

VERBATIM PROCEEDINGS  
DEPARTMENT OF PUBLIC HEALTH

CT HEALTH INFORMATION TECHNOLOGY  
AND EXCHANGE STRATEGIC PLAN

DR. JEWEL MULLEN, CHAIRPERSON

MARCH 21, 2011

101 EAST RIVER DRIVE  
EAST HARTFORD, CONNECTICUT

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RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
MARCH 21, 2011

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 March 21, 2011 at 4:41 P.M. . . .

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6  
7  
8  
9 MR. WARREN WOLLSCHLAGER: Roll call taken,  
10 okay so we have a quorum. Commissioner, do you have any  
11 introductory remarks for the group?

12 CHAIRPERSON JEWEL MULLEN: I'll just say  
13 welcome back and welcome myself back since last month was  
14 my first meeting. And I started last month's meeting  
15 saying that I was derailing the agenda because we actually  
16 -- under, you know, the guidance of Meg Hooper's  
17 presentation spent a lot of time reviewing progress to  
18 date.

19 And new to this effort it was my impression  
20 that a tremendous amount of work -- that you all have  
21 accomplished a tremendous amount of work. So I'll just say  
22 I'm glad to be back. I have no plans to derail the agenda  
23 this month but I know that we have a full and very good  
24 one, and thank you for everyone who's here with us from --

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1 you know, the potential to offer public comment, all of our  
2 other interested vested parties who are here as well.

3 MR. WOLLSCHLAGER: Thank you very much  
4 Commissioner. Alright, so if we move on to the agenda then  
5 to the review and approval of the meeting minutes from  
6 February 15th. Those were all distributed in your package  
7 of materials. I'll give you a couple of minutes to take a  
8 minute to look at them if you haven't looked at them  
9 before. Do we hear a motion to accept?

10 MR. DANIEL CARMODY: Motion to adopt the  
11 minutes of February 15, 2011.

12 MR. JOHN LYNCH: Second.

13 MR. WOLLSCHLAGER: That was Dan and John,  
14 discussion? All in favor?

15 VOICES: Aye.

16 MR. WOLLSCHLAGER: Opposed? Ayes have it.  
17 Great, thank you very much. Board business reminder  
18 updates, this should be very quick items as well. A  
19 statement of finance -- a reminder that everyone on this  
20 Board, a statute that is required to provide a statement of  
21 financial interest, I think it's due May 1st. You've all  
22 received material on it. If you need to be reminded where  
23 the website is, you can file it electronically with the  
24 Office of State Ethics.

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1                   If you need, again, assistance finding that  
2 website we'd be happy to give you that website again. But  
3 it's basically if you go onto the State of Connecticut  
4 website, you go to the Office of Ethics and it's right  
5 there on the first page. It's [www.ct.gov/ethics](http://www.ct.gov/ethics).

6                   MR. CARMODY: When you go out there though  
7 it asks you to chose a Department for an agency as to what  
8 you're a part of and it doesn't have the HITE as an option,  
9 so do you just pick DPH? I mean, I took it as a default  
10 and just said DPH and then put Board of Directors but that  
11 really -- you may want to just ask them because we're not  
12 listed. This is the next closest one.

13                   MR. WOLLSCHLAGER: Thank you. We'll have to  
14 follow-up and we'll send an e-mail out to everybody.

15                   MS. BRENDA KELLY: Yeah, I never got  
16 notified that I needed to file that because to my knowledge  
17 I didn't. So -- I mean, I will. I don't have an issue but  
18 I don't believe I ever received that notification. So we  
19 file under DPH or are you going to correct it so that it's  
20 --

21                   MS. MARIANNE HORN: We'll clarify with the  
22 Office of State Ethics --

23                   MS. KELLY: So we should hold off?

24                   MS. HORN: -- who you should file with and

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1 I'll do that tomorrow.

2 MS. KELLY: Okay.

3 MS. HORN: Whether we need to do something  
4 affirmatively to get HITE/CT registered up there as a  
5 quasi.

6 MS. KELLY: Okay.

7 MS. HORN: And we'll ship that out to  
8 everybody.

9 MS. KELLY: Okay.

10 MR. WOLLSCHLAGER: Other questions on  
11 statement of financial interests? Okay, in-kind match  
12 commitments, we have discussed the issue on at least one  
13 other occasion where our cooperative agreement with the  
14 Office of National Coordinator, we have to show in-kind  
15 matching requirements for the State of Connecticut. I  
16 believe that you've all received the correspondence -- hold  
17 on, I take it back.

18 Sarju Shah has materials to give out to you  
19 today regarding your in-kind commitment, whether or not  
20 you're able to commit any of your time that you're spending  
21 on this activity in support of our federal grant. Some  
22 folks can do it, some folks can't, it depends on your own  
23 personal circumstances. And maybe 100 percent of your time  
24 is already committed against other federal grants. It may

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1 be that you have your own conflict of interest and for  
2 awhile you can't do it. So it's really a unique case.  
3 During the course of the meeting -- well Sarju, I'll ask  
4 maybe that you pass that out after the meeting and then  
5 we'll be available for any questions that any members have.

6  
7 Finally, just a bit of good news. It's  
8 always good to start a meeting off with some good news.  
9 Regarding the update on our Strategic and Operational Plan,  
10 I'm happy to report that on Friday the 18th we got the word  
11 from our project officer that our Plan has passed program  
12 approval. It's been approved by Dr. Fazzad Mastachari  
13 (phonetic), so now it's got to go to the last level of  
14 grant's office sign off and the office of Dr. Blumenthal,  
15 but at that point it will be official and funds will be  
16 made available. We expect that to happen in the next  
17 couple of weeks, certainly no less than that.

18 So it's been a long time coming. A lot of  
19 you worked very hard on this and a lot of the folks outside  
20 of this room also contributed a lot so congratulations to  
21 all of you on that. Any questions on that? The one piece  
22 that we have heard from our project officer is that the one  
23 gap identified in the review that is going to have to be  
24 addressed by this group is a strategy showing a commitment

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1 putting boots on the ground with respect to our  
2 laboratories and bringing the laboratories into the system.

3 It's an area of the gap that they thought we addressed not  
4 as strongly as some of the other areas, so it's something  
5 we're going to have to talk about. We'll get more  
6 information out to folks in the next couple of weeks.

7 Okay, that's it for the business for the  
8 Board and let's move then into the presentations and  
9 discussion regarding the consent model. Now, this is an  
10 item that was on the agenda last meeting. We ran out of  
11 time, we said we'd put it on today. It's my understanding  
12 John, you're going to present on the consent model that's  
13 in our current Plan that came out of the Legal and Policy  
14 Committee. Ellen, I didn't know if you were going to  
15 present other information as well?

