

VERBATIM PROCEEDINGS
DEPARTMENT OF PUBLIC HEALTH

CT HEALTH INFORMATION TECHNOLOGY
AND EXCHANGE STRATEGIC PLAN

ROBERT GALVIN, CHAIRMAN

AUGUST 16, 2010

101 EAST RIVER DRIVE
EAST HARTFORD, CONNECTICUT

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 . . .Verbatim proceedings of a meeting in
2 the matter of CT Health Information Technology and
3 Exchange, held at 101 East River Drive, East Hartford,
4 Connecticut, on August 16, 2010 at 12:00 p.m. . . .

5

6

7

8 CHAIRMAN ROBERT GALVIN: Okay. Do we have
9 a quorum?

10 MS. MARIANNE HORN: We do not.

11 CHAIRMAN GALVIN: Okay. Item number three,
12 Orientation to Strategic and Operational Plan. Frank?

13 MR. FRANK PETRUS: All right. Good
14 afternoon, all.

15 VOICES: Good afternoon.

16 MR. PETRUS: I remember, when I first
17 started teaching in a Catholic school, fresh out of
18 school, and it was Sisters of Mercy, and I was the first
19 male teacher in the school, and walked in, and I did not
20 know what to expect, because I never went to a Catholic
21 school, and, so, I said, "Good morning," and they all
22 stood up and said, "Good morning, Mr. Petrus, and may the
23 Lord be with you," so you left out "the Lord be with you."
24 Next time.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. MEG HOOPER: I'm sorry. We believe in
2 the separation of church and state. (Laughter)

3 MR. PETRUS: In Connecticut? All right.
4 The Strategic and Operation Plan is out there. We're
5 going to just do a really quick orientation to how it's
6 structured. As you know, go to the next slide, we have
7 been requested by ONC to integrate the Strategic Plan and
8 the Operational Plan, and the Strategic Plan had gone
9 through public comment.

10 We had integrated the comments from DPH,
11 the community and the committee, and, so, you'll take a
12 look at the Operational and Strategic Plan. It has an
13 executive summary, which gives you an introduction, talks
14 high-level the Strategic Plan, the Operation Plan, the
15 appendices.

16 In each one of those sections, if you go
17 next, the introduction focuses on the purpose and the
18 audience, an outline of the Strategic Plan, an outline of
19 the Operational Plan, the methodologies that were
20 employed, so it navigates all of that.

21 Next in the executive summary is a summary
22 of the key components of the Strategic Plan. Next in the
23 executive summary are the strategic components of the
24 Operational Plan and a -- the Operational Plan. Yes, I'm

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 sorry.

2 Let's go on to the next slide, please, the
3 schedule, and we have developed a schedule consistent with
4 ONC guidelines with key milestones, which are the
5 diamonds, and each one of those we have identified in the
6 Operational Plan of the key activities that need to be
7 done to achieve these milestones.

8 Next? Also attached to the Strategic and
9 Operational Plan is a Microsoft Project Plan, and I'll
10 have Alistair talk to you about how the IDs, the first
11 column that goes one through 315, how the IDs are aligned
12 to the specific activities in the Operational Plan.

13 MR. ALISTAIR MCKINNON: So the master
14 schedule, which is what we call the Microsoft Project
15 document, the reason why we've included a Microsoft
16 Project document, along with the Text One document is that
17 you can't actually see all the detail, unless you access
18 it as a Microsoft Project document, so both things have
19 been issued for public comment.

20 It has been organized into these 11
21 subprojects, and within the document, itself, there's a
22 summary of what are each of the 11 subprojects, and then
23 the document follows the ONC guidelines and talks about
24 specific domains and specific areas that they request that

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 be covered.

2 At the end of each of those sections is a
3 cross-reference back to the details in this plan, so if
4 you look at the master schedule on the left-hand side of
5 what you can see there, which is the rolled-up version of
6 that, there's a number on the left-hand side, the 1, 61,
7 those numbers are the ID numbers that when you're in the
8 detail of the document and you look at the action list and
9 it says the task ID for this is 75, or 103, or whatever
10 the number is, then that refers to this number, the
11 sequential number of all the activities in this master
12 schedule.

13 MR. PETRUS: And the key is to demonstrate
14 us to the stakeholders in the Connecticut, as well as to
15 ONC, the discipline that has been done and the thought
16 that has gone into the Operational Plan of what tasks need
17 to be done, what are the interdependencies of the task,
18 who is responsible for these tasks to achieve the vision
19 and the objectives of the statewide Health Information
20 Exchange.

21 So through the work that you've done with
22 us all and the time that you've all put into this is
23 really reflected in the rigor and the discipline of the
24 plan as it's outlined for Connecticut.

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 Any questions on the structure of the
2 Strategic and Operational Plan?

3 MR. MCKINNON: The other silly fact that
4 you may notice is it's nearly 200 pages long, which is a
5 mouth full in anybody's language, but following the
6 gabblings you can really make it a lot sharper. They were
7 looking for something that has got that much depth.

8 I think, when you think about it as a
9 document and get it to the public, it starts from the top
10 down, so people can read into it. They can read the
11 executive summary, they don't need to read any further.
12 They can read the introduction as digit one and they can
13 stop there, or, if they are gluttons for punishment, they
14 can read the whole thing, and they can look at the
15 schedule and look at the detail.

16 And the reason why I put it that way is you
17 could look at it and think this document isn't designed to
18 be helpful for people to read, but I think as long as
19 they recognize that they read as far as they can stand.

20 MS. HOOPER: Just to let you all know, DPH
21 did do a walkthrough of this plan with Gartner. We
22 certainly wanted to do that before we brought it before
23 the committee. We had gone through the details. The
24 Strategic Plan was amended slightly, due to the new PIN

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 requirements, which is Product Information Notice, which
2 was about the changes from ONC. We did incorporate those
3 into the Strategic and certainly, also, into the
4 Operational Plan.

5 And, as Frank iterated earlier, or said
6 earlier, both the public comments and then your comments
7 we have a number of the committee efforts that strengthen
8 the Strategic and work into the Implementation Plan.

9 We'll talk about the need for comment
10 period, but, also, we desperately, not desperately, it's
11 really important that all of you with your expertise
12 contribute and make some comments here.

13 I don't want to assume that your no comment
14 is defaulting that you support, so we'll talk about that a
15 little bit later, but, again, we've encouraged and asked
16 Gartner to provide the Executive Summary. This will be
17 posted. It is posted on the DPH website under its own web
18 page of Health Information Technology and Exchange.

19 In addition, it was sent out to all of you
20 with the -- Warren, did the Microsoft Project Timeline get
21 sent out the folks, also? And then that's also posted
22 with the Microsoft Project Viewer, if you all don't have
23 Project at home.

24 We feel that this is enough information, as

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 Alistair just said, for the detail, but please know that
2 the Operational Plan is what's actually going to be
3 supporting and driving the new Board of Directors in
4 January and the new authority in January on how to move
5 forward, so we really are setting not necessarily in
6 stone, but we are setting the direction, so this is not a
7 sit on the shelf plan.

8 MR. PETRUS: As Alistair identified in the
9 project schedule, the master schedule, there are 11
10 projects, and for each project in the Operational Plan
11 there's a description of the project, a lot of detail
12 about how the work that you all did led to the definition
13 of the project, goals for the project, and then, for each
14 project, project management, the authority development,
15 fund acquisition for initiation and sustainability.

16 There are key action items, and those
17 action items are traced back to the discipline master
18 project schedule, and, so, that is done for each one of
19 these major projects.

20 And I'm not going to go through the
21 projects. We want to spend some time on the committees
22 talking about their sections of the Operational Plan, and,
23 so, we have Finance, Technical Infrastructure, Business
24 and Technical Operation and Legal and Policy, and then all

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 of you around Governance, so with that, Finance Committee,
2 your initial observations.

3 MR. DANIEL CARMODY: On the plan, itself?

4 MR. PETRUS: Yeah.

5 MR. CARMODY: I mean I think the biggest
6 question, and, again, this sort of falls in line with what
7 we've seen before, as far as releases, I don't believe
8 there's anything.

9 Just under release three, just one
10 clarification. This was just to integrate with
11 commercially available PHIs. This wasn't to develop our
12 own PHI.

13 MR. PETRUS: Absolutely.

14 MR. CARMODY: That's what the verbiage is.
15 I just wanted to make sure that that was the case. Again,
16 I think it falls in line with everything that we've talked
17 about. I mean I think the risk that you have up there is,
18 again, what we had talked about at the subcommittee
19 meeting, which was meeting to put some more resources
20 around building out that plan, understanding what we
21 needed, both short-term and long-term, validating what
22 people would see as the value, and actually going out and
23 going to the various constituents and understanding what
24 they would pay for, what they saw value of.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 We talked about before on the hospital
2 side, we had some folks from the Hartford Hospital. We
3 were talking about what is the value of the master patient
4 index, master provider index? How do they see that in the
5 number of people that are going between hospital systems?

6
7 How does that compare to other
8 constituents, who would say, well, by enabling this type
9 of draw of resources, how could you implement meaningful
10 use, so I think that this is right in line with what we
11 talked about.

12 We did talk about, last time, I think it --
13 we wanted to reenergize the conversation around tax
14 credits, where before, when we were talking about some of
15 the startup costs, it was mostly focused on some type of
16 contribution model, where everybody was going to be
17 assessed a certain dollar amount, but we thought that
18 there was value in looking at, going back and looking at
19 tax credits, because we just thought that only looking at
20 a contribution that was being legislated was going to be
21 difficult if it wasn't balanced between other investment
22 alternatives, and, so, we thought that there was
23 opportunity both at the State and at the Federal level to
24 see what other type of tax credits could be made available

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 to generate some type of stimulus to get people to
2 contribute to this.

3 MR. PETRUS: And we did put together for
4 Warren, based upon our last meeting, the scope of work,
5 and we'll talk a little bit more about that later, that
6 would really quantify in greater detail the value
7 proposition, and then look at the universe of revenue
8 opportunities, or tax credit opportunities, or procurement
9 opportunities that could fund the initial HIE, and then
10 sustain it going forward, and then narrow that universe
11 down, what's viable in Connecticut, because some things
12 that could work in California or New York might not work
13 in Connecticut, then do some real formulas around that and
14 how that funding scenario would play out, do some business
15 modeling, and then an alternative analysis of the five or
16 six, or three or four that come out for you all to say
17 this is the direction we want to recommend going forward.

18 MS. HOOPER: And we want to recognize that,
19 again, due to the limited amount of funds that we
20 currently have to actually start up a State HIE at this
21 time, or within the next three or four years, is not
22 likely, as far as one Health Information Exchange, but, in
23 fact, recognizing and appreciating the hybrids that are
24 there.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 One of the things, Frank, that the
2 Commissioner is interested in is also what it will cost
3 for some physician groups, Dr. Dardick, for example, in
4 joining into an HIE? What would the cost be actually to
5 the smaller practitioners? And that's something that
6 we'll also look at.

7 I didn't mean to say that we won't have an
8 HIE, but, quite realistically, with the amount of funds we
9 discussed it, there may not be one statewide, but
10 certainly DSS is going to have for the Medicaid population
11 a system in place that will be statewide. Won't you,
12 Marsha?

13 MS. MARCIA MAINS: Absolutely.

14 MR. CARMODY: Can you just add some more
15 color to that, only because, again, what we've talked
16 about was there being a very thin sort of infrastructure
17 that enabled the capability of the existing RHIO.

