

VERBATIM PROCEEDINGS
DEPARTMENT OF PUBLIC HEALTH

CT HEALTH INFORMATION TECHNOLOGY
AND EXCHANGE STRATEGIC PLAN

JEWEL MULLEN, CHAIRPERSON

FEBRUARY 15, 2011

101 EAST RIVER DRIVE
EAST HARTFORD, CONNECTICUT

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE
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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 February 15, 2011 at 4:44 P.M.

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7
8
9 MR. WARREN WOLLSCHLAGER: Thank you very
10 much, my name is Warren Wollschlager. I am the --

11 DR. ROBERT GALVIN: Could you spell that for
12 us please?

13 MR. WOLLSCHLAGER: -- and I'm the DPH
14 coordinator for the State of Connecticut, and it's my
15 pleasure to convene this meeting. It's also my pleasure to
16 introduce two new and very important members of this
17 Committee. First and foremost my immediate boss, I'd like
18 to introduce --

19 CHAIRPERSON JEWEL MULLEN: You're messing me
20 up with first and foremost.

21 MR. WOLLSCHLAGER: -- going in order closest
22 to me, I'd like to introduce our new Commissioner of Public
23 Health, Dr. Jewel Mullen. Dr. Mullen is, by statute, the
24 Chair of this Committee amongst her many other duties. And

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1 so I'm happy to turn the discussion over to you -- yes, I'm
2 very pleased. This is my second day -- two days in a row
3 I've had the pleasure of being with the Lieutenant
4 Governor. Nancy Wyman is part of the group that gave
5 (indiscernible) the dedication of the UConn Stem Cell
6 program, and we appreciated your presence there and your
7 leadership very much. So welcome to both of you and we
8 look forward to your being here.

9 LIEUTENANT GOVERNOR NANCY WYMAN: Thank you
10 very much.

11 MR. WOLLSCHLAGER: So we'd like to begin the
12 discussion.

13 CHAIRPERSON MULLEN: So thank you to
14 everybody assembled around the table and the rest of the
15 public who's here with us as well. Because this is our
16 first meeting, although I've been briefed and I actually
17 brought a lot of what the staff has given me so that you
18 know that they've been giving me information, I haven't
19 read it all yet.

20 I thought I'd like to do introductions for
21 our benefit. And also, I'll say greetings to the people
22 who are on the telephone. So could we just go around?

23 LIEUTENANT GOVERNOR WYMAN: Well, I'm Nancy
24 Wyman and I'm still the Lieutenant Governor, at least for

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1 three more years.

2 MR. JOHN GADEA: I'm John Gadea, Director of
3 State Drug Control for Consumer Protection.

4 MR. STEVE CASEY: Steve Casey, Director of
5 Business Development, Department of Information Technology.

6 MS. MEG HOOPER: I'm Meg Hooper, Chief of
7 Planning at the Department of Public Health.

8 MS. BRENDA KELLY: Hi, I'm Brenda Kelly, the
9 State Director of AARP Connecticut.

10 DR. JOHN LYNCH: Hi, I'm John Lynch. I'm
11 the Executive Director of the Connecticut Center for
12 Primary Care. It's a 501C3 Research Foundation. I also
13 wear another hat, I work with the ProHealth Physicians
14 Primary Care Group practice in Connecticut.

15 MS. ANGELA MATTIE: Hi, I'm Angela Mattie
16 and I'm with Quinnipiac in the MBA Health Care Management
17 program, and JDs who are interested in health care law.
18 And I was appointed by Senator Williams.

19 DR. RON BUCKMAN: Ron Buckman, I'm a
20 physician in private practice, family medicine in Bolton.

21 MS. BARBARA PARKS-WOLF: Barbara Parks-Wolf,
22 I'm with the Office of Policy and Management.

23 MR. MARK HEUSCHKEL: I'm Mark Heuschkel, I'm
24 from the Department of Social Services, Medical Care

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1 Administration Division.

2 DR. STEVEN THORNQUIST: I'm Steve
3 Thornquist, I'm a pediatric ophthalmologist practicing in
4 Trumbull.

5 MS. ELLEN ANDREWS: I'm Ellen Andrews from
6 the Connecticut Health Policy Project.

7 DR. ROBERT GALVIN: I'm Bob Galvin, among
8 other things I have been the Commissioner of Public Health
9 and today I feel a little bit as a wag once said, like the
10 corpse at an Irish wake -- you're necessary for the
11 proceedings but don't expect to be included.

12 DR. THOMAS AGRESTA: I'm Tom Agresta, I'm a
13 family physician and a Director of Medical Informatics for
14 family medicine at the University of Connecticut Health
15 Center.

16 MR. DANIEL CARMODY: Dan Carmody, Cigna
17 Health Care.

18 MS. MARYANNE HORN: Maryanne Horn, I'm an
19 attorney at the Department of Public Health.

20 MR. WOLLSCHLAGER: And on the phone we have
21 folks joining us?

22 MR. ED CANE: Hi, good afternoon. My name
23 is Ed Cane, I am from CA Technologies. I'm a public
24 joinee. I am the Account Manager -- I've been supporting

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1 the State of Connecticut at my company as an Account
2 Director for many, many years. Thank you.

3 MR. WOLLSCHLAGER: Great.

4 MS. LISA BOYLE: Lisa Boyle, I am an
5 attorney at Robinson & Cole. I apologize for being on the
6 phone, I wish I could be there live and may actually show
7 up, and I am the Chair of the Legal and Policy
8 Subcommittee.

9 MR. WOLLSCHLAGER: Thank you Lisa. And
10 anyone else on the line?

11 MR. PETER COURTWAY: Yes, it's Peter
12 Courtway. I'm Vice President and Chief Information Officer
13 of Western Connecticut Health Care, a member of the Board
14 and Chairman of the Technical Committee.

15 MS. ERIKA CHAHIL: This is Erica Chahil, I
16 am from Gartner and I'm Director of Development and
17 Strategic and Operational Services.

18 MR. WOLLSCHLAGER: That's Erika from
19 Gartner. Okay, thank you all very much.

20 CHAIRPERSON MULLEN: So I understand -- I
21 remember the weather last month and that the meeting had to
22 be cancelled. So I know that you have the approval of the
23 minutes from two weeks, is that it?

24 MR. WOLLSCHLAGER: It's actually approval of

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1 the minutes from December 13th. The November meeting
2 minutes were actually approved but we revised them based on
3 comments from Dr. Carmody, so we're really just looking for
4 approval of December 13th.

5 CHAIRPERSON MULLEN: Okay.

6 MR. CASEY: So moved.

7 DR. AGRESTA: I second.

8 MR. WOLLSCHLAGER: Okay, so that was moved
9 by Steve and seconded over here by Dr. Agresta. Okay,
10 those in favor say Aye?

11 VOICES: Aye.

12 MR. WOLLSCHLAGER: Opposed? The Ayes have
13 it, thank you.

14 CHAIRPERSON MULLEN: Thank you. I know
15 there's a long agenda and some decisions that we wanted to
16 get to today. I also acknowledge that because of the
17 weather we are now here in February. But also marking the
18 beginning of this work under a new administration, which
19 means that we come as much wanting to learn about the work
20 going forward and put the work in the context of the other
21 priorities, directions of the government, particularly with
22 regard to how this fits into health reform.

23 And in that regard I wanted to just step
24 back for a minute and talk a little bit. I know Meg

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1 prepared a presentation that actually would give us some of
2 that background information, but I also wanted to make a
3 few comments as someone who's been a practicing physician
4 and who has used electronic health records in one version
5 or another for over 20 years. And as someone who comes
6 from working someplace else that has often times been
7 considered a leader but in other state work and national
8 work, I know a lot of what we're trying to do is as much as
9 a challenge for us as it is for colleagues across the
10 country.

11 So one thing that I will tell you right now
12 is that I'm not sitting here with all the answers and
13 solutions for how we actually get to where we need to be in
14 this project, but wanting to thank you for all of the
15 effort that's gone into it so far. I also feel
16 particularly fortunate to Chair this because in most
17 circumstances when people have talked about meaningful use,
18 from what I understand public health hasn't been logically
19 and readily included in the conversation because so much of
20 meaningful use has related to the delivery of medical care.

21
22 So, that we are here as part of this, I
23 think, is a wonderful opportunity for us because this isn't
24 just about the delivery of health care to people. This is

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1 really about population health, which is what we do. So
2 it's I think a great opportunity for us to have Public
3 Health right here with everybody else around the table. Do
4 you want to say anything?

5 Okay, so actually what I would want to do
6 acknowledging and honoring the agenda still -- I mean, for
7 my benefit and for yours I would ask Meg whether or not you
8 would go to your presentation and maybe in a more
9 abbreviated fashion.

10 MS. HOOPER: I'd be happy to.

11 CHAIRPERSON MULLEN: Just for us to all have
12 a chance to talk about where we are at this point and how
13 we've gotten here, because that's really going to be
14 important to us as we talk about how we go forward and the
15 recommendations that we take back to Governor Malloy after
16 today's meeting.

17 MS. HOOPER: Absolutely, thank you very
18 much.

19 CHAIRPERSON MULLEN: Okay. She didn't know
20 I was going to do that.

21 MS. HOOPER: No, did you want to do the work
22 business or is that later, on the bank designation and --

23 CHAIRPERSON MULLEN: That's what I mean, I
24 derailed the agenda.

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1 MS. HOOPER: I'll just be quiet and do what
2 you asked. Anyway good afternoon -- evening, and thanks
3 very much for coming. Again, the slides were sent to you
4 via e-mail. We've provided them also as a hardcopy in your
5 packages along, with all the other meeting materials. We
6 will post this to our website for our guests. This is
7 information that we will be putting on our website. For
8 those on the phone call, you can refer to the e-mail.

9 We wanted to give just a brief overview, not
10 only for Governor Wyman and Commissioner Mullen, but also
11 for the folks that are new to either this Board -- we've
12 only met in October and November and December so I wanted
13 to give just a brief perspective. And I will abbreviate it
14 to the point that we've been doing this officially for four
15 years. Actually we started six years ago doing health
16 security and privacy where we worked with the Department of
17 Public Health, worked with the Connecticut Health
18 Foundation, with e-Health, and started to get some
19 standards together.

20 Officially many of you, for example Dr.
21 Agresta -- who else did I pull in on the table Tom? I
22 think we had a volunteer Advisory Committee and Dr. Agresta
23 was there. We developed the 2009 HIT plan. We were hoping
24 that that was going to be a baseline for the effort that

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1 we're doing right now with ONC funds and utilizing
2 Gartner's expertise and all of yours. Many of you were on
3 the Advisory Committee that served for two years, including
4 Dr. Agresta, and most of you were at the table that were a
5 part of that process -- hi Peter --

6 MR. COURTWAY: Hello Meg.

7 MS. HOOPER: -- as we put together the Plan
8 that you all contributed to, either directly or through
9 comment, the Strategic and Operational Plan, again,
10 required by ONC but also determined to be necessary to set
11 some kind of a framework and an outline for how we're going
12 to move forward in this State. This Plan was submitted
13 back in September after receiving the funds in, I think it
14 was February or March, so in six months we recognize -- I
15 hope it wasn't considered haste, but in fact the materials
16 that were presented and prepared included a number of
17 meetings that Gartner held with us and gathered the
18 information.

19 We did receive comments requesting a
20 clarification on the meaningful use requirement. We did
21 put some information -- additional information together in
22 December, sent you all that copy electronically, so we
23 recognize that you don't have those documents in terms of
24 bounded documents put before you. And so then we got some

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1 more comments, I don't know that it -- we'll call it
2 indirectly first of all. Lee Stevens is our new Project
3 Officer. Many of your met Molly Smith, who was our Project
4 Officer; she went off to work for a consulting firm. And
5 Lee Stevens, who actually ran the challenge grant program,
6 is now taking over as our Project Officer.

7 Lee Stevens directed Lisa Jenkins, who is in
8 fact the lead HIT Technical Director consulting to ONC. She
9 talked to us at a December meeting. Dr. Agresta, Sarju, I
10 and Dr. Buckman was there, and we heard clearly that the
11 Plan needed to identify in the next eight months --
12 Connecticut has to have the access to all meaningful use
13 requirements to all physicians starting with the top three,
14 access to the sharing, delivery of laboratory results --
15 no, I think that's here, sorry. On the ONC comments,
16 again, you can look at this. What they supported was more
17 than what they had concerns about. Again, the business
18 plan, the foundation, our governance policy that you have
19 all contributed to and have actually acted upon, their
20 concerns were as our concerns are, financial
21 sustainability.

22 ONC funds, the \$7 million we've spent -- we
23 will have spent about \$1 million, \$4 to \$5 million are
24 going to go for HIT/CT operations. How are we going to

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1 wisely spend that to get the things done without additional
2 funds? The financial sustainability report was not
3 submitted until after their comments Dan, so the financial
4 sustainability report that you produced was, I think in
5 mid-December. And again, so they did receive it since then
6 and again, we're looking for other funding from either
7 public or private or if we find that there are other
8 opportunities available.

