never -- the money won't  
18 actually get there for --

19 MR. PETRUS: You're looking at funding for  
20 governance and structure, operation structure, and for IT  
21 infrastructure.

22 DR. CARR: Right, so, I would agree with  
23 you that that one for governance structure is yellow, but  
24 the one for technical infrastructure is red.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: Well, see, that would push it.

2 I think, for infrastructure, it would be yellow, because  
3 I think that you have enough money to build the master  
4 patient index, the master provider index, the messaging  
5 and record locator, whether anybody wants to play with it  
6 or not.

7 I think that, with eight million, you  
8 should be able to do this, at least the setting up of the  
9 HIE, but then, when you go to the call complex operation  
10 and three releases, that's when I think you get the grant.

11 I think we can write it that way, though. I think that's  
12 a really good point to say to ONC. We've got enough to do  
13 this and this, we're challenged on this, and this is how  
14 we're going to mitigate it, and this is how we're going to  
15 move forward with it.

16 MR. COURTWAY: Frank, the only thing I go  
17 back to is that in a non-participation by providers, the  
18 risk of physicians, you know, not funding their EHRs and  
19 the connectivity to the exchange.

20 MR. CARMODY: Does it create the  
21 dependency?

22 MR. COURTWAY: Yeah.

23 DR. AGRESTA: Well even if they fund their  
24 EHRs, actually getting them connected is still a huge

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 task. It's that critical mass issue.

2 MR. CARMODY: Then I think you get into the  
3 dependency, where if you can't get the legislator to pass  
4 the assessment, you know, and, again, the reason why, when  
5 we were talking before, you know, is that you're going to  
6 encourage everybody to participate, and then you're going  
7 to have the assessment that comes along, well, gees, if  
8 I'm being encouraged to participate and I'm paying the  
9 assessment, why wouldn't I build that sort of last leg of  
10 the bridge?

11 So there's the dependency of it will be  
12 definitely be red it you can't get the assessment piece to  
13 start off to sort of create -- what you want to do is  
14 prime the pump. The whole idea is the assessment primes  
15 the pump.

16 DR. AGRESTA: We talked Regional Extension  
17 Center level. Just getting the priority primary care  
18 providers that we're supposed to get up and going is  
19 really going to be a challenge of task. And then getting  
20 them to connect into the HIE to get the meaningful -- so  
21 it's not, I mean there is a critical role on some level  
22 of, you know, folks who are going to use an HIE and then  
23 find value in it and not rebel against it, you know, and  
24 all this has got to be synchronized correctly, and it's

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 not just what you'd attach a tax and provide them with  
2 dollars that's important.

3 It's the functional capacity to reach all  
4 those milestones at that level, which may have nothing to  
5 do with desire, but everything to do with ability to  
6 change management in an office, or enough folks available  
7 to pound the ground, actually help them set their stuff  
8 up.

9 MR. PETRUS: And I think that's the key for  
10 the Regional Extension Centers, and that's in some states.

11 I know Arizona has got a very robust Regional Extension  
12 Center approach to all the things that you're talking  
13 about, because who is going to support that for them going  
14 forward?

15 MR. CARMODY: And, hopefully, again, as you  
16 guys are talking to the Regional Extension Center,  
17 hopefully it's how do you do this efficiently and  
18 effectively, so, again, is it every single office that  
19 it's going to go out and buy and EHR, or is it going to be  
20 sort of that vendor solution that gets us to what you need  
21 to do?

22 DR. AGRESTA: I mean I think you've got --  
23 you're going to have a roll out, where you're going to  
24 see, you know, hopefully, year-by-year, you'll get a

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 higher and higher penetration into the marketplace, but  
2 you've also got -- I mean the Regional Extension Center is  
3 Medicaid.

4 If you look at the total number of  
5 providers they're going to go after, it's still going to  
6 be, you know, in Connecticut maybe 30 percent of the total  
7 providers. You're still going to have here another 70  
8 percent somehow.

9 MR. PETRUS: We'll spell out more of that.

10 Technical infrastructure, here, we're really taking a  
11 look at the functionality moving forward to meet the end  
12 users' needs, all the end users' needs, and our concern  
13 here is that this is high-risk and requires very strong  
14 project management, very strong application development  
15 oversight, quality assurance, to make sure that systems do  
16 integrate with all the systems that are out there and  
17 entities that are out there, that the shared directories  
18 for patients and health service providers in those  
19 functions are working, all the moving parts.

20 We think it's a mitigatable risk, but I  
21 think it would be naïve to go in this and not thinking  
22 that the complexity of payers, payees, providers, health  
23 systems, hospitals, working with Medicaid, Medicare,  
24 Public Health, all the entities that have to be involved.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 There's tremendous complexity that this will function  
2 properly.

3 On the other hand, when we think about the  
4 adaptability flexibility regarding changing requirements  
5 that moving forward, who think that all of the systems  
6 that are out there in the components, and you talked about  
7 service oriented architecture moving forward, we think  
8 that's a lower risk.