18 MS. HOOPER: I'm so sorry.

19 MR. CARMODY: So I would still classify
20 that as a State HIE from the standpoint, as it's an
21 enabler.

22 MS. HOOPER: And I would, too. I'm sorry.
23 Let's clarify that for everybody, to make sure that we're
24 all on the same page, that there won't be one system that

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 everyone links into that one system designed by one
2 software, or one platform, that, in fact, there will be
3 one system, the hybrid system, that is going to
4 accommodate and not only address, but certainly serve the
5 State for the existing models that are in place.

6 For example, in Danbury, we're not
7 expecting or looking for Danbury to have to change its
8 hardware, software and web-base linking mechanisms just to
9 join into another Health Information Exchange, but, in
10 fact, to be interoperable and connecting with perhaps your
11 neighboring community health center, certainly, other
12 hospitals, pharmacies, laboratories beyond your immediate
13 area that is currently within your Health Information
14 Exchange.

15 MR. PETER COURTWAY: This is Peter. I
16 think that's fine, except that the practical reality of it
17 is that these individual RHIOs are quite expensive to
18 implement and operate, and Danbury is open as a provider
19 into collapsing into more of a statewide infrastructure
20 with the right value components, so I don't think we can
21 preclude or assume that the individual initiatives that
22 are currently running will continue. Some have already
23 expressed an interest that they will. A lot of others are
24 trying to get started.

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HOOPER: Correct.

2 MR. COURTWAY: At the last Connecticut
3 Hospital Association CIO meeting, we talked about what the
4 individual hospitals were planning on, in terms of their
5 own operational HIEs.

6 MS. HOOPER: Correct.

7 MR. COURTWAY: Or whether or not they
8 participate in the infrastructure. There is a formal
9 survey that I believe will be going out the beginning of
10 next week to the CIOs to identify what their potential
11 costs are.

12 MS. HOOPER: Is that through CHA?

13 MR. COURTWAY: Through CHA.

14 MS. HOOPER: And would that be Mr. Brady?

15 MR. COURTWAY: That would be Mr. Brady.

16 MS. HOOPER: Okay.

17 MR. COURTWAY: And he brought it actually
18 to the last session. I had a draft of the questionnaire
19 going to the CIOs. We did some modifications, and he's
20 just now waiting for my final comments to put out the
21 formal survey, but we are trying to identify what the
22 hospitals are budgeting and planning for, when they're
23 going to be prepared for meaningful use, and this is one
24 of the components of it, just so we can set the stage,

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 because, at the meeting, there was a lot of discussion
2 about whether or not they should continue individual
3 efforts, and it was sort of a mixed response from the
4 group, and I think the majority felt that they were going
5 to look to the State infrastructure as the way of doing at
6 least the initial connections, and I guess we're waiting
7 for the Operational Plan, which is now released for
8 comment.

9 So I'm expecting a lot of comment at the
10 next CIO meeting at the CHA.

11 MS. HOOPER: Good. I think that would be
12 terrific. Are we invited?

13 MR. COURTWAY: You're more than welcome to
14 come.

15 MS. HOOPER: If you wouldn't mind sending
16 some information, to listen and to hear, certainly to
17 incorporate some of those comments if they're not
18 submitted directly to the Department for inclusion in the
19 plan, but I think that would be really valuable to hear
20 how the hospitals are moving forward.

21 Let me make that clear. We're not
22 necessarily looking for people to develop their own RHIOs
23 at this point, but in recognition that I don't know that
24 what Hartford and St. Francis have in place, they're

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 piloting soon, is going to be the system that's going to
2 serve a certain portion of the state.

3 I don't know that the hospitals in the
4 western part of the state are all going to embrace yours,
5 so I think what we're trying to do is have the realistic
6 approach, that those that already have an existing Health
7 Information Exchange and do not want to invest in creating
8 a new one, or create some kind of an expansion of that,
9 then we need to recognize it.

10 Ideally, if we can take the operating
11 Health Information Exchanges right now and merge them
12 together into a compatible single system, that certainly
13 would be our goal.

14 What we're worried about, with only about
15 six million dollars from the Feds., can we create a new
16 Health Information Exchange system? I think we had talked
17 about it. Frank, you had talked about it in terms of a
18 default system for those that are not into an existing
19 Health Information Exchange.

20 For example, if we can't create a system
21 that everyone is going to agree to, as far as an
22 infrastructure, but certainly don't we have the
23 responsibility to set the standard for the electronic
24 health record, the transmission, the privacy and security,

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 which is why we have the consent model, the financing of
2 it.

3 I don't think we're looking for breaking up
4 those kind of issues.

5 MR. CARMODY: What I'm trying to wrestle
6 with is, when we talk about the -- we talked about
7 delivering three specific services, so if there's more to
8 it than those three specific services and we start talking
9 about other platforms, I just want to understand what that
10 is, because then that gets back into, you know, again,
11 what we'd finance, so I'm just trying to reconcile the
12 default platform.

13 CHAIRMAN GALVIN: Let me just give you a
14 little informational tidbit. I spent some time down at
15 Lawrence and Memorial down in New London last week.
16 They're already 32 million dollars into developing their
17 system and probably looking towards March/April of next
18 year to just finish their own system, so you're talking
19 about a lot of money.

20 They have a very cooperative Board, and I
21 guess they have some endowment, but that's a lot of bucks
22 for a small hospital, so six million dollars kind of pales
23 by comparison.

24 MS. HOOPER: I very much appreciate what

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 you're saying. Let's, again, for the sake of
2 clarification and to make sure that we're understanding
3 your concerns, also, let's take the T out of the HITE.

4 The technology is what I'm referring to
5 about the systems, that there are certain platforms, there
6 are certain infrastructure hardware/software that is
7 established in the Danbury system, in the --

8 MR. CARMODY: I understand that there's
9 already infrastructure in place.

10 MS. HOOPER: Correct.

11 MR. CARMODY: What I'm trying to reconcile
12 is that, if there's this other platform, that there's this
13 default platform, what is that? Are we talking about what
14 services beyond the three that we have identified?

15 MS. HOOPER: Correct.

16 MR. CARMODY: What is that?

17 MS. HOOPER: We don't have that yet.

18 MR. CARMODY: Are we planning to do that?
19 Is that something that we've decided to branch into?

20 MS. HOOPER: That's something that is in
21 the plan, but I guess that's the one that I'm not sure we
22 have the funds to even pursue, and should we even consider
23 pursuing it when we already have an infrastructure? But,
24 Frank, you've investigated that for the State. Can you

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 clarify it from your perspective?

2 MR. PETRUS: Yeah. When we first started
3 this journey, we understood there were HIE-like entities
4 out there, and that none of those entities, as they
5 currently exist, would be a statewide HIE, because they're
6 serving a very specific purpose for those entities, but as
7 other states have done and other states have said, is that
8 we will be the gateway to support those other entities
9 that are out there, and for folks that don't have that
10 service, we can provide that service.

11 In the plan, we've identified three
12 releases, and those three releases go out X number of
13 years, and we're looking for the funding necessary for the
14 initiation and the sustainability of the capacity that's
15 identified in the Operational Plan.

16 Once your Board is set up, the new Board in
17 January '11 is set up, their main mission will be to
18 implement the Operational Plan, and, obviously, ONC is
19 doing a little ready, fire, aim with their rules and
20 requirements, and meaningful use is coming out, and that's
21 still in flux, but they've identified three things, e-
22 prescribing, structured information and continuity of
23 care.

24 Those are the three major things that we

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 have built the plan around and the direction around, and
2 we don't know what the future is going to bring. I guess
3 what I'm hearing is the State saying that we want to be
4 able to leverage whatever is out there, and what kind of
5 connectivity, what kind of platform can we build to do
6 those three releases, leveraging what is out there.

7 And I think what Meg said is absolutely
8 right, and every state has done this, statewide standards
9 tied to ONC standards around security, interoperability,
10 privacy, consumer rights, all those kinds of things that
11 need to be wrapped around, and then back to meaningful use
12 to certify the certification of and attestation of
13 meaningful use using certified electronic health records.

14 So we built it around those rules that we
15 do know exist now through the environmental scan we did of
16 the technology that exists now, and then from what we got
17 from the Technology and Infrastructure Committee, and I
18 thought you guys did a great job of narrowing what the
19 scope should be and keeping it focused, that's what it's
20 been built around.

21 Now the question about how much money is
22 that going to take, we've identified a budget. We also
23 will, if we go forward with the new scope of work, get
24 into greater details about the revenue.

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HOOPER: Right.

2 MR. PETRUS: Tax credits, creative ways to
3 do procurement, keep costs more focused, how do we sustain
4 this, and those answers we don't have right now, and
5 that's in the Operational Plan as a very specific set of
6 tasks that we have to do, if that helps.

7 MR. McKINNON: So the specific default, if
8 you look at the detailed plan, there's a project, called
9 Stand-Up, the HIE. That includes master patient index,
10 master provider index and record care of service. That's
11 a default platform that HIEs can communicate with --

12 MR. CARMODY: Okay, I understand that. So
13 those are three services that we've said that we were
14 going to put together, but if somebody decided that -- if
15 somebody decided that they were going to start their own
16 HIE in a section of the state and they don't have a
17 platform, they weren't going to stand it up, there's not a
18 platform that they're looking for the State to provide
19 that said that it would do all the things that a Danbury,
20 or a Hartford, or anybody else would be doing.

21 MR. McKINNON: It's platform to facilitate
22 existing HIEs and the statewide HIE, itself. At least
23 one, two and three is using that to provide services, the
24 specific services that they're familiar with, so the exact

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 proportion of other HIEs using the infrastructure or
2 providers connecting directly has been left open-ended.

3 It doesn't pre-judge that, because there is
4 a sort of ambition in the hospitals to deal with them
5 themselves, but not a lot of that has happened so far, so
6 it's kind of risky to depend upon it.

7 MS. HOOPER: And, also, I think what
8 concerns the Department and from what I'm hearing from a
9 lot of you around the committee, and please correct me if
10 I'm wrong, is that without a default, or without a system
11 that is in place and managed by the State, Peter, can
12 Danbury's system be expanded to accommodate a statewide
13 HIE?

14 When the Hartford Hospital, St. Francis,
15 can it be expanded? You know, there's a lot of people
16 making assumptions that they can group in, like
17 regionalize some of those HIEs. We really don't have an
18 assessment, as to whether those systems how they can be
19 expanded, so that's why I think the Operational Plan, and
20 we really need your strict review of those, how we're
21 setting up a Health Information Exchange system, both
22 policy-wide, technology-wide and the exchange in the
23 meaningful use information, to avail providers the CMS
24 credits.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 This is like a seven-layer cake. There's
2 too many things, so I don't have a clean answer either.

3 MR. CARMODY: Okay. I'm just trying to
4 reconcile beyond the three services that we talked about,
5 so when I hear system, then I hear beyond the three-level
6 services, what does that mean?

7 MS. HOOPER: Okay.

8 MR. CARMODY: I mean, if it is, then, fine.
9 I just want to know what it is.

10 MR. WARREN WOLLSCHLAGER: I understand your
11 question, Dan, and I think that the answer is those are
12 the three services. Those three services are going to
13 comprise this statewide -- I forget the technical term you
14 just used, but there's not going to be something besides
15 that.

16 MR. CARMODY: When I hear systems, I hear
17 something sometimes more. If it goes beyond the three
18 that we talked about, then I want to know what that is.

19 MS. HOOPER: Right. I don't think that
20 we're planning or accommodating for that, but as we
21 evolve, should we not -- should we ignore that there is
22 going to be some expansion?

23 MR. CARMODY: Oh, no. I'm just trying to
24 reconcile where we are right now. Were you thinking

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 something beyond that?

2 MR. COURTWAY: Well I think it's going to
3 come in waves. I think that the key thing is, you know,
4 what other services, you know, does a Danbury, for
5 example, provide? Does it provide a less round
6 connectivity, an interconnectivity of the individual
7 physician electronic medical records, or order entry,
8 results reporting, test reconciliation, whatnot.