16 MS. ELLEN ANDREWS: Yes.

17 MR. WOLLSCHLAGER: Okay so John, we'll turn  
18 it over to you.

19 MR. LYNCH: Alright. Again, this is the  
20 Legal and Policy Committee results --

21 MR. WOLLSCHLAGER: And John I'm sorry, just  
22 before you start can the record show that we've had other  
23 members join us since we began the meeting. Mark Masselli,  
24 Dr. Thornquist, Lisa Boyle and Peter Courtway, thank you.

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1                   MR. LYNCH:  Alright.  The Committee over  
2                   time -- this was people who have attended Committee  
3                   meetings at some point in time during the process.  It's  
4                   not like everybody attended every meeting and there's  
5                   probably more people who have come to other Committee  
6                   meetings since then because this was created awhile ago,  
7                   but I do want to recognize the efforts of people who have  
8                   put into this.

9                   One of the things that we based our Policy  
10                  on was we looked at the federal government process that had  
11                  a white paper that talked about consent options.  And the  
12                  consent options are that -- you know, many states have no  
13                  consent option basically.  They basically follow the  
14                  federal guidelines and exchange data, etc.  The paper  
15                  talked about opt in versus opt out and various variations  
16                  of that.  The distinctions get fairly detailed at times  
17                  depending on how sensitive the data are and what type of  
18                  data you're talking about opting in and opting out of.

19                  Our Committee in the long run basically said  
20                  let's ignore these terms because they can be very confusing  
21                  because our own model is kind of a hybrid model, and we'll  
22                  explain a little bit more in detail later.  It's kind of an  
23                  opt out but then you have to give consent later on.  So  
24                  these are the kind of official ONC models but -- and

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1 they're the ones that you kind of hear about, opt in, opt  
2 out, a lot, but we encourage you to kind of get away from  
3 the term and actually get into how it's actually going to  
4 work because I think that's more important than the  
5 terminology itself.

6 Other states, there are two different  
7 sources of information on this but basically we won the  
8 models by state. There's a state HIE website that codes  
9 one record per state and you can see a number of states  
10 really haven't really documented anything else at all yet.  
11 But from that perspective 13 states use an opt out, three  
12 use an opt in. Then there's another source, initiative  
13 annual survey, which really surveys health information  
14 exchanges. So it's not one per state but some states have  
15 eight, nine, 10 HIEs within the state so from that  
16 perspective the state gets counted multiple ways.

17 That model has 36 opt in, 81 opt out and a  
18 bunch of people unsure and people with no answer. I think  
19 there's still a lot of confusion out there what models are  
20 or are not in existence in various states. So we were  
21 considering those kinds of things, what others were doing.  
22 Very important to us was we wanted to follow existing  
23 federal and state laws. You know, we didn't think there  
24 was necessarily any opportunity to change either federal or

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1 state laws so we figured we had to kind of work our consent  
2 model within those. And so that was probably the biggest  
3 consideration, that we follow existing laws.

4 Next one, we heard very strongly from the  
5 medical community. Our next priority really is patient  
6 care. We wanted to make sure that we give the best patient  
7 care and that's above all the next most important things.  
8 So we wanted to improve the quality, we wanted to have more  
9 efficiency, at the same time you do want to have values to  
10 protect privacy, usefulness, viability -- you know, in  
11 other words we didn't want to put workflows that would be  
12 impossible to do. Capabilities of existing systems really  
13 limited us in many ways and you'll see that later on, that  
14 many of the EHRs that exist today, many of the hospital  
15 systems that exist today really have no mechanisms to deal  
16 with consent and therefore, that's going to become part of  
17 the problem ongoing.

18 We wanted to support meaningful use and we  
19 wanted to build into the NHIN infrastructure. We heard  
20 loud and clear from the review of our Strategic Plan, ONC  
21 wants us to have this first year directed toward that NHIN  
22 federal infrastructure, the direct connect kinds of  
23 solutions. So we have all those things that kind of make  
24 sure we integrate with as we come up with our solution.

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1 Existing federal laws we talked about, HIPPA, obviously  
2 number one, everybody talks about. We filed a HIPPA and  
3 basically HIPPA allows information to flow for treatment  
4 payment and operations. So we're basically following that  
5 mechanism.

6 To do that HIPPA talks about business  
7 associates agreements and HIPPA talks about a policy where  
8 when you first come in you sign a document that lets you  
9 know -- you inform the patient about your policies and if  
10 HIPPA will allow restrictions to be granted and accepted by  
11 a provider. In addition there's other federal and state  
12 laws that we had to make sure we covered, HIV, alcohol,  
13 mental health, abortion, others. These are sensitive data  
14 you might explain them as, and each one of them provides  
15 different opportunities for barrier or success in flow of  
16 health care information depending on how you look at it.

17 We also wanted to prioritize the use cases.  
18 As we see in our Strategic Plan and as ONC got back to us,  
19 there's certain things that the federal government wants to  
20 make sure we do in the first year like getting lab results  
21 done, getting E-prescribing done, etc. They all come under  
22 the category of clinical care. We also focused quite a bit  
23 in our plan about public health reporting. We really did  
24 not address in our consent model the things kind of below

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1 there. We didn't address other things like research,  
2 marketing, quality reporting, etc. Those are kind of  
3 things to become more problematic in the future.

4 We wanted to make sure we got health care,  
5 get the meaningful use kinds of things going immediately.  
6 We need to make sure that the infrastructure -- you're  
7 going to be hearing about today later on in terms of our  
8 RFP is going to talk about an infrastructure and the  
9 various kinds of things that an HIE needs to build. Some  
10 of these really impact or integrate -- integrate isn't the  
11 right word, but interact with consent more than others. So  
12 for example can we reconcile patients across consistent  
13 with a master person index. That's patient data. We have  
14 to recognize how do we want patient data to flow, with or  
15 without consent, relative things like the master person  
16 index, the record locator service.

17 We want to be able to track sensitive data  
18 somehow and we want -- you know, have longitudinal patient  
19 record. Where's it going to be stored, how's it going to  
20 be stored, that will impact patient consent processes as  
21 well. Important for providers, meaningful use. There's a  
22 lot of federal money on the State for providers, from the  
23 Medicaid system, from the Medicare side of the system --  
24 hospitals, physicians, both to meet meaningful use. To

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1 meet meaningful use there are a lot of key things like  
2 exchange key clinical information between providers. So if  
3 we're going to get the information to flow this year, the  
4 ONC's desire for us to get that to flow this year, our  
5 consent model has got to be able to be adapted immediately.