9 The big risk we think is the quality and  
10 the oversight and the management necessary to get what  
11 you're paying for when you develop the technology.

12 CHAIRMAN GALVIN: But if you're under  
13 funded, how can you do that?

14 MR. PETRUS: It would be very challenging  
15 to do that, but even with the eight million you've got,  
16 though, Commissioner, even with this that you've got, I  
17 think you have enough money to build the cardiovascular  
18 system, but I don't think that it will be risk-free if you  
19 don't have the quality people in your authority and your  
20 Board that are doing the technical oversight, the  
21 portfolio project management, the PMO office, the contract  
22 and vendor management quality assurance through the life  
23 cycle of the development.

24 If that isn't sophisticated, then you'll

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 have to fit into what the vendor gives you, and it may not  
2 be what you want.

3 CHAIRMAN GALVIN: -- New York or  
4 Massachusetts.

5 MR. PETRUS: Right, and it may not be what  
6 you need. That's a big risk.

7 CHAIRMAN GALVIN: My bottom line is if the  
8 State wants this to work, they have to invest in it.

9 MR. PETRUS: That's right. Absolutely.

10 CHAIRMAN GALVIN: The venture capital and  
11 if we put this under funded and we've got people who  
12 aren't really technically competent, but are on the  
13 payroll, we're done, and it's a waste of money. I think,  
14 at some point, we might as well sit down and say if we're  
15 not going to get sustainable funding, then maybe we ought  
16 to figure out how to contract with Rhode Island or  
17 Massachusetts or somebody else. I'd rather see it work --

18 MR. PETRUS: I think that's a very good  
19 point. As you move forward with your operational plan  
20 with these checkpoints, if you see that it's not going, I  
21 think that plan B needs to be a consideration.

22 Business and technical operations, if the  
23 solution cannot be delivered within the expected timeline,  
24 and this is real critical, because you're out there now

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 with the Regional Extension Centers, with DSS, with Public  
2 Health, with all of you here in the new authority setting  
3 expectations, and if you don't start delivering on those  
4 expectations, risk number one was people won't want to  
5 participate. They're going to drop off.

6 And, so, being able to deliver this  
7 successfully and on time and within budget with minimal  
8 change orders or slippage, we see this as a high risk for  
9 the business and technical.

10 The use of vendor challenges relating to  
11 meeting milestones in the state plan and the staggered  
12 implementation impact on functionality, we think all of  
13 these are pretty low risk.

14 We think you've done a lot of diligence.  
15 You really got good stakeholder participation, and you've  
16 got, both from a legal and policy perspective, from a  
17 finance perspective, from a business and technical  
18 operation, you really have been realistic on staging.

19 You haven't been trying to over promise and  
20 under deliver, so we think, from the business and  
21 technical operation planning, that you have very minimal  
22 risk if it's staffed right with smart people, if it's  
23 funded appropriately. Disagreements?

24 DR. AGRESTA: It's got to be staffed right.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: Staffed right. I mean I  
2 really think that that is really critical. If you're  
3 going to have a small, lean organization, you can't have  
4 average staff. If you have a large organization, you can  
5 have a lot of average staff. When you have a lean  
6 organization, you've got to get to the right side of that  
7 bell-shaped curve and hang onto them.

8 Legal and policy, the inappropriate sharing  
9 of information, we think that a lot of work has been done  
10 there. We think that the legal and policy -- I have to  
11 say, of all the states we work with, you have done the  
12 most thorough job.

13 Safeguards for privacy, industry standards  
14 or security privacy, we think that that is really  
15 available. The red risk is not that it's an issue of  
16 availability or functionality. It's something that,  
17 regardless, you always have to have that as the number one  
18 risk.

19 One breach, one headline and you're done,  
20 so we think that that always should be red, and you always  
21 should be anticipating the worst that happened and doing  
22 everything to prevent it.

23 Complex participant agreement, this is --  
24 even though you've done all the work, you've defined your

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 opt out system, you have to train providers on how to  
2 educate their consumers. You have to work with hospitals.  
3 You have to work with labs. You have to work with  
4 pharmacies. You have to work with all of the participants  
5 to make sure that day-to-day consumer doesn't look at this  
6 through sound bites and mythology that the sanctity of  
7 their personal health records are going to be violated.

8 You all remember what happened with the  
9 end-of-life counseling and decision-making and how it was  
10 to be paid with Medicare funds turned into death panels.  
11 We have this red, because of that.

12 We have this red, because no matter what  
13 you have done in the operationalizing of this and working  
14 with the RECs and AARP and other patient advocacy  
15 organizations and providers, this is a lot of work. We're  
16 going to do a lot to mitigate this. Any disagreements?

17 Breaches doing inadequate training, we  
18 think that that's not the issue. The issue is really the  
19 safeguards that you put in place. Training, we think, can  
20 happen.

21 MS. HORN: I know you addressed this  
22 earlier, but the non-participation by patients was  
23 certainly one of the concerns that we had with the group  
24 in getting the amount of information that you need to have

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 in an HIE for it to be useful.