9 It's a lot of heavy lifting. That may be a
10 future of this. We're trying to understand from the
11 hospital perspective are they planning on coordinating
12 that from a hospital perspective, and then coming into the
13 state for the broader interconnectivity, you know, for the
14 public health reporting, for other aspects of it or not.

15 I don't think of it in terms of a default
16 provider. I think it's a provider of last resort. They
17 may not like that term either, but it's someplace else to
18 go if you're not going to set up your own in regard to it.

19 MR. PETRUS: Or if you're going to go
20 outside. And either you're going to do direct, or you're
21 going to use the HIE as a utility to go to those that are
22 outside of your entity, and that was always the vision,
23 that there would be this basic utility, like an electric
24 utility, that you're all going to agree on alternative

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 current.

2 You may have solar panel that you're doing,
3 and you may have wind generator, and the State may be
4 hydropower, and as long as you have the same standard for
5 the current and you could run all of your hospital on that
6 current, you don't need to come through the State, but
7 once you need to go outside, then you're going to go
8 through that, and you're going to plug in and go through
9 that utility.

10 So with these three services addressing
11 those three components of meaningful use, the State is
12 going to be setting up that kind of utility that's there
13 for you outside of your entity.

14 Now what the future would bring, that's a
15 question for the Board to answer once they get this
16 platform built.

17 MS. HOOPER: Our minimum is certainly the
18 three. We're looking at DPH's, the Public Health
19 meaningful use, you know, how do we support that?

20 MR. PETRUS: Okay and the other thing to
21 look at is that the real important component of the
22 statewide HIE is really around the Governance, the
23 Business and Technical Operations and Standards, the Legal
24 and Policy, that you're all using the same language within

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 and outside your entities.

2 And by language, I don't mean technical
3 language, but the language necessary around master of
4 client index, master provider index, HL-7, national ONC
5 standards for interoperability and for the measuring of
6 meaningful use.

7 MS. HOOPER: I'm sorry. We had the wrong
8 number. Good afternoon. This is Meg Hooper of the Health
9 Information Technology and Exchange Advisory Committee.
10 We appreciate your patience. We had the wrong number
11 dialed in. Can I ask who is on the phone?

12 DR. KEVIN CARR: Kevin Carr.

13 MS. HOOPER: Hi, Kevin. Thank you so much.
14 Who else, please? Just Kevin? Milford Press?
15 Bridgeport Post? Hartford Courant? Okay. We still don't
16 have a quorum, correct? Okay. Sorry, Kevin. Thanks for
17 waiting.

18 MR. PETRUS: The next discussion, which
19 we've already had some of it, is the technical
20 infrastructure. I don't know if your committee had a
21 chance to review what's been out there or any other
22 addition to discuss on the technical infrastructure.

23 MR. COURTWAY: The committee has not met
24 since the last meeting, and we're trying to set up this

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 month now that the Operational Plan is out. I guess the
2 question that I need to bring back is the issue of the
3 intersection of the Public Health reporting and how is
4 this interconnecting with the Public Health feed
5 structures.

6 MS. HOOPER: Yes, sir.

7 MR. COURTWAY: We did talk at the
8 Connecticut Hospital Association about whether or not
9 those feeds should still come through the CHA, or whether
10 or not there's an opportunity to reduce costs and directly
11 feed through the exchange, but I think that, at some
12 point, we're going to need to meld or understand, at
13 least, what those interface connectors are going to look
14 like to feed your systems.

15 MS. HOOPER: Yes, sir.

16 MR. COURTWAY: Or which Public Health
17 reporting will you decide to take directly off of the
18 exchange, if that's possible.

19 MS. HOOPER: Thank you very much. When we
20 had -- we participated in the visioning meeting with
21 Gartner and DSS in looking forward and the Public Health
22 meaningful use, we haven't got our hands around how we're
23 going to do that and connect it, but, certainly, that's
24 going to be -- that's within the implementation plan.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 Warren and I are going to be meeting with
2 our data managers to really get a feel for how are we
3 going to link into not only existing systems, and we want
4 to certainly talk with CHA about that.

5 And, again, this is where I do go beyond
6 Dan on the three services, that with the Public Health
7 infrastructure, yes, we want to meet the meaningful use
8 requirements, but we do see the need beyond that.

9 MR. PETRUS: And there could also be
10 another source of revenue to support that.

11 MS. HOOPER: We think so, too.

12 MR. McKINNON: Well there are a number of
13 Public Health requirements for everyone, and not everyone
14 will ever be connected.

15 MS. HOOPER: Correct. Okay. Next one?

16 MR. PETRUS: Anything else on Business and
17 Technical Operations?

18 MS. HOOPER: You did hear from Dr. Agresta
19 via e-mail, and I think he's convening his committee. For
20 any of you serving on Business and Technical, Dr. Agresta
21 I think he shared the information and requested some kind
22 of a committee meeting, I think. Anyway, you got some
23 information from him.

24 MR. PETRUS: Legal and Policy.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HORN: Lisa Boyle was going to be on
2 the phone, and I am afraid, because we had the wrong phone
3 number, she may have given up, but I don't think she had
4 much that she was going to add to the Legal and Policy
5 section.

6 We have the consent policy that was defined
7 in the strategic plan. We did have a couple of public
8 meetings on that. We have had some feedback from a
9 consumer group, that they would prefer the e-health
10 consent policy to the one that we have developed, and that
11 has been noted, and I would like to stress this is a
12 living document, and the Feds are continuing to work on
13 this issue, as are interstate groups working on it.

14 I think the group that we put together, the
15 Legal and Policy group, has worked hard to come up with a
16 model that doesn't please everybody, but it puts consumers
17 rights as a high priority.

18 It also looks to establish an HIE that will
19 have value for improving patient health and will be
20 sustainable. So that's where we are at this point.
21 There's another public meeting on Thursday night, and,
22 again, the Department is open to hearing input from people
23 on this policy.

24 And we're moving on in our next meeting to

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 looking at some of the agreements that will need to be
2 developed and handed over to the authority, based on this
3 consent policy, so digging into some more of the details.

4 MR. PETRUS: Governance?

5 MS. HOOPER: I think, again, with the risks
6 identified and what's going forward, the Commissioner has
7 directed that, certainly, as we move forward with the
8 Board of Directors, the Advisory Committee is, by mandate,
9 alive or formal until December 31st, but the new Board of
10 Directors is to be named before October 1st to meet before
11 November 1st, and that Board of Directors will have the
12 responsibility within a very short period of time, say two
13 months, to develop bylaws, to, in fact, develop the
14 process for the new authority effective January 1, 2011 to
15 move forward.

16 DPH is certainly going to be in support and
17 assisting in any way possible. The Commissioner remains
18 as the Chair of the new Board of Directors, so that there
19 will be that consistency. I think that we have two or
20 three appointments made by the legislators. Again, we
21 encourage all of you that have been either appointed or if
22 you have recommendations.

23 Lieutenant Governor Fedele, you're going to
24 remain, so we're happy to have you at least through

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 December. So there will be some changes, but we're hoping
2 that for the Advisory Committee we will meet again. It's
3 at the bottom of the agenda. September 20th is another
4 meeting.

5 We're getting the plan in prior to that.
6 We'll talk about the public forums again, but the Advisory
7 Committee we're encouraging that you stay active through
8 either your subcommittees or certainly to be on call if
9 the Commissioner needs to reconvene the Advisory
10 Committee.

11 The Board of Directors, we hope, will
12 include many of you, and that will move forward to address
13 -- the governance structure right now is not
14 representative. Again, there will be two more
15 representatives appointed. We're hoping that we'll have
16 all the information of a full Board of Directors before
17 October 1st.

18 It is then, again, that that Board of
19 Directors is going to set the governance for how we move
20 forward for the authority, itself, for the staffing, for
21 the logistics, for how this implementation plan will go
22 forward.

23 The Department is, again, going to be
24 supportive in Chairing it, but it will not be run by the

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 Department of Public Health after January 1st. So the
2 governance is similar to the systems. It's in flux.
3 Certainly, our election season is here, but the statute
4 remains that, effective January 1st, all appointments made
5 prior to the election, so that there would be no
6 substantive changes in the Board.

7 Commissioner, did you want to add more on
8 the governance?

9 CHAIRMAN GALVIN: Well you said that the
10 Department of Public Health would no longer be responsible
11 for running the organization.

12 MS. HOOPER: For the authority, itself,
13 sir. We are still responsible for the funds received from
14 ONC.

15 CHAIRMAN GALVIN: I think you need to
16 expand on that a little bit. So what is the Department's
17 role after the 1st of January?

18 MS. HOOPER: We are certainly an active
19 member and are an appointed member. The Commissioner is
20 not only Chair, but a voting member of the new Board of
21 Directors, and, so, we will continue to represent Public
22 Health and our contributions to the not just meaningful
23 use, but, certainly, Health Information Exchange, and then
24 the Department is also the continuing funder of the

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 authority, as determined by the new Board of Directors, as
2 to what funds are needed to operate, staff and move
3 forward, so the Department still has the responsibility
4 certainly to the funding Office of the National
5 Coordinator.

6 That's a continuing. We will continue to
7 support how we can support the new authority. In
8 addition, the Department has the responsibility for the
9 not only HIPAA compliance, but, certainly, with the
10 standards set in collaboration with the Department of
11 Information Technology on how State systems will move
12 forward.

13 CHAIRMAN GALVIN: Okay, but -- pardon my
14 interruption.

15 MS. HOOPER: Of course, sir.

16 CHAIRMAN GALVIN: If I were a member of the
17 audience, I might say it sounds like you guys are going to
18 back way off and let the authority run it.

19 MS. HOOPER: By legislature, the Department
20 will be a voting member on peer with the rest of our --

21 CHAIRMAN GALVIN: I understand that,
22 because the Commissioner will be an ex officio voting
23 member, but let me get back there.

24 MS. HOOPER: Yes, sir.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 CHAIRMAN GALVIN: I think this means that
2 the Department is going to back way off from this and
3 input, as we do with other things, about when we think of
4 appropriate Public Health standards.

5 MS. HOOPER: Yes, sir.

6 CHAIRMAN GALVIN: What we think is
7 appropriate information, so you'll no longer have the
8 amount of -- we have five full-time employees? Four and a
9 half?

10 MS. HOOPER: Right.

11 CHAIRMAN GALVIN: Full-time employees, so,
12 number one, you're not going to have the full-time
13 employees, number two, is you're not going to have Meg,
14 and, number three, you're not going to have Attorney Horn,
15 number four, you're not going to have Warren, then we'll
16 be undoubtedly moving on with the change in
17 administration.

18 MS. HOOPER: Depending upon the change in
19 administration and if Warren, Meg and Marianne are still
20 employed, we're hoping to stay involved, so I do think --
21 and we do have some funding that we will be staffing some
22 of the -- our role as a Health Information Exchange will
23 not change. Our role to running the Health Information
24 Exchange system --

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 CHAIRMAN GALVIN: Now you're getting into
2 the meat and potatoes, okay?

3 MS. HOOPER: Yes. That will change. That
4 is not our job.

5 CHAIRMAN GALVIN: Okay, so, if I were the
6 guy, I would say, hey, what does that mean, and who is
7 going to do what you used to do?

8 MS. HOOPER: The Board of Directors will be
9 assigning staff and/or contractors to continue the process
10 of not only establishing a Health Information Exchange,
11 operating it and securing its functions according to
12 statute.