9 DR. CARMODY: Meg, did they provide comments
10 on that or did they just get it and receive --

11 MS. HOOPER: They have not made specific
12 comments on that Dan, so we are hoping that -- what we have
13 heard from Lisa Jenkins and some of our associates in ONC,
14 they're happy to see that the Board addressed it.
15 Everybody understands across all 50 states there are not a
16 lot of either available funds, private funds, and a lot of
17 the states are looking at either payment for the purchase,
18 paid Docs and hospitals, taxing mechanisms, so everything
19 that you did identify in the financial sustainability is
20 being reviewed really across the country. So we don't
21 think that's going to be an obstacle for the next approval
22 to release the funds.

23 Gap analysis I'm going to show you, that's
24 in those tables that are in the presentation, but the

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1 biggest thing is the meaningful use compliance. I need to
2 go through that, the environmental scan. This is the gap
3 analysis and if I am rushing too fast please slow me down,
4 but you have all these slides. And again, we're all the
5 actors here. We know what this information is. We don't
6 have all the information to really assess the availability
7 of Health Information Exchange Information Systems in
8 Connecticut. We have all the hospitals that have sort of a
9 system. Many of our provider groups and even our
10 individual physicians certainly have access to either
11 laboratory and/or pharmacy linkages, but is it on the
12 receipt and the giving of information.

13 When we talk about the clinicians, we have
14 nearly 17,000 licensed physicians. How many have had --

15 DR. GALVIN: But only 13,000 of them
16 practice.

17 MS. HOOPER: -- well that that's -- you beat
18 me to the punch. Again, if there are 13,000 practicing are
19 they in full-time practice, do they take Medicare/Medicaid
20 -- you know, what the dwindling down of what those numbers
21 really mean. We don't have that information in Connecticut
22 yet. It's all part of a process.

23 Eligible providers we're estimating who
24 would be eligible for meaningful use incentive program, I

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1 think I did -- did I skip that? No. We'll get into the
2 meaningful use. Approximately 8,000 is what we're
3 thinking. That's based on a couple of different
4 methodologies and discussions. It is not a factual number.

5 There's no algorithm that actually got to that in a
6 technical sense. REC for perhaps our new members who may
7 not be familiar, is the Regional Extension Center, which is
8 represented here by Scott Cleary. And that is -- e-Health
9 Connecticut has assigned that.

10 They're initially targeting with ONC funds,
11 \$2,500 with the expansion option with additional support
12 funding and participation in the HIE of course to reach
13 that \$8,000. I don't need to go through each of these
14 items. You know what we don't know, we don't know how many
15 of the health care providers are actually having an
16 interchange of continuing care documents or diagnosis with
17 the unaffiliated partners, the individual Docs, the
18 hospitals that have their affiliations with doctors. Well,
19 what about those Docs that are not necessarily affiliated
20 with a hospital that are only serving say a nursing home or
21 within a community health center that are essentially --
22 I'm sorry, what's the term sir, on their own? Well, we'll
23 just stick with the official term of unaffiliated entities.

24 It doesn't mean they're not legal, it

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1 doesn't mean they're not licensed, they're not affiliated
2 with a health care -- a more formal health care system. Is
3 that a correct way to put that? Reasonably correct?

4 DR. AGRESTA: Yup.

5 MS. HOOPER: For the record, Dr. Agresta is
6 nodding.

7 CHAIRPERSON MULLEN: He also said yup.

8 MS. HOOPER: He did didn't he.

9 CHAIRPERSON MULLEN: Yes.

10 MS. HOOPER: When we talk about the
11 hospitals, there is an assumption that all the hospitals
12 have some kind of an electronic health information
13 exchange. Sure -- is it within, does it expand beyond?
14 Again, trying to identify the actual numbers, submitting
15 claims and verifying eligibility, we can make assumptions
16 but we don't have hard data. Many of the states do not
17 either.

18 What ONC is requiring is not the hard data
19 but how we're going to get that information. And we're
20 relying heavily on Dr. Tikoo from the University of
21 Connecticut, who's over there as our evaluation consultant
22 really to do some surveys to get this information. But
23 quite clearly it's not available despite all the expertise
24 around the table. Now, we need and we have learned

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1 respectfully, the difference between pharmacists and
2 pharmacies. We really need to identify both. We're not
3 talking about one or the other. Again, the number of
4 licensed pharmacists, we're gathering that at the
5 Department through our Licensure Bureau.

6 Pharmacies, 660 licensed. We do rely on Mr.
7 Gadea for this information and the assistants. Now the
8 non-resident pharmacies, can I assume serve some
9 Connecticut residents? Is that a safe assumption?

10 MR. GADEA: Correct.

11 MS. HOOPER: Because we have three states on
12 our boundaries. Ninety percent enable free prescribing.
13 Is the estimate -- and again, mostly with short scripts
14 right now for the chains, is that correct?

15 MR. GADEA: If you're talking about the
16 chains you're talking about receiving the data?

17 MS. HOOPER: Correct.

18 MR. GADEA: So if you're talking with the
19 physicians, the physicians don't necessarily need to go
20 through short scripts even though many of them do.

21 MS. HOOPER: Right.

22 MR. GADEA: They could go through their own
23 servers, their own private computer systems, and transmit
24 that data. Being able to receive it is where the chains

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1 come in and the further complicating factor is that
2 currently DEA now allows the transmission of schedule twos,
3 threes, fours and fives, using certain criteria for
4 security and encryption, which we're looking at as if
5 somebody's going to have to go through and have their
6 software certified from the transmission side, which was
7 the physician has to have their software certified, the
8 pharmacy has to have to their transmission certified.

9 Then if it's good enough to transmit
10 schedule two prescriptions, we're looking at some point in
11 the future to -- if we have to go to that level of security
12 for our prescription program why not just utilize that
13 level so we don't have to duplicate anything. If it's good
14 enough for the DEA at that point then we feel it's good
15 enough for us.

16 MS. HOOPER: Correct, and that's one of the
17 items for discussion that again, over the next six to eight
18 to 10 months as the HIE is developed, supported and
19 directed by this body, there's going to be a lot of
20 additional discussions. E-prescribing transactions, again,
21 what's identifiable does show and I find 180,000 Medicaid
22 transmitting every month. That's just one indicator of the
23 volume that we're looking at.

24 Laboratories -- oh, has anybody -- we'd love

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1 to have some of the private laboratory corporations and
2 folks come to the table. We're trying to get a lot of this
3 information for the 192 physician offices, laboratory,
4 providers, coordinators and anyone independent. Sorry, I
5 don't need to go through this for the licensed
6 laboratories. Okay, they're enabled for results, are they
7 actually in practice? This is another area where we would
8 be relying on Dr. Tikoo's team to in fact gather this
9 information and give us a better idea. Public health, yes,
10 we're recognized -- we were recognized as a priority by ONC
11 last year and then some of your lobbying groups I guess got
12 there and we're third now. But that's okay.

13 What we're doing with the public health
14 registries is clear. We've talked about it here, it's in
15 our Plan. We have limited access to our health care
16 providers. Our Health Information Exchange is vertical --
17 I always get that mixed up, is vertical. We can report
18 from local to state to federal. We want to expand certain
19 area public health registries particularly as we've
20 discussed the immunization registries, we have an HIVH
21 registry, which is not -- that we didn't need to get into
22 the special information that's going to be released.
23 Certainly the registry is listed here. We need to make it
24 horizontal. We want to get that information out to the

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1 hospitals and the health care providers, so that's one of
2 our goals as determined in the planning process.

3 We are happy to amend these goals as either
4 this group evolves and has a discussion -- Dan was very
5 helpful with where we might find some information on
6 payers. Oof, it's tough. Mark, you and your team were
7 able to provide everything about the Medicaid. Great, we
8 have a lot of good information on the Medicaid. Yes, CMS
9 incentive program is about reimbursing for Medicaid
10 providers. We don't want to forget from this group
11 perspective and the Department that the field is much
12 larger. Am I moving -- should I speed up or slow down?

13 CHAIRPERSON MULLEN: You're okay. There's a
14 lot to be considered here.

15 MS. HOOPER: There is.

16 CHAIRPERSON MULLEN: So I think --

17 MS. HOOPER: I'm doing the running through -
18 - meaningful use goals, I don't need to go over those.
19 Again, it's basically -- we need to do a better job not
20 only for our clients but also for our health care
21 providers. How can we do that? That one is pretty simple.
22 What we're --

23 CHAIRPERSON MULLEN: I think it's worth
24 slowing down on that slide actually.

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1 MS. HOOPER: Oh, thanks.

2 CHAIRPERSON MULLEN: I'm --

3 MS. HOOPER: No, thank you.

4 CHAIRPERSON MULLEN: I think it is.

5 MS. HOOPER: Thank you. We are making often
6 a presumption that there is that universal buy-in but in
7 fact from the federal perspective, from the physician's
8 perspective, from the hospital's, from the pharmacist's,
9 from the laboratories, from Public Health and from State
10 administration -- let's see, who am I forgetting? Oh,
11 everybody else and our dear consumers of who is using those
12 services.

13 What is the buy-in? You know that we've
14 done the value proposition, which is included in the Plan,
15 but basically most of it is supporting what we can see are
16 the identified goals from the Feds, both CMS and ONC. And
17 I think health care reform picks up this goal and carries
18 it into some of its programs proposed for implementation.
19 Improving the quality of health care is an issue that is
20 always raised particularly with Public Health's
21 observations for adverse events reporting. That's had some
22 political or public concerns about it. With the adverse
23 events, how do we collect that data? That's a Health
24 Information Exchange issue that can be used to improve, not

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1 only in a punitive way but in that educational way that the
2 Department wants to do, educating where the quality can be
3 improved. Certainly the safety.

4 Again, we go to our pharmacists and where
5 some of that information and the amount of information for
6 patient -- currently DCP has the program prescription
7 monitoring to look for controlled substances. That's part
8 of that efficiency of care of course. For all of the
9 physicians and all health care providers, how do you do
10 that job with the limitations that are before you? We want
11 and have to engage certainly not only the patients but our
12 families within that health care system. The model homes,
13 medical homes --

14 DR. BUCKMAN: Model homes?

15 MS. HOOPER: Well, I didn't say mobile homes
16 but medical homes, that concept that is being support
17 through health care reform. I believe that all of us
18 recognize being both patients and providers in many cases
19 that the care for patients and families, we get into the
20 health literacy issues, we get into the disparity issues.
21 That's such a broad area the more that the patient is
22 engaged. There are studies, and I think there's anecdotal
23 and personal support for that, that as the families and the
24 patients are engaged there is better health care and better

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1 results from public health.

2 Disease prevention has a lot to do with risk
3 behaviors and healthy behaviors, so we see that tie-in
4 there. Promoting public and population health, obviously
5 as Dr. Mullen had referred to earlier many of us are
6 looking at individual patients or groups. Public Health is
7 looking at the entire population. How do we take care of
8 and address the health status of 3.5 million? And that
9 becomes part of the issue, public health and population
10 health, and I think I should have put perhaps clinical,
11 medical individual patient health, to recognize that our
12 perspectives may be different. But I believe our goals are
13 focused here. Improved care coordination for many of us
14 and many of you that are direct care providers in
15 specialties, obviously that's a diverse area.

16 The discussions about primary care and the
17 availability of services always brings in well, how are the
18 specialties involved? Certainly the coordination of not
19 only that care but the payment, the service delivery, the
20 follow-up to that care, and then of course promoting the
21 privacy and security, we hear lots of information. Right
22 now I don't think there's a clear assessment on what --
23 with all due respect Dan, what the insurance companies are
24 -- no, I know you don't represent them all. What we're not

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1 sure of is, right now an awful lot of our health
2 information go from each of our physician and/or medical
3 visits to an insurance company electronically -- right now.

4 Do we know how that system is working? Not necessarily.
5 Are we sure of its privacy and security? Pretty much -- I
6 mean, I haven't heard about too many things coming out.
7 But again, it's not so much anecdotal but there's not a
8 great detail of information about how privacy and security
9 is currently maintained both in paper records, billing and
10 in electronic health records.

11 Our job -- sorry, the federal government has
12 taken the responsibility to hold people accountable and
13 assure the public that their information will not be
14 released. What information? When it's Health Information
15 Exchange, that implies information is exchanged. So those
16 definitions -- again, we've begun to address that issue
17 both in the Plan and in our discussions. Nationwide,
18 there's not one agreement on a certain perspective. I
19 think that regardless, everyone here is interested in
20 protecting the privacy and security of our own health
21 information and those are the people we represent. CMS and
22 ONC, different perspectives. CMS is providing the funds
23 for meaningful use incentive payments to physicians that
24 show meaningful use compliance. CMS is directing that and

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1 funding that based on proof. Okay then there's ONC, that's
2 the Grand Poobah of Health Information Exchange. ONC wants
3 to set directives on what are the variables and the
4 measures for meaningful use.