6 Current year, get things like clinical  
7 information, summary record, medication reconciliation  
8 going in a current year. The infrastructure for all this  
9 start at the federal level and gets quite complex when you  
10 see that we are basically like one node hooked into a  
11 national node where you've got all kinds of federal  
12 agencies, CDC and the VA, etc., on this infrastructure. We  
13 have to play in their game as well as our own State's game.

14 So when we determine things it's not like we can determine  
15 and go Connecticut's way and forget that the rest of this  
16 world has to communicate with us as well. Our patients go  
17 across state lines.

18 In Danbury, Danbury Hospital has got a lot  
19 of patients crossing the borders with New York I'm sure.  
20 Up here with Springfield. So we've got to make sure that  
21 whatever we do we somehow have the mechanisms in place that  
22 we can do that across state lines as well as with federal  
23 government, etc. So, we had a public process. We had  
24 various Legal and Policy meetings. We've had our own

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1 Advisory Board prior to the creation to HITE and then we  
2 had HITE voting on the ONC Strategic Plan, which included  
3 this whole Policy. So we had a very public process, lots  
4 of opportunity to get in there and talk about it.

5 I'm not going to read this for you but  
6 basically we did have a public process and the result of  
7 all that basically was a Policy. It's built into our  
8 Strategic Plan. First and foremost, the Policy follows  
9 existing federal and state laws. So HIPPA, etc., we've got  
10 to make sure that it works appropriately with that. Next  
11 component was provider participates by election. In other  
12 words, we're going to set up policies and criteria of how  
13 to play in the game. If a provider doesn't accept that,  
14 we're not going to allow them in the game. They may want  
15 to do meaningful use but if they are not willing to follow  
16 the rules, they're not going to be in the HITE game.

17 So the provider elects to participate or not  
18 and in doing so will agree to some level of business type  
19 of agreements that will have to be set up by the Policy  
20 Committee downstream. The policy agreements of how will  
21 they follow the process and procedures, etc., some more  
22 work to be done for us to develop those policies, but  
23 provider has to agree to those. It will protect the  
24 patient's privacy, security, etc. When they participate

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1 they will agree that they will provide certain amounts of  
2 patient data.

3 Now, recognize this is now all medical  
4 record data. It's not like the thick paper chart is being  
5 sent on somewhere, okay. First of all, the provider  
6 provides what's called mapping data. It's kind of like the  
7 telephone book so that you can search and find out who's in  
8 there, where are they, where their records located and  
9 everything. So you need to have that master person index  
10 basically and that tends to be like the name, address, the  
11 kinds of stuff so you know you're really sending data to  
12 and from about the right person. So consent is basically  
13 saying it's okay for that level of data to be statewide in  
14 an indexing system so we can find out where records are on  
15 a patient.

16 Second is a record locator service. It says  
17 Danbury Hospital, ProHealth, etc., will publish and say  
18 yes, I've got some data about John Lynch. If anybody is  
19 looking for data about John Lynch you can come and seek me,  
20 ask me more about it. So you need to know where the data  
21 are, not necessarily that it's stored. And our RFP will go  
22 further into do we have a central repository or not or  
23 where it is, but at this point it's really just saying  
24 we're a pointer to where the data are. So that level of

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1 data is being talked about being released.

2                   Then patient summary document, it's called a  
3 continuative care document. These are summary records.  
4 Again, it's not the full chart it's a summary record. You  
5 know, things like medications, lab results, allergies and  
6 stuff like that. Those -- again, depending on how the  
7 system is deployed could be still held local and only sent  
8 when asked for. It could be that some people would prefer  
9 that to be central because they can't manage that on a 24/7  
10 basis. But you need that information -- all this  
11 information 24/7, so in the current world we've got faxes.  
12 You go to Tom Agresta on Saturday morning asking for data  
13 on a patient and maybe Tom is taking a well earned day off  
14 on Saturday and maybe he's not back in his office until  
15 Monday and can't respond to a fax.

16                   But hopefully in this electronic world these  
17 kinds of things can be going on 24/7 whether or not Tom is  
18 actually seeing patients that day. Disclosures, so what  
19 we're talking about is this level of data being available,  
20 sent to the HIE without consent because it doesn't -- if  
21 you didn't send it and it was at Tom's office and he wasn't  
22 available, if I went into the emergency room that next day  
23 there would be no way to get it. If it's in the HIE from  
24 that perspective, at least if I want to change my mind and

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1 say -- maybe earlier I had opted out but now I'm in  
2 emergency, maybe I better change my mind, I wanted in.  
3 It's there to be pulled if I want to change my mind kind of  
4 thing as well as the fact that there's other components,  
5 following state law that data will still flow.

6 So reporting, like for public health  
7 reporting, my cancer registry record reported directly to  
8 DPH no matter what. I shouldn't have any ability to say I  
9 opt out of all the required state reporting that's required  
10 by state law. So state law, what flows by state law will  
11 flow and the summary type of data will be there as an  
12 option. So what's important to understand is evolving in  
13 our system for consent here. So you start out today in the  
14 paper world, you have a docket here with paper, what  
15 happens? The patient goes in, they get the HIPPA notice of  
16 patient privacy regulations. You have to read the HIPPA  
17 thing and you sign it.

18 We're saying the same thing is going to  
19 happen. We're encouraging the providers to add more to  
20 that, more explanation of the statewide HIE to that HIPPA  
21 notice. So the HIPPA notice will still be there, that's  
22 kind of the first telltale sale of warning that the  
23 processes will be laid out and the provider will tell what  
24 it is but it's not a consent. It's a notice of your

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1 practices and the patient signs them kind of thing. In the  
2 paper world what happens -- oh, I need the record, I have  
3 to fax it. The faxing option is a current world.

4 If I'm not there as a doctor when the  
5 request comes in, you know, you go in and you want your  
6 prescription filled and you're in on a Saturday and they  
7 send it off to your doctor Saturday, maybe they're not in -  
8 - that fax, don't receive it until Monday morning where  
9 they can finally say oh, it's okay to refill that and send  
10 it back alright. So in the paper world it's that time  
11 issue but it tends to be faxed. Now what we're adding  
12 there for is electronic systems. So if you go to a  
13 hospital let's say, the hospital might have 20 different  
14 systems. In the current world there's no consents between  
15 those 20 systems for the information to flow.

16 So from lab to pharmacy to radiology, etc.,  
17 within the hospital, they're all sent by what's a messaging  
18 system, it's called HL-7, the messages just pass back and  
19 forth using what's called a router to get the data between  
20 the multiple systems within the hospital. Next layer of  
21 that is NHIN direct. NHIN direct is saying well, that's  
22 good within a hospital but how do I get it to that small  
23 doctor, Dr. Ron Buckman, who maybe isn't in the hospital  
24 but maybe he was down the street. NHIN direct talks about

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1 using e-mail so that you would take a document -- and  
2 again, the documents, that continuity of care document may  
3 be text, it may be discrete data.