13 CHAIRMAN GALVIN: So, if I were the guy in
14 the bleachers, I would say that sounds like a big
15 transition to me.

16 MS. HOOPER: Yes, sir, it is.

17 CHAIRMAN GALVIN: And it sounds like the
18 new Board is going to have to have some full-time people.

19 MS. HOOPER: Yes, sir, they will.

20 CHAIRMAN GALVIN: Okay.

21 MS. HOOPER: And the Board will be
22 selecting how they'll go through with that. I think the
23 Commissioner at one point had talked about should we
24 consider going through a head hunting agency. We did

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 consult on that, and we think we can just put out some
2 postings on various websites.

3 Again, if the Board of Directors -- they
4 are required by statute to hire a Chief Executive Officer,
5 that it will be up to the Board, and DPH will be a member,
6 a voting member of the Board, but not directing this
7 activity.

8 COURT REPORTER: One moment, please.

9 CHAIRMAN GALVIN: Of course, you realize
10 what Meg is saying. I got about a million dollars worth
11 of staffing on an annual basis with salary and fringe tied
12 up in this program right now, okay? It's not going to be
13 that way after the 1st of the year.

14 MS. HOOPER: No, but I'm hoping that we'll
15 still stay involved certainly because we're all
16 representing important functions.

17 CHAIRMAN GALVIN: Absolutely, but I'm sure
18 I'm beating the point to death. I see some bored looking
19 faces here, but what I'm saying is this is a big
20 transition, and a lot of the support that you've had is
21 not going to be there by design, by statute.

22 MS. HOOPER: Correct.

23 CHAIRMAN GALVIN: It's going to be
24 someplace else, and, so, all of you who stay on the Board

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 are going to have to shall we say step lively.

2 MS. HOOPER: That's a good term, sir. Yes.

3 CHAIRMAN GALVIN: Yeah.

4 MS. HOOPER: Yeah, because we're not going
5 to be able to support all of the initiatives that have
6 been started here, so, for example, with the
7 subcommittees, we hope to continue our role in being a
8 member of the subcommittees, but we won't be running them,
9 unless required by the Board of Directors to do so.

10 MR. PETRUS: The one thing is you do have
11 to maintain an HIT coordinator, whether that's Warren or
12 not. That's still a State responsibility.

13 MS. HOOPER: Yes, and what we do have is
14 the Governor assigns a State HIT coordinator. Mr.
15 Wollschlager is the current appointee designee by Governor
16 Rell. We don't know, come January, that the new Governor
17 may choose to designate someone in the new authority, a
18 Board member, or retain that in the Department of Public
19 Health, so that's another responsibility that will be
20 figured in after politics quiet down.

21 MR. PETRUS: Do they ever?

22 MS. HOOPER: Yes.

23 CHAIRMAN GALVIN: Yeah. Okay. I think
24 I've beaten the topic to death.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HOOPER: Questions on the Governance?

2 CHAIRMAN GALVIN: This is a major league
3 change in Governance, and when you have big changes like
4 this, there's always things that fly off, or don't get
5 done, and the organization can degrade very rapidly,
6 unless somebody jumps in and takes a leadership role.

7 I will say, since we're all medically
8 oriented, we see this very frequently in hospitals that
9 have a major change in Governance, the president, the
10 chief nurse, the quality control guy, and it's very hard
11 to keep the organization going in hospitals.

12 That's when we see big time errors, when
13 there are big time changes, so this can get right out from
14 underneath this group if we don't act very promptly.

15 MS. HOOPER: And it makes it more
16 difficult, because we don't know who this group really is
17 going to be. Again, not all appointees have come through.

18 We certainly know that the agencies are still in this
19 position.

20 Really, the only one that we're sure of is
21 Lieutenant Governor Fedele, until January, unless the
22 statute changes or January whatever. So, again, that's
23 all we can be sure of, as we move forward.

24 So I'm going through a transition of both

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 the Board and the functioning authority. We're doing our
2 best to stay ahead of it, certainly legally and
3 contractually, how we're going to move forward, but,
4 policy-wise and function-wise, we are going to be looking
5 to the Advisory Committee to assist the new Board in some
6 kind of a transitioning familiarity, or I don't know that
7 the new Board isn't going to be all of you and that we
8 just move forward with a few additional members.

9 I don't have the crystal ball, and, as a
10 planner, it drives me crazy.

11 MR. FEDELE: And just one point, too.

12 MS. HOOPER: Yes, sir?

13 MR. FEDELE: At that point in time,
14 whatever funds are left then move over to the Board,
15 correct? And that's --

16 MS. HOOPER: Not all of them.

17 MR. FEDELE: But whatever, but I guess the
18 other important component is then how does this Board get
19 funded going forward, and I think that's a legislative,
20 potentially a legislative question, right?

21 MS. HOOPER: It is, sir. In fact, we're
22 going to appreciate your advice. The Department, to put
23 together a legislative proposal now as an executive
24 agency, really can't put together the same proposal that

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 on behalf of a new entity that is not a governmental
2 entity, so there's some tricky things that we are probably
3 going to be talking with you about separately.

4 How we anticipate it is that the Board of
5 Directors will be requesting DPH for a certain amount of
6 money for staffing, overhead, whatever the requests are.

7 The Department, through the ONC funds, will
8 be able to support. The Department is retaining certain
9 number of funds for not only staffing, also for evaluation
10 component and the development of the other requirements
11 from the Office of National Coordinator.

12 So the bulk of the funds will go to the
13 Board and hopefully to the implementation of either a
14 system, a default, a platform, based on two years' work of
15 the Board of Directors, to determine what needs to be done
16 with however much money is left.

17 MR. FEDELE: That's as important as the
18 Board's records. The monies, as I see them, from the ONC
19 are kind of going to go away.

20 MS. HOOPER: They are limited, and they
21 will go away.

22 MR. FEDELE: How does this thing function
23 beyond that point in the ongoing environment going
24 forward?

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HOOPER: Within the Governance section,
2 we are taking a look at and, certainly, again, from the
3 Department, but will meet with you and ask for your time
4 and attention to it, how do we make sure that there will
5 be some funding?

6 I don't know that the legislature is going
7 to be too keen on funding something that does have six
8 million dollars left, perhaps not in this session, but,
9 also, hopefully, that the self-sustainability and the
10 Finance Committee are being able to move forward with
11 whatever system is in place, whether it's through some
12 kind of a fee, I don't want to say taxing, a fee that the
13 self-sustainability of the Health Information Exchange
14 will, in fact, support the continuation of the Health
15 Information authority run by the Board of Directors.

16 So it's not just paying for a system or
17 services. It is going to be supporting the Health
18 Information Technology Exchange of Connecticut, also known
19 as the authority.

20 If anybody can like come in and help us do
21 all this transition, we'd really appreciate it.

22 MR. WOLLSCHLAGER: If I may?

23 MS. HOOPER: Please, Warren.

24 MR. WOLLSCHLAGER: Commissioner?

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 CHAIRMAN GALVIN: Yeah. I think after
2 Warren, Peter, you look confused.

3 MR. COURTWAY: More concerned. No
4 confusion. It's more concern.

5 CHAIRMAN GALVIN: And thoughtful, so I
6 wondered if what we're saying has been not very -- it's
7 very difficult to understand it.

8 MR. COURTWAY: I just have one quick
9 question, because maybe I read the legislation wrong.
10 After October 1st, when the Board of Directors forms, you
11 know, and the corporation forms, who is the State-
12 designated entity that gets the funds for disbursement?
13 Is it the new authority, or is it DPH?

14 MS. HOOPER: Well DPH still has the funding
15 from the Office of National Coordinator under stimulus.
16 The authority has the legal authority to, in fact, solicit
17 funds or apply for funds from both public and private, so
18 the authority can move forward.

19 Current funding right now is strictly for
20 the stimulus of establishing the plans and implementing
21 the Health Information Exchange for meaningful use.
22 Similar for DSS.

23 CHAIRMAN GALVIN: Okay, but what you're
24 saying is, so that Peter and I can understand it, because

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 I'm having trouble understanding it.

2 MS. HOOPER: Me, too.

3 CHAIRMAN GALVIN: Yeah, but I think what
4 we're saying is the money that we got now, the stimulus
5 money, will be disbursed to the Department of Public
6 Health.

7 MS. HOOPER: It will continue to, as the
8 grantee of that. We are the award recipient for the
9 stimulus funds, and we will, instead of running the show
10 for the years that the stimulus funding is available, we
11 rightfully determined that the Department is not the
12 Health Information Technology and Exchange entity for the
13 State of Connecticut. We wrote the legislation and
14 received support to change it from the Department of
15 Public Health to this new authority.

16 CHAIRMAN GALVIN: So they're responsible
17 for getting anymore money. That's kind of the point.

18 MS. HOOPER: Correct.

19 CHAIRMAN GALVIN: Once the stimulus money
20 is gone, there is no more money, except what the new
21 authority can procure, get through grants, raise through
22 assessments of various entities and the like.

23 MS. HOOPER: Right.

24 CHAIRMAN GALVIN: There's a huge

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 organizational and financial change here.

2 MR. FEDELE: That's my concern.

3 MS. HOOPER: Of course.

4 MR. FEDELE: My concern is the money is at
5 hand already, stimulus money, right? If DPH gets it and
6 they're going to assign whatever when this new group gets
7 put together, a line share of that money goes to this
8 group.

9 MS. HOOPER: Yes, sir.

10 MR. FEDELE: Whatever that number is.

11 MS. HOOPER: We're thinking between four
12 and five million.

13 MR. FEDELE: Right, but I mean, if you
14 really look at this project, that's a drop in the bucket.

15 MS. HOOPER: Correct.

16 MR. FEDELE: So the question that I was
17 alluding to is what happens when that money goes away?
18 How does this authority exist?

19 MS. HOOPER: And that's why we're
20 supporting that hybrid model, because that might be your
21 operating fund, sir, for the next four or five years, get
22 your staffing and your operating system in place to
23 solicit other funds to, in fact, support the system.

24 Connecticut, again, limited by its

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 population, number of hospitals, it's a formula, received
2 a seven million. It wasn't because we're behind in
3 anything. It was simply on a formula population and
4 access to health care, which we score well on.

5 So the seven million is it from stimulus.
6 Health Care Reform, there are a number of initiatives in
7 Health Care Reform that are coming forward, strengthening
8 certain infrastructures, but not any that are going for a
9 statewide Health Information Exchange.

10 CHAIRMAN GALVIN: But I think Governor
11 Fedele is better qualified to speak on this topic than I
12 am, but I would be very surprised if the new incoming
13 legislature doled out very large sums of money, if any.

14 MR. FEDELE: I would say not only the
15 legislature, but, also, the Federal Government. My gut is
16 that you're not going to see monies award stimulus from
17 the Federal Government.

18 They've got some grants and stuff, but
19 you're talking about a pretty sizable initiative here if
20 it's done right, and you're not going to see the dollars I
21 think that you saw this stimulus grant, and, clearly, the
22 legislature, based on other challenges that they face, is
23 not going to be there writing checks either, so that's why
24 I kind of threw that out, because that, to me, is as

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 critical as the Governance, because you're going to have a
2 Governance Board that really has great ideas, but won't be
3 able to fund them if there's no -- once the original
4 stimulus dollars are gone, so I think that's kind of a
5 parallel track as you look at Governance.

6 You kind of look at buckets that you're
7 going to need going forward, at least within maybe not the
8 first year, but maybe the out year as it goes along.

9 MS. HOOPER: And I do think that what we'd
10 like to encourage is certainly, and we appreciate that Dan
11 and the Finance Committee, along with Gartner support, in
12 looking at the funding options for Health Information
13 Exchange, and, actually, Marsha, from the DSS funds,
14 that's an ongoing reimbursement?