5 We don't have assurance that ONC has CMS
6 saying okay, we don't know right now -- again, and this is
7 -- it happens in any of the funding programs, federal
8 directives. There's two agencies that are in leadership
9 positions doing a great job. Their communication, we're
10 looking for a little better to advise us where to go
11 forward. CMS says we're going to give Dr. Agresta payment
12 on his Medicaid patients if he can show that he's
13 exchanging laboratory, pharmaceutical and continuing care
14 information with his colleagues. Great. CMS -- here,
15 we'll give you an incentive payment certainly as it
16 improves over years. ONC is going to say to the Department
17 of Public Health and the HITE/CT as two different entities,
18 is Dr. Agresta doing it right?

19 Well, CMS gave him the money. Do we -- so
20 this is an issue that again, as we move forward is part of
21 the discussion. We've been -- CMS and ONC have made it
22 very clear that nothing is set in stone, it's an evolving
23 process. Oh I'm sorry, of course Dr. Agresta is doing it
24 right and the HITE/CT would recognize that as such.

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1 Release one, which is what needs to happen in 2011. We're
2 in mid-February, we need to have something up and running,
3 tested and running before the end of the year. So we need
4 something up and running let's say in October, to make sure
5 that we can prove that it's up and running. Is it one
6 system? No. Is it the availability of systems? Yes.

7 All the work that you all have contributed
8 to in the Plan, including with our partners not only here
9 but on all the Committees which includes non-Board members,
10 our work with Gartner, and this really good input from ONC
11 and their technical support, we need to provide access for
12 any willing provider. Willing provider is those that are
13 willing to participate in a Health Information Exchange for
14 the purpose of meeting meaningful use requirements. I'm
15 not clear though that that isn't for any willing provider
16 to be part of a Health Information Exchange. The qualifier
17 for the purpose of meaningful use is an assumption.
18 Alright, I'm getting too literal here.

19 Meaningful use release one that has to
20 happen now is the basic electronic health record, the
21 variables to be included, they're not really set in stone
22 yet either. But the basic information sharing -- and
23 again, Dr. Mullen, what you shared, what was on that
24 record, is it consistent with what's being shared in

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1 Connecticut. One of the issues that we want to address is,
2 again, if I'm going to a physician in Providence and I live
3 in Connecticut, who's running what the EHR is? Same with
4 New York and Massachusetts. This is a continuing evolving
5 decision, but the fact is for what we need to say not only
6 to ourselves but to ONC for our consumers and our
7 providers, we are providing what an electronic health
8 record should include at this time. We don't have the
9 direct authority to say no ProHealth, that's the bad EHR.
10 We have to provide some kind of information how we're going
11 to be pursuing that interstate exchange.

12 What's known as NHIND Direct or what has
13 been now renamed yet again nine months after it was named
14 NHIND is now the Direct Project, it is a system offered by
15 -- I'm sorry Frank, who's actually offering that system?

16 MR. PETRUS: God.

17 MS. HOOPER: Okay, other than -- below God?

18 MR. PETRUS: It's a virtual system that is
19 put out through standards through the office of the
20 National Coordinator --

21 MS. HOOPER: Thank you.

22 MR. PETRUS: -- who is putting some of the
23 plumbing together.

24 MS. HOOPER: It is a system -- thank you,

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1 I'm thinking it is ONC providing this opportunity. Is the
2 Direct Project appropriate? It's a great opportunity to
3 offer as a default. Is it what we want to pursue? That's
4 part of the discussion. E-prescribing has to be in place
5 to meet meaningful use requirements. Receipt of structured
6 laboratory results, it's not just -- okay for our H1N1 for
7 example, hospitals and physicians and laboratories reported
8 to the Department of Public Health how many folks had H1N1.

9 Okay, there's a lot of other lab testing
10 being done that isn't required to be reported to the
11 Department of Public Health. Sharing patient care
12 summaries across unaffiliated organizations, we don't have
13 to say that it's done in December 2011. We have to say how
14 it's going to be pursued and how that process will be held
15 accountable. Secure messaging is something that we can
16 accomplish essentially right away. We're all using secure
17 messaging through many of our work systems. Secure
18 messaging is what's known as push interoperability. I can
19 get a message out to you and you can receive it, it's a
20 secure message, it might go through an encryption process,
21 it might go through a secured data network or a secured e-
22 mail process. That's in place.

23 Is it in place for 16,000 physicians, 500
24 pharmacies -- 600 pharmacies, just so many -- that's

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1 alright, I will give you a hard time continually. Long-
2 term is after 2011 and as we move into meaningful use
3 requirements for 2012, 2013, 2014 when our funds end, there
4 has to be a poll query or a poll interoperability with that
5 query function where in fact we can retrieve, share
6 information, standards of care, actually getting to what
7 HIE intends to do back to those goals really making a
8 systemic change and improving not only the health status
9 but certainly the health care system. None of that is
10 going to happen certainly in 2011, but this is the process
11 that ONC is directing.

12 CMS is partially supporting with incentive
13 payments and is expected as the baseline or the base for
14 health care reform. And why we're only getting \$7 million
15 to do it, I don't know. Secured direct messaging, this is
16 some of the facts on this. Right now what ONC has defined
17 as acceptable secured direct messaging is presented here.
18 I'm not real good with the different terms but again, this
19 is from the administrator, bureaucratic and supporter
20 perspective and consumer regulator, educator. We have to
21 make sure that the information is not only transferred from
22 and to safely, accurately, and without compromise. There
23 are technologies in place that can allow that to happen, as
24 I mentioned all ready are. We need to gather, identify and

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1 clarify what we're going to allow in Connecticut, we being
2 HITE/CT.

3 I can't say we, what you as HITE/CT Board of
4 Directors quasi-public agency, what you're going to accept.

5 That's the role that we anticipate the leadership, not
6 only for HITE/CT but with the Governor's office with an HIT
7 coordinator, whether it's continuing Mr. Wollschlager or
8 someone out of your office or wherever it's from, somebody
9 has to say okay. Are there any questions or shall I
10 continue? And I know you all read the Plan so this is like
11 a quick little summary alright? In December over Christmas
12 vacation, remember the big snow storm, that two footer? I
13 bet many of you were reading the Plan.

14 The Technology Committee, and thank you Mr.
15 Courtway for being here and for doing the work that you did
16 with the Technology Committee, also with Marianne Horn and
17 Lisa Boyle's Legal and Policy Committee, reviewed what this
18 requirement is for meaningful use and how are we really
19 going to make something happen in six months without any
20 ONC money until the plan is approved, okay. There is an
21 option and we're presenting it to you, not only today but
22 for the time that Dr. Mullen is Chairing and Governor Wyman
23 administratively determines, and the Board. We're
24 encouraging some decisions today or support but we

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1 certainly want to present to you where we are in the
2 process now.

3 Current Health Information Exchange systems
4 that can be adapted or upgraded to meet meaningful use for
5 their clients -- ProHealth, I'm sorry to put you on the
6 spot John, ProHealth has meaningful use compliance pretty
7 much all set right?

8 MR. LYNCH: Nope.

9 MS. HOOPER: Okay.

10 CHAIRPERSON MULLEN: Say more please.

11 MR. LYNCH: Alright, first of all we're on
12 Allscripts. Allscripts has not put out its meaningful use
13 version yet, it really won't be released until sometime
14 later this month. It won't be implemented till June so we
15 can't meet meaningful use without a meaningful use
16 certified EHR, to begin with. Beyond that we are on EHR
17 and we are meeting the other types of criteria. We are
18 doing e-prescribing, we are doing our lab results, etc. And
19 we intend to not meet meaningful use but to meet medical
20 home criteria as well.

21 So we will be there but technically,
22 officially, we won't be there until we have a meaningful
23 use software.

24 MS. HOOPER: Correct, and I think we see

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1 that -- may I ask around a little bit? Dr. Thornquist and
2 Dr. Buckman, individual practitioners, what do you think
3 about all this? Are you going to be pursuing to be
4 meaningful use compliant in the next 10 months? Is that
5 critical to your operations?

6 DR. BUCKMAN: It's certainly the plan of my
7 practice. We use a different software, SOAPware, and now a
8 meaningful use rendition should be out in the next couple
9 of weeks and I won't have to wait till June. I'll be on it
10 as soon as it comes out. The only thing I'll need is an
11 HIE to hook into so I can share data.

12 MS. HOOPER: Correct. Dr. Thornquist?

13 DR. THORNQUIST: Well, representing the
14 physicians who do not run on an EMR, there is some
15 resistance out there because of the cost, because of the
16 speed at which this needs to be adapted and adopted. And
17 because of the disruption in a practice, when you adopt an
18 EMR you lose efficiency, you slow down productivity, you
19 create a lot of expense for the practice, there's a lot of
20 training, there's time out. And basically one of the
21 reasons I don't yet have an EMR is because I can buy a heck
22 of a lot of manila folders for \$20,000, and that's where my
23 patient data lays right now.

24 And especially as a specialist, the value to

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1 my practice for that money is low. I can get the labs
2 other ways. You know, the problem becomes as you systemify
3 if you will, health care, when you go through medical home
4 concept, when you start to unify this and do try to
5 coordinate care better you need to bring a specialist and
6 the small practitioners along because if there are holes in
7 the system, there are going to be big holes in the system.

8 Now, several hospitals are starting to work
9 to offer subsidized EMRs to doctors affiliated with the
10 hospitals. There may -- as accountable care organizations
11 spring up you may get some of these unaffiliated people
12 coming in through those. And as long as those are
13 providing a more standardized EMR that may work for someone
14 like me and many of my colleagues. There are strings
15 attached to those though and many of my colleagues are a
16 little bit concerned about those strings and what they will
17 mean in the future, particularly when the funding runs out.

18 And there are concerns about interoperability of those
19 systems.

20 Having been to several of these
21 presentations because of the various affiliations I have,
22 the -- it is unclear whether all of those systems are
23 planning to fully exercise interoperability or planning on
24 being a small net that's self-contained as a market

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1 advantage strategy.

2 MS. HOOPER: Do you think that one of the
3 things that ONC is stressing is the -- we have to make this
4 system available to physicians forcing physicians and/or
5 any health care provider into the system is not something
6 that -- I think the federal government recognized that
7 can't be done. But again, the value proposition is there -
8 -

9 DR. THORNQUIST: Well, the value proposition
10 is key and that's the real stumbling block you will find in
11 getting smaller practitioners who do not yet have an EMR to
12 sign up and become part of it.

13 MS. HOOPER: Exactly.

14 DR. THORNQUIST: But I would submit you need
15 to surmount that because again, most -- 85 percent of the
16 practices in the State of Connecticut are five or fewer
17 physicians and many of them do not yet -- like Dr. Buckman
18 does have, many of us do not have EMRs.

19 MS. HOOPER: Right.

20 DR. THORNQUIST: And it's a big hurdle,
21 okay. It's kind of thermodynamics, you've got to get us
22 over the reaction threshold to get us in there.

23 MS. HOOPER: Right.

24 DR. THORNQUIST: Once we're there we'll be

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1 fine, but something's got to get us over that hump. and it
2 can't just be a stick it has to be some carrots.

3 MS. HOOPER: Correct, and the support of --
4 again, that's why we're very grateful with you and Dr.
5 Buckman and the others that are here on this Board. That
6 has to be addressed because our goal, again, is for the
7 public's health and those patient's health. Like you're
8 saying, those gaps are gaps.

9 I just want to ask Mark for the Community
10 Health Centers, this is all part of what you're trying to
11 do also. Do you have a comment on this part?

12 MR. MASSELLI: Well, our situation is a
13 little different. We have a version that is certified for
14 meaningful use and yet they're in the midst of upgrading
15 and that version hasn't been certified. So they have to go
16 through ONC so it's kind of a strange pickle that we're in.
17 But the larger issues, there's \$100,000 million plus
18 available for Connecticut.

19 MS. HOOPER: Right.

20 MR. MASSELLI: And when we talked to DSS,
21 and we have a couple of hundred providers in our operation
22 who would qualify, it's a lot of money, money investments
23 that we've made. So -- you know, the work that we do here
24 is very important because we can't draw down the resources

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1 unless this is done. Connecticut finds itself again
2 behind, but unfortunately they're not working in terms of
3 freeing up some capital for people to do it. And we also
4 know -- we have friends who have smaller practices who
5 aren't there yet and we want to be part of the community
6 which has all of our strategic partners on platforms that
7 work and communicate, so.

8 But I think our -- for Health Centers the
9 big issue is, it's available capital for some of them.
10 When can we draw down?

11 MS. HOOPER: Right.

12 MR. MASSELLI: And the larger issue for the
13 State is that's a lot of money sitting in Washington that's
14 going to other states, and we have to figure out how to do
15 -- I'm anxious about the dates that you used, when some of
16 us are ready to draw down. And we're looking at -- we
17 might be ready at the end of the year. Things go bump in
18 the night in Washington and if we lose some of that money
19 because there are political decisions that get made
20 Connecticut loses a big opportunity, so.