4           So it's not like it's consistently one thing  
5 that's represented in there. It could be a scanned  
6 document. But you can wrap it in an e-mail, you can  
7 deliberately get the digital identity of a doctor, maybe  
8 Dr. Ron Buckman on the other end, and crypt it to Dr. Ron  
9 Buckman and only he can decrypt it. So you kind of keep it  
10 safe going in between each other, and that's the NHIN  
11 direct that ONC wants us to deliver this current year. In  
12 that process there really is no consent capability built  
13 into the NHIN direct. Next layer would be that large  
14 groups, maybe not the individual doctor but a large group,  
15 might be able to put out what's called an edge system where  
16 they put their continuity of care documents out, make them  
17 available, they send off to the RIO, the HIE, that master  
18 person index data and the record locator data to say where  
19 the data resides.

20           It still resides back under their control  
21 but if someone -- if the patient comes in to some other  
22 doctor over here, they can request of the HIE the data,  
23 find out that it's requested over here and get it back.  
24 Now again the consent process in that, there's no easy way

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1 to do how do I tell -- when a patient comes in over here,  
2 how do I tell this other group over here that it's okay to  
3 send the data because maybe the last time you were here  
4 with this group -- you know, a previous hospitalization  
5 might have been three years ago, historical data, but I  
6 want to make sure that gets sent on to the -- I haven't  
7 gone back to this hospital let's say to say oh, in the  
8 future it's okay to release my data.

9 I'm coming in here now and trying to tell  
10 this doctor oh, it's okay to go after and get my data.  
11 There's no electronic way in this EHR or in the EHR or the  
12 hospital EHRs to represent those consents today, which is  
13 part of the reason the policy group said okay, let's --  
14 following HIPPA for patient care purposes, it would be okay  
15 to send it unless it met the criteria of psychiatric notes  
16 or something like that. So what we're -- and the same  
17 thing again with the Department of Public Health. As we  
18 automate those things we would be sending messages from the  
19 fax system down there without a patient consent.

20 So what we're talking about is adding a  
21 layer here over the HIE to try to control the HIE whereby  
22 if we were able to get a consent, whether it was faxed or  
23 whatever, into the central HIE at least the HIE would have  
24 a mechanism to do something whether it will release or

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1 won't release that data when someone requests it. But  
2 there's really no mechanisms today at the doctor level, the  
3 EHR level, the hospital system level to represent these  
4 consents and represent sensitive data throughout there in  
5 terms of making that automatic. So hopefully haven't  
6 confused you a lot but the push/pull here is that we don't  
7 know where the patient is going to be.

8 We want to allow the patient to get the data  
9 wherever they are so if I go in to a hospital in an  
10 emergency room that may be the point where I'm saying yes,  
11 I really -- I want the data to flow, I've got to somehow  
12 represent that all the way back to everybody else who has  
13 my records. And that's why the consent process becomes  
14 problematic. So we opted for a policy that would consider  
15 that as well as these others. So we wanted a uniform  
16 policy on restrictions, we wanted provider provisioning  
17 sensitive data -- excuse me, identifying the sensitive  
18 data. Somehow the provider has got to identify, is this  
19 psychiatric notes, and keep it out of the system basically  
20 because there's no way to tell when you go back to that  
21 other system where psychiatric notes might be.

22 They might be in text, it might be a PDF,  
23 etc. So unless the provider has a responsibility to keep  
24 psychiatric notes out of the system there would be no real

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1 way to detect those elsewhere in the system.

2 MS. KELLY: They have that now. They have  
3 that obligation now already --

4 MR. LYNCH: Right, correct.

5 MS. KELLY: It's just paper.

6 MR. LYNCH: So we're basically -- we're  
7 trying to follow the paper process. If the patient signs  
8 an election not to participate in the HIO, it's global  
9 across all providers. We have no good mechanism --again,  
10 these systems don't have things built in to say just this  
11 data, not that data, this and that, etc., this provider but  
12 not Angela, I don't want her -- it's global. If you either  
13 opt in or you opt out basically globally not selectively by  
14 -- oh, I want Jewel to get it but not Angela kind of  
15 things.

16 So it's a global opt out. No patient data  
17 electing will leave the HIO. The data will come into the  
18 HIO -- in case the patient changes her mind will come into  
19 the HIO so you can still fulfill other state laws like  
20 getting data reported to DPH for public health reporting,  
21 etc., but if you've opted out of the system the HIE will  
22 basically put a wrapper around that data and say no, it  
23 can't go out. Most recent election controls so you opt in  
24 today -- you say I don't want to participate, I opt out

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1 today but you go into the emergency room tomorrow -- ah,  
2 maybe I better -- I better and now I want it to flow,  
3 whatever the most recent one is at the HIE, that is your  
4 most recent consent for the global consent.

5 Disclosure of sensitive PHI is determined  
6 according to existing federal and state laws governing  
7 such. We're not really trying to change that at all so if  
8 state law says you can't send psychiatric notes, you  
9 shouldn't be sending psychiatric notes, etc.

10 DR. THOMAS AGRESTA: But you'll still  
11 collect them.

12 MR. LYNCH: We will collect master person  
13 index, we will collect the locator service, okay. That's  
14 not actually collecting the data. Where the repositories  
15 will be is part of, I think, some other process to be  
16 determined. So the provider could still be holding it in  
17 their local server or some providers may have a shared  
18 hosted services where someone shares that for them but  
19 that's under the provider's control.

20 Break glass is enabled because again, the  
21 record locator and NPI were stored centrally. If you're in  
22 the emergency room and you're unconscious and you can't  
23 give a -- you know, I changed my mind. The doctor could  
24 still say we're going to break glass, get the record,

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1 special auditing procedures take place, we have to develop  
2 more auditing procedures to have that happen but it will  
3 still allow the patients in a real true emergency sense and  
4 they're unconscious or whatever and they'll still have  
5 their dataflow, etc. Again, the detailed notice of privacy  
6 practices, the HIPPA notice, we encourage the providers to  
7 add more information to that to explain more about it.

8 For example, disclosures to HIE but  
9 basically that process is in place. The patient is seeing  
10 a notice, they're seeing your privacy practices and they're  
11 signing that. And that's done at that level. Opt out does  
12 not supersede federal state/state law. So you might want  
13 to say I want to opt out of everything. No, you're not  
14 opting out of public health reporting or whatever that's  
15 required by state law. That was our policy but the big nut  
16 here is education, education, education. How do we get  
17 this out to the patient, how do we explain all this to the  
18 patient? So as a Committee, as a Board, we have a major  
19 challenge in front of us as we adopt our RFPs and we go  
20 through the policies, etc., and actually try to start  
21 implementing how do we educate providers. How do we  
22 educate patients. How this process will work to make it  
23 work proficiently. Questions?