15 MS. MAINS: Correct.

16 MS. HOOPER: There is no -- it is not
17 limited, in terms of years or amount for the CMS
18 reimbursement for meaningful use.

19 MS. MAINS: Correct.

20 MR. FEDELE: That stays within DSS.

21 MS. HOOPER: And that stays within DSS,
22 however --

23 MS. MAINS: However, CMS seems to be very
24 open to sharing their dollars to support these types of

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 initiatives, and we were able to do that in our advance
2 planning document for our development of the incentive
3 payments to Medicaid providers, where we asked to fund
4 part of DPH's salary, because we have a large percentage
5 of the Connecticut population that are Medicaid clients,
6 and they approved it.

7 So even though it's DPH dollars, we
8 received approval to receive 90 percent and a percentage,
9 based on the Medicaid population to the whole population,
10 so we envision that we could be able to secure some
11 additional funds, because we have a Medicaid population,
12 they would be supported by the HIE, so we're seeing that
13 that's a very good potential to get extra dollars from the
14 Feds.

15 MS. HOOPER: And, again, how that's wisely
16 used will be -- DSS is also going to be a voting member of
17 the new Board and certainly a very active participant, and
18 then we do have the REC funds, which I'm certainly not
19 going to speak on their behalf, but there are going to be
20 different, as the pails of money, but I think it's more
21 that we all have this common goal.

22 How do we move forward? How does the
23 Finance Committee take advantage of leveraging as many
24 resources as possible to actually get a streamlined, safe,

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 protected Health Information Exchange?

2 CHAIRMAN GALVIN: Okay. I think we ought
3 to let Frank move on, but I will say that, as both
4 Governor Fedele and I have tried to bring out, that this
5 post-October 1st period is going to be a very difficult
6 one, which will require a great deal of time and
7 application of this new authority in order to keep us
8 running at a time when shortly thereafter the State
9 Department of Public Health will not be providing the
10 numbers of full-time employees that we have to this point.

11 MS. HOOPER: And I call tell you that we
12 have been sweating this for about six months. We're
13 working on how we're going to move this forward with the
14 authority, and I don't believe that any of us feel that
15 the Department is going to walk away if the authority is
16 not up and running.

17 Again, we might not have a job on January
18 1st, so I don't know, or 4th, or whatever day. Frank,
19 take it back.

20 MR. PETRUS: Alistair.

21 MR. McKINNON: So I don't know if you
22 talked about risks. I think we probably talked about the
23 biggest risk of all, is the Board running offensive
24 (laughter).

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 This document you were given has two
2 interesting tables in it. One is that there are 15 risks,
3 and the other one is the date that this meeting is
4 happening sometime in the far distant future, the year
5 2011.

6 MS. HOOPER: Well I just thought it was
7 like, you know, meeting in January 2011.

8 MR. MCKINNON: In the Strategic and
9 Operational Plan document, there are 15 risks identified,
10 and they are summarized in this chart here, and we just
11 wanted to give the Advisory Committee the opportunity, if
12 they are really interested in risks that you think exist
13 that are on here or any aspect of these risks and how
14 they're describe.

15 So, looking at the first one, the non-
16 participation by providers, so this is a concern that we
17 may not get to critical mass, which would subvert any
18 funding mechanism.

19 MS. HOOPER: Correct.

20 MR. MCKINNON: And the coding in this stuff
21 is the red dot, means it's a high risk. If it doesn't get
22 mitigated, then you're going to be in serious trouble. If
23 it's a half yellow, then it's less of a risk. It's a
24 medium risk. And if it's green, it's a low priority risk.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HOOPER: Alistair and Frank, are you
2 looking for viewpoints on the mitigation efforts to
3 include them? I think the implementation plan, though,
4 you have included the mitigation efforts, correct?

5 MR. PETRUS: Also, you saw this the last
6 workshop that we had. This is just bringing it back to we
7 revised it, based upon your input the last time, so we
8 could go through this rather quickly, but if there's
9 pieces that you want to specifically discuss in greater
10 detail as you review the plan with your committee, this is
11 the time to raise any questions.

12 MS. HOOPER: Correct. Just for your own
13 information, again, the mitigation efforts that you all
14 brought forward and that are summarized here are included
15 in the Operational Plan, so different viewpoints that you
16 can take or materials that you can review for your
17 comments for the final plan.

18 MR. PETRUS: And these two issues here, the
19 value proposition and perception and the lack of
20 participation by providers, are really critical, and that
21 if you can't define to the provider why they should invest
22 the time and energy necessary to participate in the HIE,
23 that's a source of revenue, because you're going to be
24 looking at do you add it on to a license every two years?

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 Do you take a look at a push/pull kind of scenario?

2 Part of the work that we're looking at
3 still to do is what are the different ways that you could
4 look at accessing revenue fairly, without putting undue
5 burden on the private docs, or the hospitals, or the
6 payers, or the patients, so we want to take a look at all
7 those kind of scenarios, but it's a moot point when you
8 have people who don't see the value, and it's a moot
9 point, because then you don't get the provider's
10 participation.

11 MS. HOOPER: Correct.

12 MR. COURTWAY: I think my comment on this,
13 in terms of non-participation by providers, I think the
14 risks are different, depending on which provider class
15 we're dealing with.

16 I think that if you really want to get to
17 the mitigation strategy, you have the hospitals, you have
18 the private practitioners, you have the FQACs, and each
19 has a separate mitigation strategy to try to deal with it.

20 COURT REPORTER: I'm sorry, sir. You need
21 to speak into the microphone.

22 MR. PETRUS: You're absolutely right.

23 Based upon the meaningful use rules, some are going to be
24 much more motivated to participate than others, and I

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 think the real challenge is going to be the individual
2 providers, most of which are in twosies and onesie kind of
3 practices.

4 MS. HOOPER: And is our goal to get 100
5 percent participation in the first three to five years, or
6 is it 85 percent? Again, the Board meets to kind of what
7 are the goals. Sure, we'd all like 100 percent, but, in
8 reality, where do we aim for and within what time period?

9 MR. PETRUS: And depending on the funding
10 mechanism you put in place, what's the sustainability
11 level?

12 MS. HOOPER: Correct.

13 MR. PETRUS: Is that 80, or 50, or 60
14 percent?

15 MS. HOOPER: Correct. And I don't know the
16 value of a one or two doc office. I don't know what the
17 value of return would be, or the value proposition, how
18 that would play out, versus a pro-health, or a hospital
19 system, or a community system.

20 MR. MCKINNON: It's a good example of why
21 we're talking about the risk analysis. It's an
22 opportunity for you to look at the plan, look at this and
23 come up with really useful that would change the plan and
24 make it more relevant.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 So if you see a risk here that doesn't seem
2 to be -- if you know of a risk and you don't see it here
3 and you think it's an important one, then we need to know
4 about it. Until you see a risk, like this one, that you
5 think the mitigation should be structured by provider
6 type, then that's a useful piece of information.

7 MS. HOOPER: Okay.

8 MR. MCKINNON: The second thing, you've got
9 a follow-up question, as which provider types are the ones
10 that are the greater risk, and what are the mitigation
11 strategies that you can think of that we should put in
12 there, because the outcome, the real useful part of this
13 is these mitigation strategies are actually built into the
14 detailed Operational Plan.

15 MS. HOOPER: Correct.

16 MR. MCKINNON: So if you see something here
17 that you think is missing and you tell us about it, I
18 should go change the Operational Plan to include that, not
19 just have it in the risk analysis.

20 MS. HOOPER: Right.

21 MR. COURTWAY: I think we need it, because
22 need to make the connection between, you know, an example
23 of the participation and what is going to be, you know,
24 what are people willing to pay for.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 We better line up and make sure that we
2 have the strongest mitigation on those things to generate
3 the greatest revenue.

4 MS. HOOPER: Correct. That's why it is
5 first. Contrary to what Alistair said, could you not find
6 anymore risks, please? (Laughter) I think he's done a
7 wonderful job of finding them all.

8 MR. PETRUS: More mitigation strategies
9 would be helpful.

10 MS. HOOPER: Yeah.

11 MR. MCKINNON: This next risk is, so, it
12 touches on what we were just talking about, so assuming
13 that everyone stands up to what they've been asked to do
14 and actually becomes part of the new Board, then there's
15 going to be less of an issue, but as people start running
16 away from it, it won't become a big issue.

17 This is extremely relevant. If you don't
18 have the money, if you don't have the long-term money,
19 some mechanism for getting the long-term money, then the
20 whole effort has been blunder, and it's not going to work
21 so well.

22 So the work that we are -- to me, it's
23 clear, it should be clear in the Operational Plan, that
24 we're not seeing that the puzzle of long-term sustainable

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 funding has been solved. The Operational Plan includes
2 the activity in order to try to do that.

3 MS. HOOPER: And for everyone's knowledge,
4 Gartner has agreed to support the Finance Committee in
5 really drawing this out and outlining this and what those
6 sustainability options are, so, no, we don't have the
7 answers right now, but you estimate, what, six weeks?

8 MR. MCKINNON: Yes.

9 MS. HOOPER: Or was it six days, Alistair?

10 MR. MCKINNON: Six weeks once we actually
11 start.

12 MS. HOOPER: Okay.

13 MR. MCKINNON: So on the technology
14 infrastructure side, there's a number of different issues
15 that are possible there, and the mitigations a lot of this
16 has got to do with how the authority engages with
17 technology vendors and what kind leading technology staff
18 they actually get in place. So open procurement and good
19 staffing practices are really the mitigation now.

20 MR. PETRUS: And, also, what you said
21 earlier, about what is it you're building as this
22 platform, so when you go out to the vendor community,
23 you're very clear, that this is what our stakeholders
24 need, this is what they agreed to, this is what we're

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 buying, and we don't want change orders and schedule
2 slippage. This is what we want.

3 And it may not be the Cadillac, but it
4 gives us the foundation to get these three basic pieces in
5 place to address the three core areas of meaningful use.

6 MS. HOOPER: But not to punish or -- I only
7 know the bad word. Punish, or minimize, or detract from
8 those systems that have more than those three basics.

9 MR. MCKINNON: -- also the technology,
10 scalability, so the things that have to -- because we
11 don't really know how much skill is really required,
12 because we don't really know how it's going to be
13 deployed, then we're looking for a solution that is
14 scalable and agile scalability. So that's probably
15 mitigated through some sort of (indiscernible) and the
16 selection of the right vendor of products.

17 MR. PETRUS: And do look at that. We think
18 we heard you loud and clear and how to stay focused, and
19 we did put in some real specificity regarding the
20 infrastructure and the Operations Plan, so would your
21 committee really take a look at it?

22 MR. COURTWAY: In regard to this innovation
23 growth and other requirements, I don't see anything in
24 here on the NHIN direct. Is that thought to not be as

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 broad an issue now?

2 I know, when they came out with it, there
3 was a lot of concern about whether or not that would
4 disintermediate the need to do some of the work that we're
5 doing. Is NHIN direct not a risk?

6 MR. PETRUS: We could add it as a risk, but
7 we did speak to it in the Operational Plan.

8 MR. COURTWAY: Okay.

9 MR. PETRUS: If you think it should rise to
10 the level of the risk --

11 MR. COURTWAY: Well let me go through the
12 detail of the Operational Plan, then.

13 MR. CARMODY: Was there two? Warren, tell
14 me if I get this right. There's NHIN direct, and then
15 there was an NHIN connect. And when we were talking at
16 our subcommittee meeting, the one technology gentleman
17 from Hartford was talking about the connect version,
18 saying maybe that's, because it's an open source and
19 that's the way we should be focusing on it.

20 MR. PETRUS: Connect is the Medicaid side
21 of the equation, what CMS and ONC tried to come up to link
22 the framework, architectural framework with the ONC
23 standards.