21 MS. HOOPER: You've been very successful
22 Mark with obtaining and garnering those funds for Community
23 Health Centers in Connecticut, the others can be -- and
24 into it. I want to just -- for the sake of this just want

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1 to make sure to acknowledge --

2 CHAIRPERSON MULLEN: Are you okay?

3 DR. MASSELLI: All set.

4 CHAIRPERSON MULLEN: Okay, she moves fast.

5 MS. HOOPER: -- to acknowledge Dr. Agresta
6 and Peter from the hospitals just to kind of -- on this
7 meaningful use, where are you with it as a practitioner?

8 DR. AGRESTA: Well as a practitioner, I
9 think we're in a place where -- you know, medical health is
10 and Ron is. We have an EMR that's up and running. We have
11 -- it's not yet a certified version. A certified version
12 is going to get released next week, two weeks from now,
13 something along those lines. We fully anticipate having
14 our practice -- you know, have it be ready to receive
15 meaningful use dollars. Primarily the Medicaid use dollars
16 because of the practice that we're in.

17 But not all of the practitioners will
18 actually qualify and we'll have to roll it out to another
19 practice site. So we're prepped and ready to do that but -
20 - you know, I mean I also have the education hat on for the
21 Regional Extension Center, you know. And working with the
22 Regional Extension Center and realize that there is an
23 enormous difference between what I'm beginning to
24 understand will be required in terms of workflows, in terms

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1 of other sort of reporting requirements in order to meet
2 the meaningful use and just having a certified EMR.
3 There's a lot of work between the adopting an EMR and
4 actually getting the use and it's really important that we
5 collaborate across the different organizations to do that.

6 MS. HOOPER: And I do think with the CMS --
7 you know their list of 87 meaningful use variables, with
8 our health care providers, with the REC, with our DSS
9 partners and certainly with DOIT and our other technology
10 advisors.

11 Peter, the hospitals are going to take care
12 of everything because you all have the money is that right?

13 And John Brady is here to attest to that too, is that
14 correct Peter?

15 MR. COURTWAY: Well done -- no, I think it's
16 safe to say that the landscape is really all over the
17 place. You know, whatever type of provider it is. And
18 some stuff is still not known. What's thought to be known
19 is somewhat misunderstood, you know, and so there's a
20 tremendous amount of work to do. I think one of the things
21 that we've learned is that developing an HIE is not for the
22 faint of heart.

23 We've had one set up since 2006, anxiously
24 awaiting to do one at the state level so I can decide to

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1 collapse the one that we do have. So there's a tremendous
2 amount of work to be done but I think the general state of
3 the hospitals in preparation for meaningful use is, it's
4 pretty much across the board, same with physician
5 practices. We have some hospitals that believe that they
6 will make meaningful use this year. They want to get the
7 90 days in before September 30th. Others think it's a
8 horse race but are deeming not to apply because they don't
9 want to lose the interim funding if they don't have a
10 continuous work from stage one, stage two and stage three.
11 So there's a lot of work to do there.

12 There's actually a meeting at the
13 Connecticut Hospital Association this Friday to review some
14 of this material and see who is actually where in being
15 able to take transactions with a statewide HIE or other
16 HIEs in the state.

17 CHAIRPERSON MULLEN: I'm a doctor, will you
18 call on me?

19 MS. HOOPER: I will. Dr. Mullen, what has
20 been your experience in meaningful use? What would you
21 like to see?

22 CHAIRPERSON MULLEN: I'm going to answer a
23 different question.

24 LIEUTENANT GOVERNOR WYMAN: She's allowed.

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1 MS. HOOPER: She certainly is.

2 CHAIRPERSON MULLEN: What I wanted to
3 reflect is how many different issues where represented in
4 the responses that you got --

5 MS. HOOPER: Yes.

6 CHAIRPERSON MULLEN: -- because so much of
7 that reflects the challenge across the country. So after
8 awhile -- you know, I just decided to think of a different
9 state when some of you were talking because these are
10 national challenges that haven't quite -- if they had been
11 figured out somebody would tell us what to do.

12 MS. HOOPER: And we wouldn't --

13 CHAIRPERSON MULLEN: And do it like
14 Minnesota. But they haven't been figured out so -- you
15 know, on one level we're going between talking about
16 meaningful use and then just talking about the basic
17 decision to adopt an electronic health record in one's
18 practice. And thank you very much for not saying the
19 decision depends on the age of the practitioner because
20 I've heard that in other meetings.

21 Well you know, the mid-career and older
22 doctors don't want to do it. Oh, now you want to add that
23 too?

24 DR. THORNQUIST: Well no, that is a factor

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1 because if you only have practice -- seriously, if you only
2 have five years of practice left why would you spend the
3 money, lose the productivity? You're going to retire by
4 the time this finally starts to pay off, so it's true at
5 the end of practice but -- you know, it's kind of like one
6 of the last six months of life when most of the money in
7 health care is spent. It's hard to pick that out at the
8 beginning of those six months, you know.

9 A lot of us may not know or may not be
10 planning on retiring in five years or a lot of us may be
11 planning on retiring much later too. I wouldn't make it a
12 solely age-based things because I'm in that mid-practice
13 thing. I would like to take one on but again, it's just
14 not practical economically for me right now.

15 CHAIRPERSON MULLEN: Alright, so --

16 DR. GALVIN: Dr. Mullen excuse me, I'm going
17 to make one comment and then I have to move on to another
18 venue. I've heard the five year thing a lot. If you don't
19 put -- let me lay it right out straight for you. If you
20 don't do something with the electronic medical records, at
21 the end of five years your practice will be worthless and
22 no one will buy it. And if you go to a younger person and
23 say Tommy, I want you to come in and take my practice over
24 and he comes in and he looks at the office and there's

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1 these big cartons full of manila files you know what he's
2 going to say? I'm not going to buy into your practice.

3 You won't be able to get an associate and
4 your practice will be worthless. So that's what I tell
5 people, and they get mad at me and they what do you mean it
6 will be worthless. Who's going to buy it? Nobody. Who's
7 going to come in and do sweat equity and take it over?
8 Nobody. So the five year thing, fallacious.

9 CHAIRPERSON MULLEN: Are you getting ready
10 to stand up? Was that your last word?

11 DR. GALVIN: That's my last words.

12 CHAIRPERSON MULLEN: Well, thank you for
13 your service to the State of Connecticut. Thank you for
14 being here with me today. Dr. Galvin graciously,
15 graciously, agreed to accompany us to this meeting today.
16 He did not have to do that. Thank you for -- I just want
17 to tell people that in this past month and a half with my
18 transitioning in he and I agreed early on that we were
19 going to do a really good position handoff, which gets to
20 one of my other points before I finish.

21 So I just want you to know that he pledged
22 that and I feel that we have done that. And I still owe
23 you lunch.

24 DR. GALVIN: You're on. I'm sorry to leave

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1 with a sour note (clapping) --

2 CHAIRPERSON MULLEN: I'll help you out
3 tomorrow. So we're having that -- you know, we're talking
4 municipal use but we're still talking about the basic
5 adoption of electronic health records, and I don't know the
6 most recent statistic but I thought across the country only
7 15 percent or so of practices are -- have adopted EHRs?

8 MS. HOOPER: Depends on the definition
9 because of the differences in EHRs.

10 CHAIRPERSON MULLEN: Okay, alright. Okay,
11 so we're having that conversation. And then we're talking
12 about how all this applies to practice models which have
13 still -- you know, are waiting to be born.

14 MS. HOOPER: Yes.

15 CHAIRPERSON MULLEN: So -- you know,
16 somebody asked me yesterday so when are ACOs beginning?
17 You know, who's medical home looks just like somebody
18 else's model home, right?

19 MS. HOOPER: Yes.

20 CHAIRPERSON MULLEN: Okay, so there's that
21 and how that plays into it as well. And then when we start
22 talking about what hospitals have done then I go well, how
23 is that working in transitions of care to extended care
24 facilities and nursing homes and do they really have the

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1 information as well as all the provider groups? So we have
2 all of that to tackle at the same time that we think about
3 not wanting to lose the dollars and going forward.

4 But as I said when you all briefed me on
5 this yesterday was, we still haven't been able to fully
6 define the work because there's so many elements of work
7 that have to be done.

8 MS. HOOPER: There are, and that's why one
9 of the things that -- the requirements for the funding and
10 the requirements for what we want to do as a collective and
11 simply common sense agreement to it, are going to be
12 daunting. I think what we've tried to do with, again, the
13 assistance of all here, Gartner and everybody that's
14 participating on the Committees, is in fact to break apart
15 some of those issues, the Legal Policy, the Technology, the
16 Business and Technical, how do we operate this. We spent a
17 lot of time certainly on just the governance. How do we
18 establish this to be the discussion group to move it
19 forward?

20 I'm not fond of the term baby steps, but the
21 small steps that have had to take place -- we're in a
22 position now, and I think this is where the push from the
23 Feds is to make this happen so that we can provide
24 physicians the carrot -- so that we can support the

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1 physicians getting the carrot. It has lost some of its
2 emphasis on the care for the individual. The transition to
3 nursing homes was one of the issues that the challenge
4 grant was going to address. John Lynch and Lev Johnson
5 from Middlesex Hospital put together a really good proposal
6 about -- hey, from emergency rooms, from physician offices
7 and from hospitals, transferring folks to their skilled
8 nursing facilities, here's that?

9 We didn't get funded because they really
10 didn't give us a good enough reason.

11 MR. MASSELLI: So DSS is out with their
12 health home application which is all about transition,
13 needs of care, and we'll see where that goes. So there are
14 a lot of people trying to look at this from a lot of
15 different angles within the state, so.

16 MS. HOOPER: Correct, and I think that's
17 where -- and to address some of your concerns there, we've
18 tried to do as many assessments, identifications -- let's
19 just call it an inventory, not even assessments but really
20 an inventory of what's what and what's where in trying to
21 put this together.

22 I believe that the ONC, and we've heard it
23 from many of the other agencies including CMS, ONC
24 Partners, CDC, we've heard it from also -- holy smokes, we

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1 have to make this happen, we have to fix this problem.
2 Kind of like what you have to do for example tomorrow, wow.

3 LIEUTENANT GOVERNOR WYMAN: Thank you very
4 much.

5 MS. HOOPER: Oh, I just thought I'd let you
6 know. We have -- I believe that the, I wouldn't say -- and
7 the administration are basically are saying we really have
8 to fix this. Okay, it does take 87 different steps.

9 MR. MASSELLI: Meg, what are our next steps
10 though because I know -- we could be in a couple of
11 conference calls, we've got some --

12 MS. HOOPER: Correct, thank you very much.

13 MR. MASSELLI: Okay.

14 MS. HOOPER: What we've decided with the
15 Technology Committee, the Legal and Policy -- and I put it
16 in the e-mail, we have a number of partners. What are we
17 going to do to get those carrots available to in fact meet
18 some of the meaningful use requirements that we can.
19 What's our, not minimum but what can we do? What can we
20 actually accomplish? We can get an HIE default system in
21 place. A health HISP is health information systems
22 provider --

23 DR. CARMODY: Service provider.

24 MS. HOOPER: -- service provider. So a

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1 health information service provider can in fact be an
2 opportunity to link an existing EHR system with another.
3 Can it make sure that Greenwich Hospital is talking to St.
4 Francis and an OB/GYN? Not yet, but we know that can't be
5 a realistic goal for 2011, '12 or even '13.

6 So to start, what it's bringing to the Board
7 today is the recommendation to do an RFP with an ambitious
8 timeline essentially issued by DOIT, and CIO Bailey is here
9 indicating his support -- well, I think that's why he's
10 here. But he has indicated his support and we are very
11 grateful that DOIT would issue an RFP. Let's get the six
12 or seven, we don't anticipate that many more, vendors that
13 can provide the full service HISP to any willing provider
14 in the State of Connecticut. Have that system be the
15 certification system also. Beyond ONC we have to have a
16 State certification -- Dan.

17 DR. CARMODY: So ONC is going to pay for the
18 implementation of it?

19 MS. HOOPER: Thank you very much, we'll go
20 back to our Finance Committee. It's recommended that this
21 RFP and the funding of this vendor to provide the HISP will
22 be allowable for the funds to be released. If we go with
23 our original idea, one of the concepts -- no, but ONC
24 wasn't happy that if we have \$4 million we're just going to

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1 get some really cool staff and maybe a really cool office
2 and support the HITE/CT Board to facilitate the hybrid
3 model of all the HIEs coming together.

4 ONC is really saying, if we're going to
5 invest the \$6.7 million that we owe you, you better have an
6 operational HISP. Yes Tom?

7 DR. AGRESTA: I think it's fair to say that
8 when we had the meeting in mid-December --

9 MS. HOOPER: Yes.

10 DR. AGRESTA: -- and we got -- and when we
11 were down in Washington at the all grantee sort of meetings
12 for ONC, there was a growing awareness across the U.S. and
13 there was a growing direction from ONC that they basically
14 said we want to stand up rapidly functional HIEs to meet
15 meaningful use. And that's what we're going to permit our
16 dollars to primarily be spent on. We're going to support
17 what states want to do for larger goals, but we want to be
18 sure that an HIE at each state level permits meaningful use
19 at each state of implementation to occur for any willing
20 provider who is also kind of doing their due diligence to
21 move forward.