24 MS. KELLY: Just one little question. When

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1 you were talking about the systems, the chart -- the  
2 systems not being able to do everything that we might want  
3 them to do --

4 MR. LYNCH: Yup.

5 MS. KELLY: -- and you mentioned consent.

6 MR. LYNCH: Yup.

7 MS. KELLY: Under the model that we have  
8 where people are opting out, if they want -- if they're  
9 over here and they want their record do they have to give  
10 consent because you said other places over here don't have  
11 the ability to do it without consent.

12 MR. LYNCH: Right, so --

13 MS. KELLY: How do I get my record?

14 MR. LYNCH: -- alright, so I envision one  
15 thing but again, we haven't necessarily discussed a deploy  
16 mechanism I'll call it amongst the Committee. We selected  
17 an opt out to try to address all these other issues but an  
18 actual technical way to do it, one way to do it might be  
19 similar to when you want your no-call list where the HIE in  
20 theory could have a call-in mechanism where a patient calls  
21 in and says I want to opt out. And the HIE controls that  
22 because they can put the tag on the patient's master person  
23 index over here and build that capability once whereas  
24 every EHR, every hospital system wouldn't necessarily have

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1 that capability at least until you put it out in Regs and  
2 five years later they finally got it implemented kind of  
3 thing.

4 MS. LISA BOYLE: But isn't -- aren't you  
5 asking --

6 MS. KELLY: Yeah, because you were saying  
7 that they don't have the -- you specifically mentioned NHIN  
8 and you said no consent capability so that I -- and again,  
9 I --

10 MR. LYNCH: The mechanism today would have  
11 to be you'd sign a piece of paper, they have to fax it to  
12 the HIE and the HIE would have to get it into the system to  
13 link with your MPI to say you wanted opt out.

14 MS. KELLY: I'm not talking about opting  
15 out, I'm talking about I'm in.

16 MS. BOYLE: Yeah, how does she get her  
17 record?

18 MS. KELLY: I want to know how I get my  
19 record and do I have to consent?

20 MR. LYNCH: Oh no, you don't have to get  
21 consent to your own record at all. The meaningful use  
22 criteria, etc., tell all these providers to do meaningful  
23 use and we'll get to that, they've got to give patient  
24 their data in whatever form the patient asks for. Now that

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1 becomes a challenge now for this doctor with his EHR to say  
2 oh, the patient wants it on a -- oh, they want it on a  
3 floppy disk, I don't have floppy disk capability. I don't  
4 have an old system that has a floppy disk.

5 MS. BOYLE: Well, today you would have to go  
6 to every provider and get -- under today with paper you'd  
7 have to go to every provider and ask for your record.

8 MS. KELLY: Right.

9 MR. LYNCH: Right.

10 MS. BOYLE: So the benefit of an HIE as it  
11 evolves is that you can go arguably -- you have to still go  
12 to the provider --

13 MR. LYNCH: Right.

14 MS. BOYLE: -- but he can collect all of  
15 your data.

16 MR. LYNCH: Right.

17 MS. KELLY: But I'm trying to understand,  
18 okay, because this is the biggest reason I'm here is I  
19 think this is extraordinarily exciting, alright.

20 MR. LYNCH: Yes.

21 MS. KELLY: But I'm trying to understand now  
22 how it's going to evolve, how it's going to be when we get  
23 the system up and running this fall hopefully after we've  
24 picked our vender. And also, who's responsible for doing

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1 this is it the vender, is it this group, is it the doctor  
2 that we're already trying to get in the system? Is that  
3 going to be built in to what we're asking the vender to do  
4 so that we can get it out? That's what I'm trying to  
5 understand.

6 MR. LYNCH: Yup, some of that I'll have to  
7 defer to the next discussion when we get into the RFP what  
8 is or isn't in there, okay.

9 MS. BOYLE: We have -- the personal health  
10 record, that's the big thing. I mean, there's two  
11 different pieces. There's a personal health record which  
12 we have to talk about where we stand on that, and this is -  
13 - actually this is the consent model which is really the  
14 data that the providers and physicians in the hospital  
15 forward.

16 DR. AGRESTA: Right, and I think it's really  
17 critical Brenda to think about this as really staged --

18 MR. LYNCH: Right, plus --

19 DR. AGRESTA: Because the first thing you  
20 need to have happen is you have to be able to exchange  
21 data. And then you have to be able to look at how data --  
22 as a provider, as somebody who has an electronic medical  
23 record I can tell you if you came to my office and I have  
24 this consent model, I theoretically can go out there and

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1 pull all the data but that practically might not be the  
2 best way for you to get it.

3 We haven't really thought about can you go  
4 directly to the HIE and request your data. That would be -  
5 - and we haven't scoped that out, we haven't thought about  
6 that as part of our initial planning. We talked about it  
7 in the Advisory group as being a long-term goal so that you  
8 could actually get it into a personal health record or  
9 portal, etc., but these are technical challenges that I  
10 think are -- we're exploring as part of the RFP but I can  
11 tell you that most EMRs don't have the capacity to do that  
12 yet. But we're moving there.

13 MS. BOYLE: But --

14 DR. AGRESTA: But if you came to my office  
15 and asked me can you tell me what all the medications I'm  
16 on, what my allergies are, from across all these systems in  
17 this model when this gets set up and everybody's connected,  
18 then I could do that.

19 MS. ANGELA MATTIE: But I think maybe if we  
20 think of it as two steps, one as a policy prospective.  
21 Right now we're in the cross. What policy do we want to  
22 adopt? The first slides that John started out with, you  
23 know, do we want to say no opt in and really just think  
24 about it in terms of, what are we going to require from a

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1 policy perspective from the provider and what are we going  
2 to require from a policy perspective from the patient. And  
3 to some extent our hands are within the framework of the  
4 state and federal laws and HIPPA laws.

5 Then the second stage, and this was going to  
6 be my question John, what are the next steps. The way I  
7 see the next steps is for us to come to some agreement  
8 about the policy. And then once we come to agreement about  
9 the policy, then we go to the level that you're talking  
10 about how do we operationalize this and how do we put  
11 systems in place to move up to the policy. So you know, my  
12 question was John what do you want for next steps --

13 MR. LYNCH: Next step, there is a couple --

14 MS. MATTIE: -- and I would assume the next  
15 step would be an agreement and a discussion about the  
16 policy both from a practitioner level and a provider level.