24 MR. CARMODY: And what's the difference

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 between that and the direct? The direct sounded like it
2 was sort of point-to-point. The connect sounded as if it
3 was that it allows sort of it to be that hub to a bunch of
4 different spokes.

5 MR. PETRUS: Right.

6 MR. MCKINNON: The NHIN, so that there's a
7 set of standards, NHIN direct is trying to facilitate
8 individual providers to interconnect directly with each
9 other across those basic set standards, and it's a pretty
10 ambitious thing to do.

11 It doesn't matter how open and how much
12 support, you're really talking about providers having
13 sophisticated IT capability to be able to make it happen,
14 so it's a concept, there's a lot of working parties
15 talking about it, and they may pull off something more --
16 I'm very skeptical about it. That's the way I've thought
17 about it. That's a personal opinion, that it's a very,
18 very hard thing to do.

19 MS. HOOPER: Well I'm also not sure what
20 changes they might make further down. I think NHIN either
21 which way can be both a risk and a mitigation. It depends
22 on how you're looking at it.

23 MR. MCKINNON: Yeah, but as part of our
24 strategy, part of the plan strategy, in order to make sure

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 that interstate things from the HIE's point of view goes
2 across State boundaries, that those standards are things
3 it's going to use and going to live by in order to
4 facilitate that, but when it comes to individual providers
5 interconnecting using a, yes, it's possible, yes, it's an
6 option, I'm skeptical about how difficult it's going to be
7 for people that maybe are skeptical of the internet, but I
8 don't --

9 MR. PETRUS: And I think connect is in the
10 same conceptual stage.

11 MR. MCKINNON: It is, yeah.

12 MR. PETRUS: The concept of connect started
13 in August of last year. Basically, it came from the
14 State, saying, well, wait a minute, you maybe spent all
15 this time and money on a Medicaid Information Technology
16 Architecture framework for 2.0 and do self-assess, now
17 you're telling us we have to look into the Nationwide
18 Health Information Network standards, and how do we bridge
19 that, and that's where this concept of connect comes from.

20 And I haven't seen a whole lot on it. I
21 don't know, Marsha, if you have. A lot of talk about it,
22 but I haven't -- like you didn't believe me with a
23 fork(phonetic).

24 MS. HOOPER: What?

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MR. PETRUS: Billion with a fork(phonetic).

2 MS. HOOPER: That's cute. I like that.

3 MR. PETRUS: Okay, next?

4 MR. MCKINNON: Excuse me, if you go to the
5 last page, this will really get you to look at these
6 things and come back with more. You'll see NHIN gets
7 mentioned in here as part of the mitigation towards
8 conforming with interstate requirements, so that's with a
9 mitigation built into the plan. That was in the next one.

10 MS. HOOPER: The next one.

11 MR. MCKINNON: One more.

12 MS. HOOPER: One more.

13 MR. MCKINNON: Another one there.

14 MS. HOOPER: Can you just page down on the
15 slide? Oh, I'm sorry. I saw inadequate in both of them.

16 MR. MCKINNON: So what we really did here
17 is you've got a 200-page document that may be a bit
18 inedible, unless you've got a lot of hot sauce on it, so I
19 don't know alternative is good to the risk analysis. Read
20 the risk analysis, dwell on it, and if you can see
21 something there that you think is really a concern, or you
22 don't think that the mitigation is very well represented,
23 then tell us, and we can modify the plan.

24 MR. PETRUS: I think the two pieces to look

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 at are the executive summary and the risk assessment. The
2 middle part is the real meat of the 11 project areas,
3 where you get into the real detail of what are the action
4 items in each one of these key domains.

5 But I think, starting with the executive
6 summary and the risk, then, if you go to the project, the
7 individual projects, you could see how the mitigation
8 activities were dumped into the key project schedule.

9 MR. COURTWAY: That's a good question.
10 Marianne, on the Legal Committee, did the Legal Committee
11 address the surrounding states, in terms of rationalizing
12 Massachusetts, New York, you know, the border states, in
13 terms of what we have to do on the interstate?

14 MS. HORN: No, we're not to that stage
15 formally. There is a project that Marsha and I are
16 working on with a group, called NESCO, and the states,
17 including New York, are looking at possibly a master
18 provider index, so I think that's something that we are
19 just getting some sense of what that project is, and we
20 can bring it back to your group, or Business and Technical
21 group.

22 We've had informal conversations with other
23 states, but we haven't gotten to the level where we would
24 reach an agreement about if you have a different consent

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 policy, which I think is what you're asking, how is that
2 going to work? We have to do it through agreement.

3 MR. CARMODY: Have you looked at some of
4 those ONC, those tiger groups?

5 MS. HORN: Yes.

6 MR. CARMODY: Okay, so, we're even looking
7 at some of the stuff on that?

8 MS. HORN: I wish they were a little
9 further ahead than they are, but there are some good
10 agreements. The NHIN actually has a prototype,
11 DURSA(phonetic), that has multiple states, so that's kind
12 of our next step, is to look at that, and it's going to be
13 challenging, but I don't think we all have to have the
14 same policy in place for it to work.

15 MS. HOOPER: We just need to make sure that
16 we're accommodating where those patients are being served
17 across the state lines. Again, I think that this actually
18 -- people say Connecticut might be behind. We're actually
19 in the right place, because all these things are happening
20 at the national level.

21 Instead of investing or making
22 determinations prior to this, we have the opportunity to
23 move forward, and, again, Legal and Policy subcommittee
24 had talked with the other states, but considering in the

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 other states they had different health care systems, you
2 know, Delaware has one major health care system, not 31
3 acute care hospitals with different CEOs, CIOs, I mean you
4 all got your own thing, not many of them have 169
5 municipalities and two tribal nations and eight boroughs
6 and 77 health departments. Again, the configuration
7 within the state.

8 MR. COURTWAY: You have 77 health
9 departments?

10 MS. HOOPER: Yes, sir. Only 41 are full-
11 time. We're working on it. Massachusetts has 359.

12 MR. PETRUS: Next steps, one of the next
13 steps is the detail that the Business and Technical
14 Operations and Finance Committee both have really talked
15 about, is quantifying the value proposition for different
16 constituents by population to really say how do you sell
17 this if you don't quantify what the return investment is
18 going to be?

19 Next is to finalize what really are the
20 costs, what it's going to cost to implement this and to be
21 able to sustain it going into the future, because Meg is
22 absolutely right. There is not enough money in the ONC to
23 do all that you are planning to do, even in the
24 implementation phase.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MR. CARMODY: Can I ask a question? So
2 when we look at the three sort of three services that
3 we're talking about, when you look at it from a technology
4 and infrastructure standpoint, how far have you gotten
5 from the standpoint of understanding what that is, or who
6 is out there that can provide those types of services, or
7 is that work to be evaluated?

8 MR. COURTWAY: I think it's work to be
9 evaluated. There are vendors on the market, some that
10 have been out for a long time, a lot of new entrants to
11 the market, so I don't think that we'll have difficulty
12 finding a product set. I think the challenge will be
13 where everybody else is in that integration of being able
14 to even send or receive a CCD, as an example. That's our
15 phase one.

16 I can tell you today, from all the vendors
17 we have with electronic medical records and physician
18 practices in the community, only one states that they can
19 do it, and that one is only as a document, not as discreet
20 data, so the challenge is going to be where all of these
21 different products are lining up, so that you can stitch
22 them together.

23 The other part will be the question of the
24 risk of the entrants in the field. How many entrants will

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 actually be in business three or four years from now, and
2 how do you structure this, so that you can protect the
3 business, in terms of being able to either own it,
4 maintain it, or move on to somebody else in the event that
5 you have a failure of a business partner.

6 MR. PETRUS: We had done for the Office of
7 National Coordinator a year ago a landscape of the vendors
8 out there for different components of the Health
9 Information Exchange. We do track some of those vendors,
10 so that we get some sense of who is going to be around in
11 the future.

12 MR. CARMODY: It's just a general thought
13 process of what we're seeing out there, as far as is there
14 a ballpark range of what you think it would take in order
15 to stand up these services, as well as ongoing?

16 MR. PETRUS: The Operation Plan does
17 contain a budget. I don't remember it off the top of my
18 head.

19 MS. HOOPER: And it's not unreasonable, but
20 it depends on the size and, of course, the service
21 providers, but you also presented a budget according to
22 certain specifications, and I can't for the life me
23 remember what the amount is. Quiz. Who read it? Warren,
24 you read the whole thing. Do you remember how much it

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 was?

2 MR. JEFF PERKINS: It's in the 30 million
3 plus dollars over like the first four years total.

4 MR. CARMODY: So that's startup, as well as
5 ongoing, for about that time period?

6 MR. PERKINS: And, actually, we had assumed
7 more of like a service provider approach, as opposed to
8 maybe buying a software and implementing that over time,
9 and that kind of spreads the cost out. It's just what
10 we're seeing in the marketplace these days, more of a
11 hosted or service provider versus a licensed approach.

12 MR. PETRUS: And because we spread it out
13 for the full life span, if you don't go to the -- it would
14 still be roughly the same amount, but you have different
15 costs upfront.

16 MR. CARMODY: So that gives you a more even
17 distribution, where they may be fronting some of this and
18 then picking it up on the tail end, so it's more of a --
19 is it more transactional, or how do they typically
20 structure those?

21 MR. PERKINS: They're all different. There
22 are a lot of different ways, and I think, even within a
23 vendor there, you can work with them to negotiate
24 different ways of paying for it, but I've got the details

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 in a few of the vendors that we talked to. I can share
2 them.

3 MR. PETRUS: So the first step was to
4 quantify value. The second step is what we estimated the
5 cost to go down a little bit deeper than we have in the
6 plan at the moment. The third, then, is to take a look at
7 all of the potential ways you could fund this, and that
8 would be looking at what other states are doing and
9 looking at that connected to your population, your
10 providers, your transactions, your beds, your discharges,
11 your admissions, all the kinds of things that would go
12 into a formula, and then, from there, narrow it down to
13 some viable alternatives. What could possibly work in
14 Connecticut?

15 And then the next step would be to develop
16 scenarios, business cases, and formulas, and project those
17 formulas out for each of the viable alternatives, and
18 we're estimating maybe there's three or four, I'm not sure
19 what the number is going to be, and then, from there, do
20 an alternative analysis of the challenges, the strengths,
21 the political issues that may be around them, and really
22 do some force field analysis through the alternative
23 analysis to score it against certain criteria, and then
24 get down to the two, or three, or the one that you would

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 want to move forward with the recommendation, because to
2 implement it, you may need legislative action, you may
3 need some kind of memorandum of agreement.

4 There's a variety of things that we don't
5 know yet what those universe are going to end up being,
6 and then, from that, you would really have, at the end of
7 six to seven weeks, more substance and a recommendation
8 for the initial and ongoing funding, because the bottom
9 line, if you don't think you can secure that, then should
10 you go forward?

11 MS. HOOPER: Correct, and, no, unless there
12 is something to go forward with within the constraints of
13 the budget.

14 MR. CARMODY: And, again, Warren just gave
15 me the statement of work in more detail today, so I'll
16 look at that, then we can get it up to the other
17 subcommittee members.

18 So one of the questions I would have, it
19 sounds as if, when I look at this high level again, it
20 looks in sync with what we talked about, as far as what
21 the subcommittee asked for a statement of work, which is
22 good.

23 Do you think, out of this, we would also be
24 able to -- we'd also be coming up to like knowing what we

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 think the range of potential costs would be, we'd also be
2 able to identify potentially the shortfall? Is that what
3 I just heard? That was the last piece, that said, look
4 at, I tied my value to what I think people could pay to
5 what I think we could push for, and we're either positive
6 or negative?