2 MR. PETRUS: Meaningful.

3 MS. HORN: Meaningful. And, so, that might  
4 be a concern there. If the consent policy is such that it  
5 is too complicated, maybe we'll address that in the one  
6 above, but this is a slightly different take on that, or  
7 cumbersome, or requires them to (coughing) concerns that  
8 they might not have, then they might not opt to be part of  
9 it.

10 MR. PETRUS: That's very good. We should  
11 add that.

12 MS. HORN: And then the only other piece I  
13 had on that concerning that that we've been talking about  
14 is interoperability with other states. If we have a  
15 policy that is slightly different from what other people  
16 have adopted, is that going to set up a barrier there?

17 MR. PETRUS: We should add that. I would  
18 see that more as a yellow risk, because what ONC has tried  
19 to do is standardize, but that doesn't mean that everybody  
20 is going to play.

21 MS. HORN: And I think there's technology  
22 that will help out with this.

23 MR. PETRUS: Good. So what we've got is  
24 these as our key risk areas that we will write mitigation

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 to. Anything missing? Anything that we should add?

2 MR. COURTWAY: So it's basically all red  
3 across the board?

4 MR. PETRUS: No, it's not. I'd say,  
5 considering this subcategory, that's not too bad. The  
6 biggest challenge for you, I believe, is they're going  
7 through an election time, and you're going through one of  
8 the most difficult budget times since probably '83, maybe  
9 even '62.

10 If you saw the report that came out of PEW  
11 a couple of weeks ago, the report that came out of the  
12 Association of State Comptrollers and basically saying  
13 things are not going to get better until the third quarter  
14 of 2012 and that 2011 probably was the worst budget year  
15 for states since the early '80s, so when you start to  
16 think about what you're trying to do from a financial  
17 stability, when you talked about subscriptions or fees,  
18 people want to translate that into taxes, and they want  
19 government to be shrunken, and if there's not a strong  
20 value proposition and you have all the major entities,  
21 house systems and hospitals and payers and docs on board  
22 and, as the Commissioner said, talking as a constituency  
23 to elected officials, that the return on investment of  
24 this, the return on investment of this lowers more

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 intensive and invasive and costly medical services,  
2 because we have the information that we need to support  
3 better decisions for better health outcomes and better  
4 cost, whether that's for the payer, or the health  
5 hospital, or health system, or doc, or patient.

6 How do you get that return on investment  
7 message out there when people are looking to shrink and  
8 not spend anymore money? To me, that's your biggest  
9 challenge.

10 It's not technology. It's not privacy and  
11 security. It's not getting providers to play with you, or  
12 health systems, or payers, or hospitals. It's getting the  
13 financial stability necessary to make this happen, and  
14 eight million isn't enough to do it. It's enough to get  
15 it started. To me, that financial sustainability, if  
16 that's not there, no reason even to look at the other red  
17 dots.

18 Document structure, basically this is the  
19 structure we're using. This is the guidance that has come  
20 from ONC. I don't think there's anything --

21 MR. MCKINNON: We are going to follow the  
22 guidance?

23 MR. PETRUS: Yes. Very religiously. Next  
24 steps? Again, any comments that you have as you take this

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 away, you think about what we discussed today, the reports  
2 that came back from the committee, any input, please get  
3 on to Lynn, or is it Meg is the point of contact?

4 MR. MCKINNON: Lynn.

5 MR. PETRUS: Lynn? Get your comments on to  
6 Lynn. We are looking to have that additional feedback and  
7 further direction by the close of business on July 16th,  
8 so the end of this week, please get that information to  
9 us, any thoughts that you have, anything that you feel are  
10 really critical, and then we will move forward with  
11 drafting the operational plan with we hope clarity about  
12 the PIN for the Department of Public Health, and then, as  
13 we did with the strategic plan, bring it back to you for  
14 the same kind of debriefing we're doing now.

15 Anything else before we -- we went five  
16 minutes over.

17 CHAIRMAN GALVIN: Good job, Frank.

18 MR. PETRUS: Good job, team. Good job, all  
19 of you.

20 MR. MCKINNON: Any other public comments?

21 MR. PETRUS: Any other public comments?

22 No?

23 MR. WOLLSCHLAGER: There's another meeting  
24 beginning here right now.

HEARING RE: DOIT/HITE  
JULY 12, 2010

1 MR. PETRUS: We got the coordination  
2 meeting. Let's take a 10-minute break before the  
3 coordination meeting.

4 MR. WOLLSCHLAGER: You know what? We  
5 really don't want to.

6 MR. PETRUS: Don't take a 10-minute break.

7 MR. WOLLSCHLAGER: How about a five-minute  
8 break?

9 MR. PETRUS: Five-minute break before the  
10 coordination meeting.

11 MS. TOWNSHEND: Motion to adjourn?

12 MR. WOLLSCHLAGER: So moved.

13 MS. TOWNSHEND: And seconded?

14 A MALE VOICE: Seconded.

15 (Whereupon, the hearing adjourned at 4:06  
16 p.m.)