17 And the second question I had just to sort of fill in on  
18 that policy discussion is how does this compare with what  
19 other states are doing because I know -- and Dan, thanks  
20 for sending out the Hartford Courant article in terms of  
21 raising my education level in terms of what's going on.

22 But what are other states doing because to  
23 me that's always a good argument for this is potentially  
24 the right direction. Not that the majority rules but --

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1 CHAIRPERSON MULLEN: Before you answer, I  
2 would like to ask you whether or not your question was  
3 answered to your satisfaction.

4 MS. KELLY: No.

5 CHAIRPERSON MULLEN: Okay, then let's not go  
6 on.

7 MR. LYNCH: Let me try to add one more  
8 component for you Brenda.

9 MS. KELLY: Well no, can I just interject  
10 something because -- I guess I'm feeling like the policy  
11 has to drive what we're building and I don't think that we  
12 really -- I understand that we may not be able to build  
13 everything that we might want. But the policy has to drive  
14 it and I'm not seeing in this presentation what AARP would  
15 feel is a comprehensive approach. And I did bring some  
16 materials that I do want to distribute that I believe lays  
17 out some of the things that we believe should be there.

18 But my bigger question with you Tom is, if  
19 we get this running this fall, and I know it's going to be  
20 a phased in thing, are we going to start making medical  
21 decisions about me based on what's in the system? In other  
22 words we're building it, I hope, so that if I land in an  
23 emergency room that people are going to have information  
24 about me that might improve the chances of me getting good

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1 care, alright? So is that where we're going to be?

2 When are we going to get there so that  
3 there's going to be -- I know we're not going to put it all  
4 in at once but there's going to be information that could  
5 help us improve patient care.

6 DR. AGRESTA: So -- I mean, I think that's a  
7 really good question. And I think it really depends on  
8 when the people who care for you -- we'll use you as an  
9 example. Suppose you get care in my practice and my  
10 practice is one of the first to get online and you get care  
11 -- you've been seen in Danbury Hospital and you've been  
12 seen at Hartford Hospital and you come to some other  
13 emergency room. If all of those places are connected you  
14 theoretically could, once you educate the ER docs, etc.,  
15 about how to use it so there's a lot of work to do there,  
16 but you theoretically could start to see benefit when all  
17 of those steps have occurred.

18 So when the places that store your  
19 information are connected, when the places that you will  
20 receive care are connected and when the folks who actually  
21 care for you are educated to do it in a usable way, and  
22 those are all steps we need to take, I would say that  
23 they're really important aspects. Some places will be up  
24 faster in our state than others. I mean, some hospitals

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1 and care providers are going to be more capable of doing  
2 it.

3 MS. KELLY: Well, I guess from my  
4 perspective when that happens, and I know it may happen  
5 differently in different parts of the state, but when that  
6 information about me is being used to make decisions about  
7 my care, then I think I should be able to access my  
8 information. Not by going to seven different people and  
9 giving pieces of paper but the thing that is telling the  
10 doctor that's making decisions about my care.

11 And I don't think it's -- you know, I'm not  
12 saying that everyone here has done a terrible job. I mean,  
13 I think part of this is the way this whole thing is  
14 evolving. But I'm not hearing that come through.

15 MR. MARK MASSELLI: Can I just --

16 MS. KELLY: Yup.

17 MR. MASSELLI: -- ask Peter if that's  
18 something that we can add onto the RFP and ask for a model  
19 that would include that because it's a good request and we  
20 could at least look at it and let the numbers drive the  
21 timing of what that would take to do.

22 MR. PETER COURTWAY: We certainly could. I  
23 mean we do need to be able to allow the patients to see the  
24 information that is collected. And the RFP as its

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1 currently developed has a lot of questions about the  
2 personal health record and the connectors and whatnot but  
3 we could certainly strengthen that in the RFP before it  
4 goes out to make sure that it's quite clear that that is an  
5 expectation and to move that expectation earlier in the  
6 process.

7 MS. KELLY: I saw some places in the RFP  
8 that I would change some of the wording a little bit to  
9 accomplish that. But I think it's also a matter of, for  
10 me, who's going to do this and who's going to be  
11 responsible. I'm having a hard time and it's not even just  
12 on the consumer issue, of understanding what the venders  
13 that we're going to select is supposed to be doing, what  
14 we're supposed to be doing, what someone we're going to  
15 hire is supposed to be doing, what the doctor is supposed  
16 to be doing.

17 And it's not even just on this. I'm the  
18 consumer representative so I'm concentrating on this but  
19 I'm having trouble with other things as well.

20 MR. LYNCH: Let me take a shot at that.  
21 Some of that is that huge amount that we still need to do  
22 in the Policy Committee. This was only a very narrow  
23 policy on consent. You've got a much broader charge of all  
24 that policy to put that in place so that we would put --

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1 you know, if technically we put a patient portal so you  
2 could get access directly and not have to go to 10  
3 different places but to go right to the HIE and get it,  
4 you've got to put that policy in place about how to enable  
5 you to do that, how do we make sure it's you, etc.

6 So there's a lot of other policy work that  
7 is still to go and that's part of an answer to both your  
8 previous questions and you were asking what's next. What's  
9 next is the Policy Committee has to continue a lot of work  
10 because that's only one little policy and consent. We've  
11 got a broad set of policies of what's the agreement going  
12 to look like between the doctor who signs up for the  
13 process, the BAA agreement, what's the policy relative to  
14 the patient if we're going to allow the patient in and get  
15 their own access to data, etc. So that's one next step is  
16 to develop a lot more of the other policies that we need.  
17 This is only one set of policies.

18 MS. ELLEN ANDREWS: I had another  
19 presentation --

20 CHAIRPERSON MULLEN: Excuse me, I just need  
21 to finish my sentence, thanks. Because otherwise I'm not  
22 doing my job, thank you.

23 So I know we gave this an hour, and then we  
24 have some other things on the agenda, and I know you have

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1 some other questions.

2 MR. MASSELLI: I don't have any questions -  
3 -

4 CHAIRPERSON MULLEN: Not you, but there  
5 might be some other questions and I imagine you want to  
6 address --

7 MS. ANDREWS: I have a presentation that I  
8 put together.

9 CHAIRPERSON MULLEN: Okay, so -- but are  
10 there any other -- Angela, did your question get answered?

11 MS. MATTIE: Yes.

12 CHAIRPERSON MULLEN: Okay.

13 MS. MATTIE: But I think just as a  
14 Committee, you know, do we have an action item today and is  
15 that to come to some agreement about the opt in, opt out  
16 policy or is it just an education we're being presented?