7 MR. PETRUS: The scenarios may not work. If
8 we look at the formula and we say, you know, there's no
9 way you're going to get a quart out of this. You're going
10 to get two pints.

11 MS. HOOPER: And just so everybody does
12 understand, this is a separate, not a separate, but a
13 distinct responsibility that Gartner is working with
14 certainly with DPH, but, also, with the Finance Committee
15 to get at this issue. It is not going to be finalized
16 before we submit the plan to the Office of National
17 Coordinator, but will certainly be a part of the ongoing
18 process, obviously.

19 MS. HOOPER: We do want to make sure that,
20 in following on the agenda, that the common period starts
21 today and extends until August 27th, correct?

22 MS. LYNN TOWNSHEND: Correct.

23 MS. HOOPER: And Lynn is going to talk
24 about the public forums that she's established and how

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 we're encouraging you, but I can't stress enough how we're
2 hoping that you share that e-mail with your colleagues.

3 We're not just looking for your input, but
4 we're trying to get as broad an input as possible on the
5 plan. We want to be inclusive of anybody's opinion before
6 we submit it to ONC.

7 We didn't get a strong response from the
8 Strategic Plan, so we really are hoping for both positive
9 and critical comments to make sure that we are, in fact,
10 representing what Connecticut is looking for.

11 We feel that, again, administratively, we
12 have a good product. The Advisory Committee has been
13 instrumental in getting it to be a valid document. We
14 want to make sure that we're considering all the opinions,
15 so please share it broadly.

16 Please take the time as Advisory Committee
17 members to read through as much as possible that you'd
18 like to comment on. We're also wondering if we could ask,
19 be assessed for a formal letter of comment, so that we can
20 include that with the plan, and that we'll be approaching,
21 also, REC, that if there are any comments that can be
22 made, we'd like to include that to ONC, that are
23 partnerships are real and valid.

24 COURT REPORTER: One moment, please.

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HOOPER: And we're also encouraging
2 that any Advisory Committee member that would choose to to
3 send us a letter either of support, consent, concurrence.

4 I don't think we'll ask the entire committee to sign
5 something, but you've all been great, in terms of not
6 saying, no, I don't agree, or I disagree, or whatever,
7 but, again, as I said in the beginning, we don't want to
8 presume concurrence by your silence. Yes, sir?

9 MR. WOLLSCHLAGER: Given the relatively low
10 numbers of commentaries last time, I was just thinking.
11 Do we have a campaign, where we've actually tried to reach
12 out to a variety of potential stakeholders?

13 MS. TOWNSHEND: Yes, we do. In fact, we've
14 been working with E-Health Connecticut, who is present
15 here today. We have the list of stakeholders that we have
16 from the leadership meeting.

17 E-Health has sent it out and posted it,
18 posted it to their website and sent it out to their
19 channel partners. I don't know if DSS is -- I don't even
20 know if we asked you, but if you have any additional
21 people you think it could be sent to and maybe even do it,
22 if you think their partners were not included in all of
23 this, but I know that, at least on the physician side, the
24 REC has a great list of channel partners that we're

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 working with, and there were 89 on the list that we had
2 for the leadership.

3 And just to follow-up on what Meg had said,
4 we do have two public forums coming up. They are this
5 Thursday, August 19th, from 5:00 p.m. to 7:00 p.m. at the
6 Legislative Office Building in Hartford. The second one
7 is a week from this Thursday, August 26th, from 9:00 a.m.
8 to 11:00 a.m. at the North Haven Holiday Inn, which is
9 easy on and off I-91.

10 We would love to see you there. There are
11 certainly no requirements that the Advisory Committee be
12 there, but we would love to see you and get your support
13 at those meetings. If you happen to be in the
14 neighborhood, we would love to see you there.

15 I think one of the meetings was just you
16 and Marianne the last time around, and tell your friends,
17 tell your family. Anyone who is interested in HIE is
18 certainly welcome to come, to comment. They can make
19 comment there. We won't necessarily be responding to it,
20 but we will take that comment, bring it back to DPH for
21 consideration, as we are doing with all of the comments
22 that are being made.

23 You can also make comment on the DPH
24 website through Survey Monkey, exactly the way we did it

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 last time with the Strategic Plan. I welcome you to send
2 out that link. I know that Tom Agresta sent it out this
3 morning to a number of people, so I'd welcome you to do
4 that.

5 The plan is out there. You can send that
6 link. The master schedule is out there. You can send
7 those three links together, along with information on the
8 forums and when the time -- I made it 5:00 p.m., so that
9 we don't leave until midnight for people to do their
10 Survey Monkey on a Friday night, but I will be closing out
11 Survey Monkey probably around 5:05 that afternoon.

12 I do want to let folks know that E-Health
13 Connecticut has chosen a date for their first major
14 meeting. Sent out the date on Friday, but if you haven't
15 heard, that is happening September 29th at the Trumbull
16 Marriott. Is that correct, Steve?

17 A MALE VOICE: That's correct.

18 MS. TOWNSHEND: And I'm sure E-Health will
19 be getting more information out to you on that. That is
20 aimed at health care providers and health care practice
21 managers, who want to know more about what is meaningful
22 use, and who is going to help me get set up with an EHR,
23 and where am I going to get this information?

24 E-Health Connecticut really has the lead on

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 that as the REC in Connecticut, but DPH will do a
2 presentation, as will DSS. I believe DSS. They've been
3 invited to. Whether or not they're going to, I don't
4 know. I can't speak for Marsha.

5 You can also fax comments. People can fax
6 them to the office of the Commissioner, and that is listed
7 on-line. You can send them to me. That address is listed
8 on our DPH website, so we're pursuing a number of avenues
9 where people can make comment.

10 MS. HOOPER: We will accept whatever you
11 can send us.

12 MS. TOWNSHEND: Smoke signals.

13 MS. HOOPER: Well, no. That, I don't think
14 we can. We, from the Department of Public Health, we
15 don't encourage smoke signals.

16 MS. TOWNSHEND: Morse code.

17 MS. HOOPER: Okay, Morse code, maybe.

18 Thank you very much, Lynn. Any questions on the public
19 forums? Again, please encourage all to take a look at the
20 plan. As was explained earlier, the executive summary,
21 risk analysis, whatever sections are appropriate.

22 We are, after the public forums and on
23 August 27th, we will be taking those comments received
24 throughout that period and working with Gartner to

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 finalize. Yes, sir? Oh, you were just waving?

2 MR. CARMODY: No. I have a comment. I
3 didn't want to jump in. I was just waiting for you to
4 finish.

5 MS. HOOPER: It's a good time to jump in.

6 MR. CARMODY: Have we reconciled sort of
7 what we are doing here to what's going on with what we're
8 doing in the Medicaid, as to what's going on with E-Health
9 Connecticut is doing and sort of look at these are our
10 services, this is how we compliment one another, this is
11 how we're taking advantage of the pockets of money,
12 whether it be reimbursement-wise, how we're going to spend
13 our seven million, how they're going to spend their five
14 million?

15 MS. HOOPER: Not in that detail, but we
16 have started with what we call the 3C3, which is
17 collaboration, coordination and --

18 MS. TOWNSHEND: Communication. You changed
19 it.

20 MS. HOOPER: We think it's communication,
21 but it was another word in the beginning, but, anyway, so
22 we call it 3C3, just because there's three
23 representatives. Anyway, with DSS and E-Health and DPH,
24 we do have some overlap in our grant requirements, and our

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 deliverables, and, of course, in the intent, so that
2 effort has begun of trying to link those things, but how
3 much money is going into this and that hasn't yet been
4 finalized, but those discussions are going on.

5 DPH is working very closely with DSS,
6 because, obviously, I think we've done it before. We're
7 Health Information Exchange, of which DPH is a member, is
8 the foundation. DSS reimbursing the Medicaid population
9 is certainly a big portion of that, and then E-Health,
10 separate with REC, is 14 hundred providers, I think, for
11 the training, so that there's that.

12 So the building on each, we're trying to do
13 the reach out, but we're envisioning that the Health
14 Information Technology and Exchange of Connecticut
15 authority is, in fact, going to be the baseline, so we're
16 trying to work very closely with DSS to support their
17 planning process.

18 With the REC, we're trying to be as
19 supportive as we can, as they're going out and developing
20 their training and communication programs, and then DSS
21 and E-Health.

22 MR. CARMODY: I guess my question would be,
23 at some point in the near future, you know, within the
24 next month or so, is there where you see sort of a gridded

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 way that says, look at, these are the areas of focus?
2 Even if there's no money attached to it that says this is
3 --

4 MS. HOOPER: No. We can --

5 MR. CARMODY: Okay.

6 MS. HOOPER: Yeah, we do have that.

7 MS. TOWNSHEND: We do have that, where
8 there are areas of overlap between all three and how we're
9 going to be working together, and I can say that
10 communications is a subcommittee of the 3C3 that's working
11 on communications already.

12 MS. HOOPER: Warren, do you want to send
13 that out to the committee?

14 MR. WOLLSCHLAGER: I'll be happy to send
15 that out. I will say the big issue, though, is these
16 three pots of money, and how do we make sure that we spend
17 those dollars in an efficient and effective way? That has
18 not yet been heard. That's the next big thing.

19 MR. CARMODY: Well, at a minimum,
20 especially as maybe this gets into when we get into what
21 DSS is doing, is, again, how would they view, you know, if
22 we're delivering three -- if we're delivering these three
23 services, even if E-Health Connecticut is focused on the
24 training and the communication and sort of, again, what

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 their focus has been, how would you see the adding of
2 these three services, and can we reconcile that at a
3 minimum, even if we don't have the E-Health capability,
4 because I would imagine you'd look at these three services
5 that we deliver and say it provides value, it doesn't
6 provide value.

7 MS. HOOPER: And that's why we're working
8 with DSS from that approach, and then E-Health, and as the
9 REC is working with DSS on making sure that they're both
10 giving the same message out to the provider community
11 about what's acceptable for meaningful use.

12 We did talk about some of the options of
13 leveraging funds for having the new authority be the
14 catch-all, be-all for administrative responsibilities,
15 where there might be some overlap and duplication of
16 efforts.

17 All three of these are through essentially
18 stimulus funding, so they have somewhat similar
19 contractual requirements should there be kind of one
20 central resource for that, so we've gotten into the weeds
21 a little bit with those kind of issues, but certainly no
22 answers and not, as Warren said, about the money.

23 But I think that Marsha has been so
24 knowledgeable. I don't know if that's the word either,

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 but acknowledging that the planning process and
2 supporting, so I think that we're good on how do these two
3 State agencies really get not only the biggest bang for
4 their buck, but how do we make this done correctly?

5 MS. TOWNSHEND: And, also, my favorite term
6 is singing from the same hymn sheet from the
7 communications point of view, so that we're all saying the
8 same thing.

9 MR. CARMODY: I agree. I think that the
10 communication is clear, but we have an opportunity now
11 that says we have a State agency. The question that I
12 would have is just as we have to go out and do this to a
13 lot of other constituencies, I will say we have a captive
14 audience to say, well, if you were going to pay for this
15 and this is a valued service, how would you go about it,
16 and can we look at it to say how would you go about the
17 assessment piece, because it may be different on other
18 ones that we have to go figure out.

19 MS. HOOPER: We're going to support how DSS
20 needs to go forward, again, not as a minimum, but that's
21 kind of the baseline of those three services, and with
22 those providers we have to expand to all the providers,
23 also.

24 MS. MAINS: Right, for our incentive

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 payments, but we, in turn, also want to be able to support
2 the statewide HIE for our Medicaid population, and that's
3 where we get into that, well, we're a certain percentage
4 of the entire Connecticut population, and I think that's
5 where CMS is being very open to say, well, ask us.