22 And so what they've come to discover is
23 required -- and I would say it's come to discover because I
24 think they were groping to try to figure out what an HIE

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1 would look like. They've come through looking at a number
2 of the plans to figure out that they need to have this
3 direct type exchange. And this is what they're willing to
4 kind of allow their dollars to primarily be spent on from
5 their perspective. Now how the rest of the funding goes,
6 etc., they were very open to states going much further and
7 they're very willing to kind of support that, but that
8 seemed to be like more how they would be encouraging
9 additional funding to kind of support that. That's at
10 least what I took away from what they said.

11 DR. CARMODY: So isn't it the intent of the
12 RFP to get the quote not only on the system but all the
13 ongoing costs associated with it so we can understand what
14 it means in relationship to the \$7 million that we have?

15 MS. HOOPER: I think that as the RFP is
16 developed -- and again, the draft that was submitted to you
17 is clearly a draft. The Technology Committee, I think
18 those discussions -- because there is that maintenance
19 issue, the upgrade issue as all this comes forward, I think
20 that we were going to look at -- and Peter, please correct
21 me -- actually Peter, I don't need to answer for you, I'm
22 sorry.

23 MR. COURTWAY: But you're doing so well Meg,
24 I'll sit back. I think in regards -- what we did here from

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1 the feedback from the ONC in regards to the concern about
2 how long this would take in getting something out, the main
3 concern being what's the path of least resistance to get --
4 somebody said they could use some exchange of transactions
5 and qualify themselves -- it was less about what the state
6 was doing and more about getting providers in the state to
7 meaningful use.

8 We took that advice, we went back and
9 charged us, the Technical Committee, which has been working
10 hard both in the Committee sections and all five -- and we
11 are coming back to the Board today to say beyond what ONC
12 wants it is perhaps a very narrow and dead ended direction
13 to take to limit the information request in the RFP to just
14 -- you know, putting up a direct project. That it is
15 likely that there may be no single player that can
16 ultimately do what we want to do, so in the selection of
17 our initial player we want to make sure that we understand
18 how they work with the other players.

19 So what we are looking at is issuing an RFP
20 for the full breadth of what the vision of this HIE looks
21 like from the combined players for the original high tech
22 work that was done, some refinements from folks that are in
23 it or who have an HIE outline -- you know, a large player
24 putting it on from a hospital perspective so we can put up

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1 a full-blown RFP for everything with a very short
2 timetable. But very specific deliverables in regard to
3 what we need to have up in the August timeframe, because if
4 we're talking about hospitals achieving meaningful use,
5 somewhere in that last 90 days of the fiscal year for the
6 hospitals, they've got to do some exchange and
7 transactions.

8 For the physicians, it's the last 90 days of
9 the calendar year that they have to drive a transaction
10 through. So we have some very specific short-term goals
11 and it really covers the gamut. They have players out
12 there like Verizon offering credentialing, you know, and
13 digital identities nationwide. Well, how does it really
14 fit into an -- I don't know, but the thought is it would be
15 very helpful for the players who are in this HIE space to
16 today say what are you doing? Are you providing a
17 certificate of authority in and of yourself? Are you
18 partnering with somebody? How much does it cost? How much
19 does it cost to maintain? So we see not only the first
20 part of it but we saw the long tail that's going to come
21 with it so the Board can make the most informed decision
22 about which one to go with.

23 Toward that end, the Technical Committee is
24 driving the completion of the RFP itself so that that can

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1 get out by the end of March, but the Technical Committee
2 can recommend an order of the -- we would recommend for the
3 finalists. But ultimately the finalists have to be
4 reviewed by each of the Committee Chairs between Finance,
5 Business and Technical Operations and so on, so that we're
6 sure that we have a real well informed recommendation
7 finally to the full Board on how to set it up and then to
8 move forward with the funding. I think that there's also a
9 lot of work to do in terms of the use cases, you know,
10 because there was -- some of these cases were worked on
11 when it was still the Advisory Board.

12 But to your point, the connection of the
13 ECFs and the SNIFS -- you know, or the other folks that
14 maybe have nothing to do with anything, if we're just going
15 to be reporting the continuity of real care -- you know,
16 they are very important. So I think the use case
17 development for the providers outside of meaningful use,
18 the use case for population health and management, the use
19 case for improved -- you know, quality improvement in the
20 state really still needs some development. And I don't
21 think that we need to hold up the RFP and the selection
22 because the technology is somewhat independent because in
23 the technology RFP we are seeking -- even though it's not
24 pointed out anywhere, the data mining aspects of it and all

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1 the other things for performance improvement.

2 So there's still a lot of work to do but at
3 the Committee today what we are seeking is ultimately the
4 Board vote the expansion of an RFP beyond the direct
5 project. Secondly, the approval to do a pre-
6 notification to the HIE vendor community with the general
7 guide of what it is that we'll be putting an RFP out for
8 and what the timing of that might be so that they can
9 prepare their parts of the organizations if they wish to
10 respond to that.

11 MS. HOOPER: And that is something that we
12 have -- again, many of the Committee members, we're
13 bringing it to you as a full Board. And ONC has been
14 involved in those discussions and have supported that this
15 would be something that ONC could support the release of
16 funds to pursue. Again Dr. Agresta, you said it perfectly.
17 They're evolving -- ONC is coming to realize okay, this
18 game plan can't work within the timeframe. Warren?

19 MR. WOLLSCHLAGER: Just a question Meg. Do
20 you think it might be helpful, to go to Mr. Masselli's
21 question, to have the next filing that actually hits the
22 dates --

23 MS. HOOPER: Yes, what I wanted to say --

24 MR. WOLLSCHLAGER: -- to make it sensible to

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1 --

2 MS. HOOPER: -- the proposal that Peter just
3 eloquently stated, the requirements that are going to be in
4 the RFP as you've just stated, and then to Mark's --

5 DR. CARMODY: Can we just go back to the one
6 -- just so we can walk through it --

7 MS. HOOPER: -- anyway, the RFP requirements
8 that are being proposed again at this time. I believe
9 Peter you'd be looking for much more input in the actual
10 drafting as we go formal with the RFP, actually having it
11 put together. Certainly secure messaging has to be the
12 initial and the formal -- exchanging with the others, does
13 this entity offer that information.

14 Issuing certificates, again, whether these
15 are going to be weighted as top priorities for the
16 selection or not will be up to the Selection Committee. So
17 this is a draft of essentially what the minimum set of RFP
18 requirements are. More can be drafted. Peter, I'm sorry
19 is that correct --

20 DR. AGRESTA: Your RFP is actually quite
21 deeper than this.

22 MR. COURTWAY: It was way --

23 DR. AGRESTA: Far deeper than this.

24 MS. HOOPER: Oh --

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1 DR. AGRESTA: This is just listing the
2 things that we need to have in place in order to do sort of
3 what ONC is requiring.

4 MS. HOOPER: At a minimum but again, in the
5 draft RFP that was electronically sent to you and is in
6 your package, it goes much deeper. I just wanted to do
7 that highlight.

8 DR. CARMODY: Can we -- at some point I'd
9 like to be able to understand the reconciliation of the
10 operating model to the capabilities --

11 MS. HOOPER: Okay.

12 DR. CARMODY: -- to understanding what and
13 who's going to support the entire effort because then you
14 get into the issue of okay, so you can issue the technology
15 and say I need you to provide this functionality --

16 MS. HOOPER: Exactly.

17 DR. CARMODY: -- is DOIT going to provide
18 all of the other resources around keeping it up and
19 running? How does that interrelate? I mean, it's those
20 pieces and parts that I don't understand.

21 MS. HOOPER: Exactly.

22 CHAIRPERSON MULLEN: Good question. So let
23 me just say this is a really good question. Not that the
24 other ones weren't but -- I mean, just to clarify the

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1 process here. I mean, it's a key question because we don't
2 have the answer and until we talk to the Governor we can't
3 give that answer. And you already talked about what
4 tomorrow brings, so --

5 MS. HOOPER: I'm thinking maybe you might
6 want to wait until Thursday.

7 CHAIRPERSON MULLEN: -- so, but it's
8 important for -- but all of your points are necessary to
9 get the clouding out because I would like this body to at
10 least be able to move forward a recommendation that we can
11 take to the Governor. And you're enumerating the other
12 detail that needs to be there to even be able to bring
13 forward some kind of a vote that we -- and say this body
14 voted and we can carry the recommendation of the body
15 forward to the Governor and as we consider things such as
16 what's DOIT going to do here.

17 MS. HOOPER: Right, and what can DOIT do.

18 CHAIRPERSON MULLEN: Am I making sense?

19 DR. CARMODY: No, that makes sense. The one
20 thing that I would add to that is just the -- and sort of
21 resonated in some of the comments that came out was again,
22 how this is tied to payment -- I mean, because at the end
23 of the day there's the economic model around if it doesn't
24 make sense it has to tie into his business model as to

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1 what's going to get him there because this is only an
2 enabler.

3 So even when we went back and looked at the
4 meaningful use requirements and everybody agrees it's
5 around quality and improvement and all those pieces, if we
6 don't bring it in -- the piece in because again, it's not
7 about the technology. The business model doesn't work on
8 the technology, it really doesn't.

9 MS. HOOPER: Right.

10 DR. CARMODY: It only works on the
11 economics, and you have to look at those economics.

12 MR. MASSELLI: Dr. Mullen, were you saying
13 that we should wait to vote on this RFP until we check
14 back, or was that --

15 CHAIRPERSON MULLEN: No, I --

16 MR. MASSELLI: -- the larger --

17 CHAIRPERSON MULLEN: -- I wanted people to
18 understand that the vote wasn't going to then have a spring
19 to action, but that we would at least be able to go forward
20 and reflect the recommendation from the vote to the
21 Governor.

22 MR. MASSELLI: But the vote -- let me just
23 say, the vote is just to go out for to prepare an RFP not
24 necessarily to do more than that right? It's to go out and

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1 solicit the bids and we just want to do a timeout and check
2 in with the Governor's office?

3 CHAIRPERSON MULLEN: And an RFP is asking
4 people to do something so we also want to be clear that
5 what we're asking people to do allows for understanding
6 what the Department of Information Technology will be doing
7 because the RFP is to move this piece forward.

8 MR. MASSELLI: Yes.

9 CHAIRPERSON MULLEN: And there are State of
10 Connecticut question marks there that we need to be able to
11 answer.

12 MR. MASSELLI: And the only thing I would
13 comment going back to the other point about this larger
14 issue about Connecticut's innovation and preparedness, the
15 rest of the country, even though they're struggling, people
16 are moving forward. And we want to also, in addition to
17 identifying to the Governor's office here, are the costs --
18 hidden costs to do it. And the challenges that are there,
19 our sort of readiness for anything that's going on in the
20 country in the health care environment without having this
21 platform out there, is going to put us way behind.

22 DR. AGRESTA: Well let me ask a sort of
23 philosophical question too in terms of how this body
24 functions, because this is a quasi-public agency. And I

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1 think that this body probably, as a quasi-public, makes
2 recommendations about how this process works but then
3 collaborates with the government. So sort of like how --
4 we're going to have to sort that out because we're in a
5 brand new phase of being --

6 CHAIRPERSON MULLEN: That's right.

7 DR. AGRESTA: -- but at times quasi-publics
8 might be in conflict too. So I think we might make
9 recommendations that try to move us faster or in a
10 different path. And we're going to have to, I think, start
11 to --

12 MS. HOOPER: I think that -- if I may
13 interrupt, I think that that's one of the issues that we've
14 all been struggling with. Right now the Department of
15 Public Health is supporting the Board gratefully, happily.
16 We've got the cooperative agreement, we're moving the plan
17 forward. Department of Information Technology, as one of
18 our key partners, has discussed their willingness to be the
19 issuance of an RFP. But the Department of Information of
20 Technology cannot be this HISP, doesn't provide a platform
21 for all health care systems, certainly for the State
22 agencies.

23 So if they're in the long -- we're hoping
24 that again, if and when funds are released -- no, when

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1 funds are released, not if, that the staff that you need,
2 the HITE will be in fact an agency not supported or
3 convened or -- that we need to do some of the
4 administrative functions. This Board has authority by
5 legislation, but the Board is Chaired by the Commissioner
6 of the Department of Public Health, has to of course have
7 the State's support. But the Board does have authority and
8 one of the best things, there is obviously the
9 collaborative spirit. But right now we're asking both DPH
10 and DOIT to not work on your behalf but to provide great
11 support and work.

12 So we're happy, very happy, that Dr. Mullen
13 and Governor Wyman are here to assist with that either
14 support, direction or however.

15 LIEUTENANT GOVERNOR WYMAN: Can I say to
16 that also, I think it's the timing of everything and the
17 fact that you have a timing problem. And we, being the new
18 administration coming in, trying to learn about everything
19 else that's going on has a timing problem. And I must
20 admit for the last six weeks our timing had to do with
21 what's giving me agida for tomorrow. And I think it's
22 really -- it's not that this administration wants to stop
23 anything that's going on or anything else.