17 MR. LYNCH: This was an education because  
18 we've already adopted that with the overall continued plan,  
19 etc., the opt out process. But we've got to continue a lot  
20 of work on the Policy Committee on all the rest of the  
21 policies that are on there.

22 MS. MATTIE: And how does this policy --  
23 just so I know and especially given the recent Hartford  
24 Courant editorial, how does this Policy compare with other

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1 states?

2 MR. LYNCH: This Policy -- one of the  
3 earlier slides showed you that most states have opt out  
4 more than opt in. In that perspective we're like other  
5 states.

6 MS. MATTIE: Okay, thanks John.

7 DR. RONALD BUCKMAN: If I may, just a  
8 question and then I'll follow it up with something but my  
9 understanding is that in Connecticut regulations state that  
10 the patient, whoever the patient is, is not the person who  
11 can cause records to go -- their own records to go to any  
12 individual. So for instance if you were the patient and  
13 you were my patient, if you want your records to go  
14 somewhere else you have to make that request to me. And  
15 then it's up to me, and I have 30 days to do it, to get  
16 those records to some other entity either another provider  
17 or somebody else.

18 If you as a patient -- and this is current  
19 state law in Connecticut, if you as a patient are sitting  
20 in the phlebotomist chair getting blood drawn and you say -  
21 - and I as your primary care doctor ordered a bunch of  
22 blood tests for your physical and we do it automatically,  
23 it's done. You're sitting in the phlebotomist chair at  
24 7:00 in the morning and you say to the phlebotomist oh by

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1 the way, I want that blood work to go to my cardiologist,  
2 my oncologist, my gynecologist and my dermatologist. You  
3 know what the lead peck says to you, lead peck says I'm  
4 sorry, I can't do that. I can only do that if you get an  
5 order for me to do that from your primary care doctor. Do  
6 you have any knowledge that that's different?

7 MR. LYNCH: That's the current paper world,  
8 yeah.

9 DR. BUCKMAN: Right, and that would  
10 interfere with what we're trying to do here. So I just  
11 want to put it out that this Wednesday there is a Bill  
12 coming out in Public Health for discussion, for public  
13 comment, that would take care of that issue, that would  
14 give the patient the responsibility and the authority to  
15 designate who would get their information from the testing  
16 facilities so they can designate that their information  
17 goes to the HIE, that it goes to their various doctors,  
18 okay.

19 MR. MASSELLI: But am I right --

20 DR. BUCKMAN: And that's going to be  
21 discussed this Wednesday.

22 MR. MASSELLI: -- doesn't this model though  
23 ultimately --

24 DR. BUCKMAN: No, you can't supplant State

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1 law.

2 MS. BOYLE: There's an issue related to labs  
3 and it's been --

4 DR. BUCKMAN: Well it's not just labs, it's  
5 all testing.

6 MS. BOYLE: -- yeah, and there's been a lot  
7 of discussion and different people interpret it different  
8 ways. So it's one of those areas of debate I think in  
9 terms of what that means.

10 DR. BUCKMAN: But there is a -- there will  
11 be a Bill discussed this Wednesday at Public Health to try  
12 to fix this issue.

13 MS. BOYLE: Do you know what that -- because  
14 I haven't seen that.

15 DR. BUCKMAN: The language isn't finished  
16 yet because I've got to tell you what happened.

17 MS. BOYLE: Okay.

18 DR. BUCKMAN: I started this thing, but what  
19 happened was is that the language went to wherever it was  
20 supposed to go, the clerk who was handling it lost it,  
21 interpreted it the way they thought they remembered it and  
22 it came out wrong so now they're looking to fix it.

23 MS. BOYLE: Can you maybe circulate it come  
24 -- sorry.

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1 CHAIRPERSON MULLEN: We have another  
2 presentation on the consent model.

3 MS. BOYLE: It may not come out until  
4 tomorrow night.

5 MS. BOYLE: Okay.

6 DR. BUCKMAN: And any support would be  
7 helpful.

8 MR. LYNCH: Do you have a Bill number?

9 CHAIRPERSON MULLEN: So I just want to point  
10 out to people that No. 4 says consent model presentations,  
11 so that's plural. Thank you very much.

12 MS. ANDREWS: I asked to put this on the  
13 agenda because we as -- I'm going to describe a different  
14 process that came up with a different answer through e-  
15 HealthCT that's being used right now in the Medicaid  
16 transformation grant. We -- I actually started an HIE  
17 because this is a win/win and I want you to understand  
18 because it comes from a very sincere place of wanting to  
19 make sure that this health information exchange is viable  
20 and survives and is sound and doesn't end up in the middle  
21 of a scandal at some point. That's what we're really  
22 concerned about.

23 I took a view, and this is just a view of  
24 recent press pieces nationally and Connecticut, around

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1 privacy. It's a very sensitive issue. Right now at the  
2 national level browsing history is a huge issue. People  
3 are very concerned about Google and sharing with marketers  
4 where they've browsed on their browsers. I think we can  
5 all understand that HIV status might be a little more  
6 sensitive than whether you went to a home shopping network  
7 or something. In Connecticut there have been 15 Bills  
8 since 2005 to allow red light cameras at lights to give  
9 people tickets when they go through cameras. That's been  
10 blocked every year up until now because people are  
11 concerned about their privacy as they're driving on a  
12 public road.

13 I think HIV and substance abuse is far more  
14 sensitive and I think this is a very sensitive issue and  
15 it's really important that we have a public trust of this.  
16 This came from the Tiger Team recommendations to ONC that  
17 ultimately to be successful in the use of health  
18 information exchange to improve health and health care we  
19 need to earn the trust of both consumers and physicians.  
20 And I'm hoping that everybody can agree to that. Without  
21 public trust patients won't participate, it won't be useful  
22 to providers if it's not populated, policymakers won't  
23 support this with funds, with facilitating legislation.

24 Uses for the data will be very suspect, this

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1 has been an ongoing problem in the HUSKY program is that  
2 people don't feel comfortable that the data is actually  
3 valid. And then the uses for it have not been able to be  
4 used to drive policy planning. Funders won't support it,  
5 it invites vigorous oversight, which has also happened in  
6 the HUSKY program because the data is not well respected  
7 and credible, therefore, people are very skeptical when  
8 they see it and it's been hypervigilant, and it discourages  
9 collaboration. And if patients are not confident that  
10 their privacy is protected and control the access, they're  
11 not going to participate in this system and it will fail.  
12 We had a process for the Medicaid transformation plan. We  
13 put together a Committee that Kevin and Brenda and I co-  
14 chaired. That was actually more fun than I thought it was  
15 going to be and I learned a lot, I learned a lot.