6 MS. HOOPER: Correct.

7 MS. MAINS: And we've already demonstrated
8 their willingness to fund DPH. In many other states,
9 these agencies are all together.

10 MR. CARMODY: There's two questions there.
11 There's the could we get reimbursed from CMS in order to
12 be able to do that, but then there's the real, I guess the
13 real point of my question, is how much is that, the
14 services that we're creating, what value of it?

15 Even if you can get reimbursed or not,
16 which is a separate issue, how do you calculate the value
17 to what this HIE going to do?

18 MS. HOOPER: Correct.

19 MR. CARMODY: If you didn't have it, what
20 would that mean to you?

21 MS. HOOPER: And I think that that's part
22 of not only your process with Gartner, but I think that
23 really is for the discussion here, of the people not only
24 here around this table, but of the larger discussion of,

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 okay, there's the value of both financial and policy.
2 Obviously, the Department is concerned with the value, in
3 terms of improved health outcomes and access to quality
4 health care.

5 I mean we're leaning there. How are you
6 going to actually -- what is the value-based assessment
7 coming from?

8 MS. MAINS: And another value to DSS is the
9 ability to share that health information. Our clients are
10 a little bit more mobile and transient than your, you
11 know, your health insurers, your normal health insurers,
12 so there you're going to eliminate the duplication of
13 tests.

14 We've identified a person got the same test
15 20 times within a very short period of time, so there
16 would be a tremendous cost savings to the State, as well
17 as the benefit to the client.

18 MR. PERKINS: I was going to say, I think
19 that's a great way to look at it, to start looking at the
20 outcomes, particularly around the efficiencies, what are
21 the cost avoidance factors, so reducing duplicate testing
22 and imaging, reducing readmissions, reducing the
23 administrative burden around all these physical medical
24 records, so starting to look at outcomes I would say would

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 probably, you know, a Cigna customer, you know, you would
2 still be looking at the same sorts of outcomes as you
3 would on the Medicaid side.

4 MR. CARMODY: There's no question. I was
5 trying to -- I was looking at your service, trying to
6 canvas a lot of different places that we don't normally
7 have outreach to go and try to quantify this. I was just
8 thinking where we're at with DSS, is that you're sort of
9 already at the table.

10 Getting you up to speed is going to take a
11 lot less time, because you're already there, so, then, do
12 we have an opportunity to start the ball rolling even
13 sooner than getting this lift off the ground?

14 MS. HOOPER: I think that's where you get
15 into the REC, because they are working -- I mean that's
16 where the three agencies or funding recipients are working
17 together. I mean the message is going out. E-Health is
18 having a forum in September. We're having the public
19 forum. DSS is working with all its providers.

20 But I do think that how we're going to move
21 forward is, again, the strength of the Board, the
22 direction of both Commissioners of both agencies, and the
23 Board of Directors at E-Health.

24 The more vocal and more active the Boards

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 are the more productive it's going to be seen, and I think
2 that the leveraging is not only going to be cost
3 efficient, but, again, the value. Community health
4 centers are the ones that also with the transient
5 population, different insurance-based, you know, they're
6 looking at not only improved health outcomes, but reduced
7 costs. Peter?

8 MR. COURTWAY: I guess let me take it where
9 Dan is going and bring it up and bring it down to a
10 particular level. Each one of these initiatives is trying
11 to become self-sustaining.

12 MS. HOOPER: And that's an issue that we're
13 going to have to address.

14 MR. COURTWAY: So where is the coordination
15 of the product development and the interrelationship of
16 this? So, for example, on the REC, you know, is the REC
17 going to, as part of its business plan and sustainability,
18 offer, for example, an EHR for physician practices?

19 MS. HOOPER: Right. We would have to talk
20 with the REC about that.

21 MR. COURTWAY: Is that coordinated, where
22 with DSS, in terms of the Medicaid, in terms of
23 formulating a plan for those Medicaid providers that do
24 not have an EHR, I know they bought into that same model,

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 is that EHR potentially that's being, you know, sponsored
2 by the REC so tightly integrated with our plans for the
3 HIE that we know what that funding and that flow of data
4 is going to look like, so that we're presupposing who is
5 selling what product in the State of Connecticut for the
6 money?

7 MS. HOOPER: Understood.

8 MR. COURTWAY: So that we're not all
9 developing products in competition with one another.

10 MS. HOOPER: And that's why we're having
11 the communications, and back to that kind of picture, the
12 HIE in this plan is the baseline, that what DSS and RECs
13 and the other providers need to follow from.

14 I mean this is the foundation that, if you
15 don't have something that is compliant with the HITE plan,
16 then it's not necessarily -- well it isn't necessarily
17 acceptable or appropriate for Connecticut. The purpose of
18 this plan is to lay that baseline and then to move up
19 through those specifics if it doesn't meet certain
20 standards, if it doesn't meet this.

21 I think that, again, we're all trying to
22 work together on this. There are two Boards. The REC has
23 its own Board. This will have its own Board of Directors,
24 then DSS and the DPH will have Commissioners in our

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 executive agencies to the Governor's office, so there's
2 going to be a lot of, again, the more active and
3 consistent that the membership is and the Board members
4 and asking questions across the different Boards.

5 MS. TOWNSHEND: If I may, let's not forget
6 we also, by the cooperative agreement, must have an HIT
7 statewide coordinator, who is supposed to make sure that
8 all these things are neatly tied in a bow. That's a big
9 job for one person. It's probably a job for five people,
10 but the requirement is one, so I think, in using that
11 position, which not only it will, I believe -- have we
12 decided where it's going to reside?

13 MS. HOOPER: No. We said earlier the
14 Governor is going to decide that.

15 MS. TOWNSHEND: The Governor is going to
16 decide, so, wherever that is, that person will have
17 oversight not just of DPH and the authority, but, also,
18 will make certain that the coordination with anything that
19 has to do with HIE that is funded by the Federal
20 Government is coordinated and leveraged appropriately.

21 MR. PETRUS: I think, also, the
22 sustainability models are different. DSS's sustainability
23 model is make sure you put a plan in place where you can
24 get 90 cents on a dollar to manage it and 100 percent on

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 the dollar to fund the incentive program.

2 The Regional Extension Center has got a
3 substantial amount of money over X number of years, maybe
4 even with a sunset clause at the other end, depending on
5 where all that goes.

6 It's the HIE that has the biggest challenge
7 around sustainability, because there's no guaranteed CMS
8 90 cents on the dollar to manage this, and the grant to
9 the HIE was smaller than the grant to the REC, so there's
10 a real different challenge, and that's why we see that as
11 a major risk, making sure you can spell out the value
12 proposition and come up with a formula and the right
13 funding streams that will allow this to be developed and
14 go forward. If not, then you have to fish or cut bait.

15 MS. HOOPER: And I do think those are the
16 kind of comments that, in writing, will be very effective
17 for us and, also, to carry forward with our partners.

18 MR. PETRUS: And something I think is
19 important in a briefing paper or a whitepaper for the new
20 administration, because it's not unreasonable, as other
21 states have done, to get some kind of -- from the State
22 legislature, even though it may be small, that provides
23 some foundational funding for X number of positions, or
24 heat and light, or something that makes sure that there's

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 some marginal level of support from the State, because,
2 ultimately, the State has a tremendous return on
3 investment and a variety of -- employment, public health,
4 Medicaid, child welfare, etcetera, to improve the health
5 conditions within the State.

6 And I don't see any reason why this
7 governing body could not get a whitepaper together that
8 goes to the new administration and legislature about that.

9 MS. TOWNSHEND: 3C3, Communication
10 subcommittee, is already on that.

11 MS. HOOPER: And, again, I think it's the
12 responsibility of the State agencies in their own
13 perspectives, as to how this is incorporated within their
14 own programming.

15 The transitioning, I think we've covered
16 that in the agenda. We're taking care of some of the
17 legal issues as that goes forward, and we'll come for
18 advice, as needed.

19 Public comment? Any public comments? If
20 you could? John, would you like to come up and use a
21 microphone?

22 MS. TOWNSHEND: Right over there, next to
23 Dan.

24 MS. HOOPER: And have a seat.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MR. JOHN LYNCH: Hi. John Lynch,
2 Connecticut Center for Primary Care. One, congratulations
3 on staying on time target, because I think that is our
4 biggest risk, is time, with all the things we have to
5 accomplish.

6 Comment on three projects versus the 11.
7 Looking at your 11 tasks in your project plan, the first
8 seven, I believe, are before you even get to phase one,
9 two and three, so I think it's probably important to
10 recognize it's not just three phases, but that there are
11 seven major steps that are all critical to get done in
12 order to get to phase one and two and three.

13 And standing up the HIE I believe is one of
14 those steps that's critical in order to accomplish phase
15 one and two, three, as an example, so you can't
16 necessarily pull them apart, but it is more than those
17 three.

18 The other is I think there's some
19 inconsistencies in the titling of the first three phases.
20 Phases one and two seem to have a little bit of confusion
21 whether it's Public Health versus CCD versus whatever in
22 some of the different pages. I can show you different
23 pages, but it would be good to have them more consistent.

24 They're always talking about, you know, for

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 example, I think, in one spot, you'll see MPI as in phase
2 one, but other spots you don't see anywhere that MPI is
3 part of phase one, so it's just that consistency, because
4 realize there are a lot of things to be done, and we want
5 to make sure we get them all done.

6 MS. HOOPER: You did read it, didn't you?

7 MR. LYNCH: Those are my comments.

8 MS. TOWNSHEND: Thank you, John.

9 MS. HOOPER: That's it? Thank you very
10 much for your comments. Any other comments for public
11 comment? Again, please share with your partners on the
12 plan and get those comments in. Before we stop, are there
13 any other issues that the Advisory Committee members would
14 like to -- yes, sir? Oh, good.

15 MR. LYNCH: Sorry. There was one other,
16 and that is, if you could split up the document, maybe
17 appendices as separate? You really can't e-mail this
18 around. It gets blocked, because of the size.

19 MS. TOWNSHEND: You can e-mail the link,
20 though, can't you?

21 MR. LYNCH: Yeah. I think that's what Tom
22 Agresta had to do. Even then, trying to print it out was
23 clogging --

24 MS. HOOPER: Can you do that for us,

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 Alistair?

2 MR. LYNCH: I think it's easier to print
3 the smaller components, if you can.

4 MS. HOOPER: Yeah. Can you send two
5 documents, and we'll see if we can forward at least the
6 main document, not the appendices? Thank you, John. If
7 we can, we will.

8 MR. MCKINNON: There's also an interesting
9 piece of software, called Chainsaw.

10 MS. HOOPER: Really? Alistair?

11 MR. MCKINNON: It slices up documents.

12 (Laughter)

13 MS. HOOPER: Can we not be advertising
14 software named Chainsaw or Slasher? Are there any other
15 comments that need to be made from the Advisory Committee?
16 Warren, have we missed anything?

17 MR. WOLLSCHLAGER: No. We have to have
18 some follow-up discussion regarding this.

19 MS. HOOPER: So, Dan and Warren, if you
20 could stay, and then, also, for I think Rick and Marsha,
21 and, Lynn, there's a meeting with Gartner, also, on kind
22 of your status meeting for your Monday, if you can stay.

23 Commissioner, any last comments?

24 CHAIRMAN GALVIN: No.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
AUGUST 16, 2010

1 MS. HOOPER: We'll see you on September
2 20th. Hope to hear from you sooner, and if you can come
3 to the public forums and support us, we'd appreciate it.
4 Thank you, all, very much.

5 (Whereupon, the meeting adjourned at 2:00
6 p.m.)