24 I think we need some time to get

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1 knowledgeable about it and we will do that as quickly --
2 and I think what the Commissioner is suggesting is that if
3 you vote for this RFP it will give us something to go back
4 to the Governor with so that we have something to explain
5 to the Governor what this is. Because as we look at what
6 the budgets are going to be looked at as they go forward,
7 there might not be a whole lot of extra money for DOIT to
8 be able to do what you might need unless we make sure that
9 we have --

10 MR. MASSELLI: Well can we take some time to
11 go into layout, the other elements that the Governor's
12 office should know past the transactional elements of this
13 deal, which are important to talk about the
14 transformational ones because I think the -- those are very
15 important strategically for the health care community of
16 Connecticut to start advancing itself into this area albeit
17 with lots of concerns on lots of provider's plates about
18 this.

19 But there's not only the large amount of
20 money that is available for Connecticut providers right
21 now. And they go, as Tom mentioned earlier, to some of the
22 safety net providers first, the Medicaid dollars, so that's
23 important to make sure that they're out there. But really
24 this whole issue around patients that are in medical homes,

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1 sort of a readiness for all of the larger transformations
2 that are coming in the state. So I think it's a fair
3 request, but we should also go in there and make sure that
4 the ledger lays out the big broad strategic issues as well
5 as the nittey gritty ones, which will drive everybody crazy
6 if they're not on the agenda for the Governor to understand
7 because they have cost implications.

8 Not just on this side but Dan, when you ran
9 the numbers on our other model we really looked at the tax
10 user fees or whatever awards, shares from the Governor's
11 office to fund this. So trying to get a little picture of
12 how big this commitment is, is an important one because
13 we're going to need the Governor's office. We know ONC has
14 narrowed our focus to say use this money wisely and just do
15 this, get this going right away and we think you can do it
16 within this framework. But the larger thing that Peter
17 laid out, the operational costs and other things, we should
18 somehow put a précis together from the Committee about
19 these issues so that you can see them from the thinking of
20 the Committee, not make it too long but just right to the
21 point of what we're trying to accomplish.

22 MS. HOOPER: Right, and I do think the
23 maintenance issues of this vendor and the other -- just
24 again, I want to respect the time, the agenda and however

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1 the Commissioner and Governor Wyman want to move forward --

2 CHAIRPERSON MULLEN: Are you all okay with
3 the conversation? I think we needed to have you go first
4 to be able to get to this point.

5 MS. HOOPER: Oh, absolutely.

6 CHAIRPERSON MULLEN: So I'm just looking at
7 the group and nobody is even looking at their Blackberry,
8 so.

9 MR. LYNCH: Do we need a motion on the floor
10 to kind of approve the RFP process to go to the next stage
11 or can that just take place without any --

12 MS. HOOPER: We do have -- what we've --
13 again, for your consideration we have a full supplement
14 that we're going to submit to ONC. It's going to include --
15 - here's the RFP for how we're going to move forward, it's
16 going to include more about the environmental scan and how,
17 with Dr. Tikoo's help, we're going to fill in those blanks.

18 They need a revised executive summary, so we're going to
19 put pieces of paper together and we need to get -- I'm
20 sorry, we're recommending that we get this piece of
21 information together, notify ONC first of all informally
22 and then formally at the Governor's discretion and the
23 Governor's Commissioner's discretion -- Governor's
24 direction or vice versa that ONC, here you go.

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1 We've heard that they would be happy to then
2 release funds. That's what we've heard, there's nothing in
3 writing. That provides the Department of Public Health
4 with, through the cooperative agreement, an opportunity to
5 then contract with HITE/CT Board of Directors, the
6 Treasurer Dr. Agresta, if you trust him with the money --
7 you know, there might be an opportunity to get those monies
8 out to in fact support part of this process, as Peter
9 mentioned, a pre-solicitation announcement to see what kind
10 of vendors that might be responding to it in two weeks. In
11 a month issue the RFP, this is where the development of the
12 RFP and making sure that the pieces that we really want to
13 assess and have available to the HITE/CT are there,
14 certainly within that time an evaluation team, and so on
15 and so forth.

16 That's crazy but God Bless you Mr. Bailey
17 for one, issue the RFP and then seven days later have a
18 bidder's conference. Ellen, you had a question?

19 MS. ANDREWS: Yeah, so the -- this is not
20 set in stone because I don't want anything to slow us down
21 --

22 MS. HOOPER: Oh, no --

23 MS. ANDREWS: -- because I've got like tons
24 of questions --

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1 MS. HOOPER: -- not at all.

2 MS. ANDREWS: -- about priorities and how
3 you came up with things and I could keep us here for
4 another three hours but I won't.

5 MS. HOOPER: Okay.

6 MS. ANDREWS: Okay, so we're not voting on
7 this going out in stone.

8 MS. HOOPER: No, in fact that's why we kept
9 it as draft. And I hope that -- and if I haven't I want to
10 make it very clear. we need more input, this is a draft. I
11 think what we're asking for is your consideration of the
12 process to move forward instead of building an HIE, making
13 sure that we're transparent with the area of funds that we
14 do have.

15 We're not just going to give the money to
16 somebody in the room or outside of the room. We're going
17 to have a process to select a HISP vendor to support what
18 the Plan identifies.

19

20 CHAIRPERSON MULLEN: Okay, but would you --

21 MS. HOOPER: I'm done.

22 CHAIRPERSON MULLEN: -- because scanning the
23 room there are eyebrows and hands and before you get too
24 far I want to make sure that we're on the point that is

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1 actually going to get to a question and a motion because
2 you put a lot of information in there.

3 And where should we begin, shall we just go
4 around?

5 MS. KELLY: Well my question actually backed
6 up to when the gentleman from Danbury Hospital was talking
7 and you said you raised a good point. And I'm not certain
8 as a consumer I totally understood it.

9 CHAIRPERSON MULLEN: Okay.

10 MS. KELLY: But --

11 CHAIRPERSON MULLEN: Thank you for saying
12 something.

13 MS. KELLY: -- yes, but basically what I
14 heard, I thought, was there's one thing involved in giving
15 the technology -- you know, bidding to say I'm going to
16 deliver the technology to be able to do this, alright. But
17 then the issue is, I think is what you were talking about,
18 is who operates this thing on an ongoing basis? And then
19 that's where the issue of DOIT or somebody else, like
20 Hospital Work Connecticut -- I mean, I could dream of all
21 sorts of somebody elses.

22 Is that that what I understood, and that's'
23 my first --

24 MS. HOOPER: You may have understood it, let

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1 me clarify it.

2 MS. KELLY: Okay.

3 MS. HOOPER: The vendor would be selected to
4 be this Health Information System -- Service Provider for
5 the term. There will not be a different operator. So
6 we're not actually looking to buy technology but we're
7 looking actually to buy -- and I'm not going to throw --
8 ABC Corporation Company runs this kind of a system or the
9 interoperability, the direction for where something is
10 going to go, making sure it's in direct -- that it has
11 those communications with laboratories and pharmacies and -
12 -

13 DR. AGRESTA: Meg, can we clarify that
14 because I think --

15 MR. COURTWAY: Let me make a point of
16 clarification. The reason why we're here today from the
17 Technical Committee is to inform the Board that from the
18 last session that we had with the ONC that the Technical
19 Committee is recommending changing the scope of the
20 selection process to not just select what the ONC is saying
21 that you must have this up this year, that we believe that
22 that would bring us down a very narrow path, increase the
23 ultimate cost and not provide the value that we believe
24 that this technology can apply.

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1 So that first and foremost is saying it's
2 not just direct that we want to make a decision on. We
3 want to make a decision on the vision of the HIE. So --
4 and the concern of the ONC in December was, how the heck
5 would you get an RFP out the door and get anything set up?
6 Well, what we've done is some innovative things. I find my
7 best work is found in stealing thoughts from others. So
8 we've gone out to other states, we have other experts that
9 we've added to the Committee as advisors and we actually
10 have created a fairly robust RFP for all of the technology
11 besides what ONC asked. And we believe that we'll be able
12 to surface that as an RFP to the issue that will come back
13 and let the Board make an informed decision about which
14 technologies to get. The priority order is not set but
15 it's really meant to get the broad view.

16 So today it's not voting on an RFP. It's
17 not voting on anything other than the concept and the
18 belief that we are going to go for a broader view in a very
19 short timetable so that we can make some decisions. The
20 other part of it that really hasn't been talked about is
21 the role of the players. It is not known, and with all the
22 changes in the administration and the timing and the
23 payments and how it's going to be funded, how we will set
24 this up. So in the RFP what you will see, and if it's not

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1 clear we'll have to make it more clear because it's really
2 seeking clarity before it gets up -- what we're asking the
3 vendors to do is to tell us how you would do this.

4 Do you provide a service model that we can
5 buy this from you and don't have to set it up ourselves?
6 Do you partner with others to set us up if we didn't want
7 to do it and if we wanted to do it ourselves, however we
8 did it, whether or not it's as a separate contract for a
9 data center or technology and operation -- you know, what
10 is the estimated cost on that? So really the RFP is
11 designed to surface the myriad of decisions that would have
12 to be made it's not meant to drive us to any one particular
13 decision because -- so that's really where we're trying to
14 get to today.

15 CHAIRPERSON MULLEN: Are you okay?

16 MS. KELLY: I think so, and we're looking -
17 - and the RFP is going to be seeking one entity like we're
18 making a decision on one entity?

19 MR. COURTWAY: I think that we'll find the
20 reality is that we'll have one entity that will be in the
21 lead but they will bring partners into this, that this is
22 not going to be one size fits. And I think that that's
23 also good for the --

24 MS. KELLY: And basically one of the

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1 requirements to make this work for ONC's purposes is that
2 any willing provider that wants to be in this, regardless
3 of where in the state they are, will be able to do that.

4 DR. AGRESTA: Yeah, that's a baseline
5 requirement.

6 MR. COURTWAY: Yeah, a baseline requirement.

7 MS. KELLY: Right.

8 MR. COURTWAY: And in order to be able to
9 get all the providers beyond the eligible practitioners and
10 hospitals it's got to be set up, we believe, by September
11 1st to start that testing process.

12 MS. KELLY: And then my other final question
13 is, we have \$7 million that's hinging on -- is that what --
14 and is all of that potentially going to fund this thing or
15 -- and how are we addressing it? I mean, I'm certain your
16 Committee has looked at what it would take to do this. You
17 know, is that -- because I think that comes in -- I gather
18 that that comes in to part of the issue for Governor Malloy
19 and Lieutenant Governor Wyman, is -- you know, are the
20 resources -- are the federal resources at least at this
21 point in time sufficient to be able to pull this off. Do
22 you understand my question?

23 MR. COURTWAY: I do and I think it's safe to
24 say that there is insufficient funding to pull this off

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1 with just \$7 million funding in any long-term, that we do
2 need to develop a business model. I think that's what Dan
3 Carmody's team is doing, is to say how -- what makes sense,
4 where do the benefits lay, how do we line up and set the
5 benefits and the payments.

6 I don't think that the Technical Committee -
7 - in fact I know we have not addressed any of the cost
8 issues. We also have not put into the RFP how much money
9 we have to spend, although it's pretty much public
10 knowledge and the vendors will recognize that it's really
11 insufficient. So really it's really going to be to say
12 okay, how would we buy this if we buy it in increments. I
13 mean, you wouldn't buy all the technology at the same time
14 because frankly, you wouldn't be able to implement it that
15 fast. But I think that we'll be informed by the vendors
16 who respond to the RFP what the sequencing is and what the
17 timing and dollars would be and then that could come back
18 to the other groups to weigh in on.

19 So I think that what we're seeking is not
20 only the questions you have today that are the broad
21 questions but in looking at the RFP, which parts of it are
22 highly technical. So for those other parts that really
23 aren't here and don't have what you think or the clarity
24 that you would understand what the answer would be, that

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1 needs to come back to us so that we're not so technical
2 oriented and can get it into different terms. I think it's
3 a real critical role.

4 CHAIRPERSON MULLEN: Okay.

5 MS. MATTIE: We worked together a long time
6 ago.

7 CHAIRPERSON MULLEN: Now it's your moment.

8 MS. MATTIE: Peter or Meg, I wonder if you
9 could just clarify for me, give me some points, what are
10 the benefits of the broader vision as opposed to what ONC
11 is offering and number two, and I think this speaks to
12 Mark's point in terms of having a strategic document where
13 we pull all the things together? Because prior to what
14 I'll call the semester break we were heading down the path
15 of hiring an Executive Director, which Mark, Don and I were
16 guests on that Subcommittee. So where does that fit with
17 all this?

18 Also, can we really develop its technical
19 RFP without consideration for the financial stuff? So I
20 guess it's two questions. Number one, why a broader
21 vision, what are the doc points, what other states have
22 implemented it, I guess that's a third. And this is maybe
23 less of a question but a statement solidifying Mark, we
24 need a strategic plan for this -- how do all those pieces

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1 fit together because personally I don't feel comfortable
2 signing or voting on anything until I could see the bigger
3 picture.

4 MR. COURTWAY: Well, I guess in terms of --
5 like an example of how the broader vision is to our
6 advantage, it goes with how we bond within that broader
7 vision. If you start with where ONC started -- you know,
8 just put up a direct project and we know that MPS positions
9 is the direct group in the state -- you know, we could in
10 essence contract and pile money into a direct
11 infrastructure with a separate plan to do this that would
12 otherwise be imbedded in the overall cost of the rest of
13 the HIE.

14 So what winds up happening is that when you
15 -- if it was an embedded cost it was something that came
16 through because it was part of the product. Now you have a
17 contract running with one and you have no offset to the
18 other. The RFP side does not preclude us from cherry
19 picking. All it does is it informs us of how these
20 different vendors structure the HIE because there are
21 switch players they have in it, how they -- you know,
22 perceive their costs. And we were very careful in the
23 discussions with Legal and Policy that we had put words in
24 this that say that we reserve the right not to select any

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1 of those so that we have all things open to us.

2 So I think right now the Committee will get
3 bogged down in the force of the card -- you know, try to do
4 it -- well, we'll lose time and if we don't get something
5 out the door that is going to at least give us some
6 framework for the position we'll be boxed out.

7 MS. HOOPER: And if I may answer that?

8 MS. MATTIE: Thanks Peter, and thank you for
9 all your work.

10 MR. COURTWAY: Well, you know I'm the one
11 not doing the heavy lifting. We have a lot of Committee
12 members that are working -- Mark has been doing a
13 phenomenal job doing this stuff that makes your eyes glaze
14 over. It's been fine work by the whole Committee.

15 MS. MATTIE: Well thank you.

16 MS. HOOPER: To answer your question for the
17 Board, you have both a statutory responsibility outlined in
18 the enabling legislation for what you're to do. We have
19 the Strategic and Operational Plan that describes the
20 governing function. ONC is providing funds that will go to
21 the HITE/CT to implement the Strategic and Operational
22 Plan. This is one of the avenues that's being suggested to
23 pursue. The Board will be the determinants.

24 The Department apparently has currently a

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1 budget allocated approximately \$1 to \$1.2 million a year
2 for the next four years -- three and a half years is where
3 we're down to now. That \$1.2 million is essentially to
4 implement the Strategic -- or the Operational Plan. How
5 that is done, hiring staff and contracting for RFP and
6 cherry picking for services, that really is for -- that is
7 not a decision to be made by any one individual but rather
8 by the group. How it can be supplemented with other funds
9 and/or services and leveraging partnerships is great. But
10 there will be approximately \$1 to \$1.2 million if the Plan
11 is approved and Congress doesn't take away all the funds,
12 that will be offered through contract between DPH and
13 HITE/CT to implement the Plan.

14 So you have directives in the statute, you
15 have directives in the Plan and there will be minor
16 contractual obligations for accepting the check.

17 CHAIRPERSON MULLEN: Okay, so it's 6:15, in
18 case anybody wasn't looking at their watch. I don't want
19 to stifle conversation but I did want to point that out. I
20 appreciate the clarification and for anybody who thinks
21 that this -- who hasn't done anything. It's impressive how
22 much work has already been done. I have a colleague who
23 talks about building an airplane, the same time flying it,
24 and this is a real example of that.

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1 It's a scary example but I think it's a real
2 example of that. And I think that there are a lot of
3 points that have been brought up that have to be addressed.

4 So I understand the discomfort in feeling like you have
5 decisions to make when you haven't even fully flushed out
6 the authority and leadership of the group but you've
7 managed to come a long way to this point. So -- you know,
8 I pointed out the time because I know other people have
9 comments. I understand some people might not want to hear
10 a vote brought to the group but I also want to enable the
11 possibility of moving forward the way we need to so that we
12 can stay on track. Yes?

13 DR. CARMODY: If there's a motion that
14 somebody has, the understanding of what that motion, then I
15 think if you brought that forward on a conversation piece
16 then we could figure out are we uncomfortable with the
17 motion. I don't think anybody has the motion so we're not
18 quite sure what it is.

19 CHAIRPERSON MULLEN: Yeah, I understand. I
20 understand and part of what -- you know, the way -- the
21 reason why I intervened is because I didn't want it to
22 sound as detailed as what it might have been inferred to be
23 from everything that you were listening.

24 We can take a couple of more questions now

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1 or wait and raise the question and then have a motion and
2 then ask the questions. But you look like you want to say
3 something.

4 MR. LYNCH: Quick response to Angela's
5 question.

6 CHAIRPERSON MULLEN: Yup.

7 MR. LYNCH: If I were to go to the emergency
8 room today there would be no way for the direct kind of a
9 proposal for the hospital to actually find my record and
10 pull it in. That's why the larger vision. So therefore I
11 put a motion on the table that one, we endorse the larger
12 vision of scope, not just the immediate and indirect kind
13 of thing but the larger vision that the Committee has put
14 on the table. In other words, this is endorsing it for a
15 process that would come back to this Board in a month so.

16 In other words, we can meet the kind of time
17 schedule hopefully. So it's really endorsing the process
18 to move forward with further creation of the full RFP
19 looking at that larger scope as one component of that RFP
20 process. And in that one month between now and the next
21 meeting that we do have some discussion with the Governor,
22 etc., around approval of use of DPH and DOIT staff for this
23 near short-term bit. We're not asking for long-term or
24 money at the money at the moment, we're asking for their

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1 support to enable the RFP process to move.

2 The RFP process will give us time to go
3 further through some of this stuff because by the time we
4 get to June where we award the RFP maybe by then we'd have
5 also the next piece for the Finance Committee to work with
6 the Technical Committee to work on the financial component
7 of that to balance the two together so that by the time we
8 get there --

9 CHAIRPERSON MULLEN: This is a motion?

10 MR. LYNCH: It's a motion basically to move
11 the process forward to the RFP -- that it will move forward
12 on a larger scope and it will get the Governor and these
13 other components involved in the short-term as part of that
14 process.

15 MS. KELLY: I'll second it just so we can
16 discuss it.

17 CHAIRPERSON MULLEN: Okay, could you --

18 MR. WOLLSCHLAGER: The abridged version was
19 that the Board would endorse this larger scope, not just,
20 again, HIN, and endorse the process which would come back
21 to the Board in a month. The process would move forward
22 with the larger scope of services to be provided.

23 MS. HOOPER: The RFP.

24 MR. WOLLSCHLAGER: It was the RFP process.

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1 MS. KELLY: Okay so at our next Board
2 meeting my question --

3 CHAIRPERSON MULLEN: Excuse me, but we have
4 a question.

5 DR. BUCKMAN: Comments, questions.

6 CHAIRPERSON MULLEN: Okay.

7 DR. BUCKMAN: So first my recollection is,
8 is we never endorsed this Board going with an indirect. So
9 it's unclear to me why it's even mentioned in any motion or
10 anything. I think -- you know, in a clear motion. It
11 would make more sense to me just a clear motion, we're
12 endorsing the development of an RFP for a full blown HIE.
13 Is that correct?

14 MR. COURTWAY: That's correct.

15 DR. BUCKMAN: Okay, simple, because HISP has
16 been thrown around. We're not talking HISP we're talking
17 full blown HIE correct?

18 MR. COURTWAY: Correct.

19 MS. HOOPER: No, we're --

20 MR. COURTWAY: That is correct.

21 MR. WOLLSCHLAGER: Would you accept a
22 friendly amendment --

23 MR. LYNCH: Part of the problem is that the
24 staging was -- the first stage of that would deliver more

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1 of a HISP than the full blown but we really -- the Health
2 Information Services Provider --

3 DR. BUCKMAN: That's not the --

4 MS. HOOPER: Yeah, it is --

5 MR. LYNCH: -- well no, it is in there --

6 LIEUTENANT GOVERNOR WYMAN: It is. It says
7 the RFP for full service HISP.

8 DR. AGRESTA: Can I bring back a clarifying
9 point to remind us why we ended up at this spot because
10 that may help us bring up the spot, because our original
11 stage one, stage two, stage three plan was out of sync with
12 what ONC wanted -- our stage one, stage two, stage three
13 plans, that got all submitted at the same time as ONC was
14 deciding what it wanted and we overlapped. And they said
15 what they wanted sort of after we were submitting our plan
16 and our stage two included things that needed to happen in
17 stage one from ONC's perspective, okay.

18 So our stage two really was -- I think we
19 had more sort of public health early on, we had more sort
20 of document sharing early on, and I believe -- I'm trying
21 to remember which thing got kind of out of sync but we had
22 to kind of respond to that. And so what we need to have
23 the motion say is that we want to pursue probably our full
24 blown vision but we need to change the timeframe. And the

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1 timeframe needs to kind of be in line with what ONC
2 requires for stage one, stage two, stage three kinds of
3 work. And the RFP should be subsequently aligned in that
4 fashion. I mean, I think the RFP should say it has to meet
5 stage one but it can extend beyond that in the first
6 timeframe.

7 Is that -- that's what you were trying to
8 address I believe.

9 MR. COURTWAY: It was the meeting where we
10 received where we received from the Deloitte consultant
11 saying if you want to be successful go with this. And the
12 Committee members that were around the table said yes, that
13 sounds like a plan, let's go with this. We brought it to
14 the Technical Committee and the Technical Committee said
15 whoa, if you go with that here's the pitfalls. We think we
16 can get the job done.

17 So if this doesn't need a motion you know
18 Warren, to do this, fine. But now that we've brought it
19 the motion would be to -- you know, the Technical Committee
20 to develop the full HIE RFP, be returned to the Board
21 within 30 days and to allow the pre-solicitation notice to
22 be issued for the RFP.

23 MR. MASSELLI: So Commissioner, it sounds
24 like we have a simple motion from Ron and we have lots of

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1 intents that are separate. So the simple motion is to sort
2 of accept the recommendation of the Committee to move
3 forward with the RFP process. And then we have intents
4 that are in somewhat -- they're open for the Committee and
5 somewhat -- just sort for framework we've got new members
6 coming -- some new members who have joined us and there's a
7 change in ONC.

8 So we're acting a little confused around the
9 table because the game has changed on us. So Ron just sort
10 of put forward a straightforward motion and then we might
11 want to lie out separately. But we -- remember as a
12 Committee that we've always had a good collective process
13 coming back and nobody goes out ahead of anybody and it
14 sounds like Nancy's reminded us -- the Governor has
15 reminded us of the need to have good communication with the
16 Governor's office around this.

17 So if we just simply move forward with that
18 simple motion with the understanding that we have a lot of
19 nuanced issues here which will come back to the Committee
20 and they'll require -- and Commissioner, you've done a
21 great job of saying let's get everybody's issues out on the
22 table. I think we'll continue that process.

23 CHAIRPERSON MULLEN: So I'll --

24 DR. BUCKMAN: If John will withdraw his I'll

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1 make mine.

2 MR. MASSELLI: Yup.

3 CHAIRPERSON MULLEN: -- what I had written
4 here was vote to recommend RFP process to Governor.

5 MR. MASSELLI: Yup, yup good.

6 CHAIRPERSON MULLEN: And then you can -- and
7 if anybody wants to put that in the form of a new motion --

8 DR. BUCKMAN: Well, there's already a motion
9 on the floor. We're not voting to recommend the process to
10 the Governor.

11 CHAIRPERSON MULLEN: But we have an RFP
12 process. The next thing to vote was --

13 DR. BUCKMAN: We're voting to -- again, is
14 there another motion on the floor? Till that's withdrawn -
15 -

16 MR. LYNCH: There's a motion on the floor so
17 are you going to make the motion to amend it --

18 DR. BUCKMAN: So the motion is to accept the
19 Technical Committee's recommendation to move forward with
20 an RFP process for a full HIE.

21 DR. CARMODY: Is there a second?

22 MR. LYNCH: Second.

23 DR. CARMODY: Discussion -- as far as on the
24 discussion piece my only question is so we have these

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1 different things that ONC wanted us to work on. And then
2 we had our original scope that we had outlined. Beyond
3 what the ONC addition was in our original scope, is there
4 anything else in this RFP that we need to know because
5 remember, we were building three things originally which
6 was master index master, provider index, and record
7 locator.

8 And then we had these other pieces so is
9 there anything beyond that in the RFP that was --

10 MR. COURTWAY: Yes, the surfacing for the
11 vendors about whether or not there would be a service
12 provider to HIT/CT to set up the infrastructure, do we rent
13 it from them -- you know, what's the operational cost --

14 DR. CARMODY: That's right but as far as
15 functionality and deliverables associated beyond that, so
16 that's -- maybe how those capabilities were being
17 delivered. Is there anything beyond that?

18 MR. COURTWAY: No.

19 DR. CARMODY: That's the only thing I had a
20 question on.

21 MS. KELLY: Could someone read the motion
22 that Ron made again?

23 MR. WOLLSCHLAGER: Well, it's changed a
24 little bit but it was to accept the Technical Committee's

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1 recommendation to develop --

2 MS. HOOPER: For the IFP process.

3 MR. WOLLSCHLAGER: -- yeah, for the
4 development of a full RFP -- RFP for a full HIE.

5 MS. KELLY: Alright, I guess dealing with my
6 Board members concerned it sounds like that if this is
7 going to proceed according to the plan that we've had.
8 Then I think that as part of that motion, and I'm willing
9 to put it in as an amendment, that we do need to add the
10 pre-solicitation announcement, that they can proceed with
11 that, but that -- and it's missing on this next step when I
12 looked at our next Board meeting, which is March 21st, that
13 the pre-solicitation announcement would go out.

14 But on March 21st we would give the final
15 approval and could actually vote it down if we didn't like
16 it. And then the issuance of the RFP would occur after the
17 Board meeting on April 1st. And I think that for me to
18 feel like I'm not just giving up my authority in a blind
19 sort of way to something I really haven't even totally
20 seen, I think that needs to be in the motion. And then my
21 other question is your comment Commissioner, about are we
22 recommending that the -- asking the Governor can we do
23 this? And I'm not sure whether we have to or we don't
24 legally.

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1 I was thinking more when we started this
2 with your report that the Governor comes into play if
3 perhaps we need resources that go beyond the federal money.

4 But I need to be sure what is the role of the Governor in
5 this? What does the Governor have to -- or do they --
6 could we do this independent of the Governor saying --

7 DR. CARMODY: Brenda can you just make --
8 what is your actual amendment?

9 MS. KELLY: I don't have one but it would be
10 if the Governor doesn't -- if we can do this without the
11 Governor, okay, my amendment would be to add to the motion
12 that we have authority to go ahead with the pre-
13 solicitation agreement and that the RFP would be reviewed
14 and voted on by the Board at its March meeting.

15 MS. HOOPER: I think that --

16 MS. KELLY: So that we could adhere to the
17 timeline that was in the document that we got.

18 MR. MASSELLI: That was the -- Brenda, I
19 think it was the recommendation to follow --

20 MS. KELLY: Okay, but I think -- Ron, if it
21 was -- I just want to make sure that that's there, yeah.

22 MR. MASSELLI: But you know, to the issue of
23 the communication with the Governor's office, we need to
24 have a very strong partnership because one would hope that

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1 the Governor will see the value and will talk -- because
2 we've talked a lot about the education we need to have
3 happen across the state.

4 The Governor's office is the best
5 spokesperson for this issue understanding the
6 transformation in Connecticut's -- he's bringing about and
7 Lieutenant Governor Wyman's bringing about, so we want to
8 have that -- I think it's implicit in what we're saying
9 here and yet Tom mentioned that we're a separate authority.

10 But it's a partnership --

11 MS. KELLY: Yeah, I don't --

12 MR. MASSELLI: -- and I think it's not we
13 have the ability to move forward but I think we're all in
14 agreement here that we want to work together hand-in-hand
15 in a relationship.

16 MS. KELLY: Right, and I don't have a
17 problem with that at all. I was just trying to clarify
18 exactly what has to happen legally to make this happen.
19 And I'm concerned, I don't want to jump out and do
20 something stupid but I'm looking at the ONC requirements,
21 I'm looking at the fact that we want doctors to be able to
22 come to meaningful use. We have a timeline that is very
23 compressed but I think could be met. And then -- you know,
24 what do we have to do to get there?

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1 And certainly I want the Governor to be as
2 involved as the Governor can be. But the timeline, that
3 would have to be between 2/15 and whenever the pre-
4 solicitation announcement, which is supposed to be March
5 1st, which isn't very much time.

6 MS. HOOPER: So what's everybody doing
7 tomorrow?

8 MR. WOLLSCHLAGER: So Brenda, you're
9 offering an amendment that --

10 MS. KELLY: That we -- Ron's amendment, and
11 I think he said it was inherent in it, that we grant the
12 authority to go ahead with the pre-solicitation
13 announcement and that we would approve or we would review
14 and act on the RFP approval at the March meeting.

15 MS. HOOPER: Was there a second to that --

16 DR. CARMODY: Second.

17 MS. KELLY: That would be my amendment but I
18 guess someone has to second my amendment or if we just
19 added it to --

20 MR. WOLLSCHLAGER: Dr. Buckman --

21 DR. BUCKMAN: I'm okay with adding the
22 language.

23 DR. CARMODY: You have to vote on the
24 amendment and then you eventually have to vote on the

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1 entire motion.

2 MR. WOLLSCHLAGER: And the amendment was
3 seconded by you Dr. Carmody?

4 DR. CARMODY: And I will second.

5 MR. COURTWAY: Call for questions?

6 CHAIRPERSON MULLEN: Does that mean there
7 are no other questions?

8 LIEUTENANT GOVERNOR WYMAN: At 6:29, that's
9 pretty good.

10 MR. WOLLSCHLAGER: So we're voting just on
11 the amendment right now and in the amendment we authorize
12 the Technical Committee to move forward with the issuance
13 of the pre-solicitation announcement and also require that
14 the draft RFP come back in front of this body at the March
15 meeting for review and/or approval?

16 MS. KELLY: Hopefully for approval.

17 DR. BUCKMAN: We're voting on whether or not
18 to amend the motion to include that.

19 MR. WOLLSCHLAGER: That's right, that's all
20 we're voting on, whether or not that amendment --

21 DR. THORNQUIST: Can I ask a very concrete
22 question?

23 MR. WOLLSCHLAGER: Sure.

24 DR. THORNQUIST: This -- basically the

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1 mechanism by which this gets generated, if the people
2 around the table have specific concerns about what's in
3 here, and I admit that this is a relatively 11th hour
4 document for most of us, we can communicate by e-mail
5 directly to the Technology Committee and the Finance
6 Committee.

7 We cannot engage in a dialogue remember,
8 because that's not a public meeting anymore, but we can
9 send them one way communications and they can take it into
10 account in their deliberations. It's not like this is in a
11 vacuum.

12 MS. HORN: No, right.

13 DR. THORNQUIST: And the Committee is an
14 open meeting as well. Subcommittee meetings, it's an open
15 meeting, so.

16 MS. HORN: And Legal and Policy will be
17 meeting and this is their agenda item for 3/1 -- March 1st,
18 so if anyone wants to participate in that.

19 MR. WOLLSCHLAGER: I need -- so we called
20 and questioned, all those in favor of accepting and adding
21 the amendment to the original motion?

22 VOICES: Aye.

23 MR. WOLLSCHLAGER: Opposed?

24 MS. BOYLE: Hi, this is Lisa. I'm an Aye.

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1 MR. WOLLSCHLAGER: Thank you, so noted Lisa.

2 So the --

3 MR. CARR: This is Kevin Carr on the line.

4 I'd just like to recuse myself from voting on the RFP
5 discussion.

6 MR. WOLLSCHLAGER: Yes, so noted Kevin that
7 you're recusing yourself from discussion or voting on the
8 RFP issue.

9 So the amended motion then is that we accept
10 the Technical Committee's recommendation for the
11 development of an RFP for a full service HIE, also
12 authorizing the Technical Committee to issue the pre-
13 solicitation announcement. And finally, that the draft
14 product put together by the Technical Committee with other
15 assistance come back in front of this body for review and
16 approval at the meeting in March.

17 MS. HOOPER: Nicely done Warren.

18 MR. WOLLSCHLAGER: All those in favor?

19 VOICES: Aye.

20 MR. WOLLSCHLAGER: Opposed? The Aye's
21 have it.

22 MR. COURTWAY: Are you going to ask for
23 abstentions?

24 MR. WOLLSCHLAGER: Oh yes, abstentions

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1 Kevin? None noted.

2 MR. CASEY: So Warren, is there -- now that
3 we've done that do we need another motion to amend the plan
4 in accordance to that timeline? Is that necessary Meg?

5 MS. HOOPER: I think that what I'm hearing
6 is that we can notify ONC exactly what's happened tonight,
7 is that we are supporting that this process continue
8 forward and that this is -- again, the decisions about that
9 process will be forthcoming. Is that acceptable?

10 There does not need to be a vote but is it
11 acceptable that we can notify ONC about the discussion and
12 the desires and the motions made tonight?

13 VOICES: Ahum.

14 MS. HOOPER: Thank you very much.

15 CHAIRPERSON MULLEN: Yes?

16 MS. KELLY: One of the things that when the
17 March meeting comes around in addition to the content of
18 the RFP is, I'm going to want to -- and maybe this is what
19 we were discussing but to me the issue of who does this
20 selection and how that process works given the fact that
21 there's so many potential conflicts on this Board,
22 including my own, so I'm not saying -- you know, but that
23 to me is part of being -- you know, of making certain we
24 have a transparent process that can defend. And we didn't

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1 have a lot time to talk about that tonight, which is fine
2 because we're not at that stage, but if I'm going to vote
3 to go forward in March that's going to be something that
4 I'm going to have to feel real comfortable about because I
5 think it's very important.

6 When we have a Board like this, which I
7 personally think is necessary to get the right people at
8 the table, but then it makes it very hard to have objective
9 people that can make a decision like this. And so how we
10 handle that is going to be an important part of my
11 decision, and I don't know what the answer is. I just need
12 -- that needs to be an important part of our discussion in
13 March, I think.

14 CHAIRPERSON MULLEN: Thank you.

15 MR. COURTWAY: So the framework part would
16 be that you're not issuing the RFP, we'll get all of the
17 options available and all the costs available so we have
18 all of that. The thought was to bring each of the
19 Committee Chairs that are responsible for bringing aspects
20 of the HIE -- Operations, Technical, Financial and
21 different groups, to be the core review team that tears
22 them apart and gives the final recommendation and ranking
23 order to the full Board.

24 So it's not the Technical Committee it's the

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1 Chairs of everybody who's going to finance and operate and
2 whatnot to sit there and be able to answer the questions of
3 the full Board in regard to why a particular vendor, why a
4 particular sequence. That does not preclude any action in
5 between that time from members of the Board to weigh in, to
6 provide questions that the Committee Chairs should take
7 into account and then to bring that final thing back to the
8 full Board for the review at the final vote.

9 MS. KELLY: The question I would have, and
10 it doesn't have to be tonight, is not knowing exactly who
11 the Chairs of the Committee are and what their business
12 connections and other connections are.

13 MS. HOOPER: There will be full disclosure.

14 MS. KELLY: That has to be -- that would
15 have to be part of what I want to hear, a full disclosure.

16 CHAIRPERSON MULLEN: Thank you.

17 MR. WOLLSCHLAGER: So we're up against the
18 time now and I appreciate everyone's patience as we work
19 through very complex issues. We're going to have to at
20 least table some of these issues. They're important and
21 we're going to have to bring them forward. My
22 understanding is that we certainly want to offer public
23 comment and we're going to do that at this meeting. My
24 understanding is that there's literally a 30 second

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1 announcement regarding the bank process that was mandated
2 in the follow-up from last meeting?

3 MS. HORN: I can do it in under 30 seconds.
4 Several meetings ago we had a resolution that was passed on
5 opening up a bank account and the Board designated the Bank
6 of America as the bank it kept. I'm back here to ask that
7 we have that designation changed to allow the Board Chair
8 to have the latitude to choose a bank.

9 We did some due diligence after that meeting
10 and we found that there may be better rates -- there are
11 better rates, there certainly are lower minimum balances
12 for where we are.

13 MR. WOLLSCHLAGER: Do we have a motion?

14 MALE VOICE: So moved.

15 VOICES: Second.

16 MR. WOLLSCHLAGER: All those in favor?

17 VOICES: Aye.

18 MR. WOLLSCHLAGER: Opposed? So moved.

19 CHAIRPERSON MULLEN: Twenty-nine seconds.

20 MS. HORN: Thank you.

21 CHAIRPERSON MULLEN: Thank you for your
22 endurance. Now it's your turn, we have to listen. Is
23 there anyone who would like to make a comment? Yes.

24 MR. WOLLSCHLAGER: Can you actually just

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1 stand and move up to the table?

2 CHAIRPERSON MULLEN: Yes, and identify
3 yourself please?

4 MR. ED VAN BAAK: Good evening, my name is
5 Ed Van Baak and I work at Asylum Hill Family Medicine, in
6 part with St. Francis Hospital and in part with University
7 of Connecticut Medical School, for teaching the medical
8 students and residents.

9 Several people here tonight have suggested
10 that Connecticut is behind and whether that is the case
11 today, I would just encourage you that we are all here
12 today doing something about it. A very aggressive timeline
13 but by the end of this year we may very well not be behind
14 at all. There are several states that certainly aren't yet
15 to this point. Just a word of encouragement.

16 CHAIRPERSON MULLEN: Anyone else?

17 MR. CANE: Hi, this is Ed Cane. I have no
18 public questions or comment. Thank you.

19 CHAIRPERSON MULLEN: Thank you. Anyone
20 else? So do we have a motion to adjourn.

21 MALE VOICE: Motion to adjourn.

22 CHAIRPERSON MULLEN: And a second?

23 MALE VOICE: Second.

24 (Whereupon, the meeting was adjourned at

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1 6:11 p.m.)

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