16 It included AARP, the Connecticut Health  
17 Policy Project, the Hispanic Health Council, Connecticut  
18 Legal Services, it included many providers -- you'd have to  
19 tell me who the providers were, hospital and practice base,  
20 substance abuse treatment providers, Mental Health Clinic,  
21 Connecticut Aids Coalition, 1199, the Connecticut Center  
22 for a New Economy, the office of the State Comptroller, the  
23 State Health Care Advocate, New Haven Legal Assistance and  
24 the Universal Health Care Foundation were all included. We

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1 developed a public process that included two forums at the  
2 Capitol attended by over 100 people at the two forums.  
3 They were televised on CTN. AARP had volunteer flyers and  
4 volunteers in lovely red shirts.

5 We had put it on blogs, list serves, flyers  
6 at community meetings. We also had conference calls, we  
7 had media outreach, we had online comment on our policies,  
8 a dedicated web page on our websites that gets over 140,000  
9 visits a year, we had webinars, we surveyed stakeholders.  
10 It lasted over months -- most of the year, and we ended up  
11 with an opt in policy and I'll describe why. The policy  
12 that we talked about was an evergreen policy. You would  
13 fill it out once and you could change it later. It was  
14 changed later due to concerns where now, as I understand  
15 it, it's being done every -- at every visit which is  
16 onerous and I agree with that.

17 And we never envisioned that. I think that  
18 the process has gotten to that place as I understand it  
19 because there isn't a permanent policy in place. So people  
20 don't feel comfortable making a decision and implementing  
21 something because this question is still unresolved at the  
22 State level. But we had always envisioned an evergreen  
23 policy. The reasons that we went for an opt in were that  
24 it's consistent with surrounding states, New York, Rhode

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1 Island and Massachusetts all use opt in policies. It makes  
2 access and care across the borders more complicated if you  
3 use an opt out. Vermont recently shifted from an opt out  
4 to an opt in.

5 Under current state law as John said,  
6 exchanging information on sensitive conditions requires  
7 affirmative consent, it requires providers to pull out that  
8 information. That's very error prone, it's -- and they  
9 have to set the liability for doing that as well. It's  
10 incomplete records, could compromise quality, a physician  
11 would never know in an emergency room whether they're  
12 looking at a complete record. And if there was a notice of  
13 a deletion I suggested maybe you should make a big red flag  
14 so we make it -- just attach stigma here.

15 So either way, you're really causing a  
16 problem for people who don't want this information shared.  
17 I think it's important to point out that I've gotten a lot  
18 of very angry e-mails recently and I think it's very  
19 important to point out that health care still gets  
20 delivered in Massachusetts, Rhode Island and New York. It  
21 hasn't shutdown the medical system. It's operating quite  
22 well in fact. Other reasons, a study in Massachusetts  
23 found that contrary to concerns between 88 and 92 percent  
24 of patients have elected to participate in their opt in

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1 system. Either opt in or opt out as John said, requires a  
2 very substantial public education campaign. It can be  
3 integrated into the HIPPA notice, we worked on that at e-  
4 Health as well. So it doesn't have to be more work.

5 If there was ever a breach of medical  
6 information I think we can all understand the sensitivity  
7 of this process, there would be a public outcry that could  
8 lead to very reactive policies, very reactive legislation,  
9 that could really hinder the ability of this HIE to work  
10 forward. The other issue is just a basic respect. I mean  
11 patient center medical homes, the current movement in  
12 health care is to empower patients to help themselves, to  
13 take care of themselves, to manage themselves. That's very  
14 difficult to do when you take away such an important  
15 decision from people. You know, the way I put it is you  
16 need to trust consumers if you expect them to trust you.  
17 And I think it's inconsistent to take that away and just  
18 opt everybody in.

19 And the federal recommendations, the Tiger  
20 Team has made recommendations to ONC that are very broad.  
21 We must consider patient needs -- I can read them actually  
22 if you want, it's quite long. But patient needs and  
23 reasonable expectations, patients should not be surprised  
24 about or harmed by collection, uses or disclosures of their

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1 data. I think it's very possible that if we do an opt out,  
2 patients and education doesn't happen which why would it.  
3 If you're in a busy practice and you can just -- the  
4 defaults that people are in, I'm very concerned that  
5 there'll be a brochure on a wall, there might be a flyer,  
6 there might be a web page, but no one will every really  
7 know that they had that right to opt out.

8 If there's a breach and somebody's  
9 information is shared that they didn't expect it to, they  
10 didn't know anything about it, there will be a justifiable  
11 public outcry that will harm this HIE. Also, if the Fed's  
12 do come up with something that's more restrictive, more  
13 conservative, then the current Policy -- what are we going  
14 to do, shut it down and go back to everyone for consent? I  
15 think it's just wise and prudent to be more conservative  
16 especially in the beginning and go with an opt in. And I  
17 think that that's it. Are there any questions? Anybody  
18 want to shoot spitballs?

19 MS. BOYLE: Well I was -- I don't want to  
20 take up anybody's -- I've said a lot but I did bring some  
21 material as well. And Ellen and I were together with Kevin  
22 on this Committee and I agree with the privacy issues. You  
23 know, some of the concerns that I've been raising go well  
24 beyond the privacy issues it's the way the whole thing is

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1 set up.

2                   So what I did bring, and I don't need to go  
3 over it as we need to move on, but AARP on the national  
4 level has been part of a couple of groups at the Marple  
5 Foundation on community privacy. And what I did was I  
6 copied the testimony we gave on the legislation that Ellen  
7 introduced or had introduced which gives some of the Marple  
8 principles because basically I was told to just lift those  
9 because we signed off and agreed with them. And there's  
10 also a document that Marple came up with in 2008 that I  
11 think is particularly good because on the back it has  
12 actually an example -- yeah, I'll pass these around, an  
13 example of Millie and what an ideal system would look like  
14 from the patient perspective.

15                   And then on the tail end of what I copied, I  
16 did attach some of the ONC materials on privacy, the ones  
17 that had the most germane -- most connection to what we're  
18 talking about tonight. I didn't attach everything but  
19 these are from the ONC privacy framework. And my  
20 perspective is is that their tone and their approach is  
21 much more consumer friendly than how we have things laid  
22 out now. And that's what worries me, is that we're getting  
23 ready to move into a major expense on designing a system  
24 and I think it's going to go wrong if we don't -- it's not

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1 even the detail. It's the tone of what it is we're asking  
2 people to do and also the clarity as to who's  
3 responsibility is it to do it.

4 Because, you know, there's the doctor,  
5 there's the hospital, there's the NHIN and that's what I  
6 don't see in the RFP. So anyway, I don't need to say  
7 anymore. This is kind of information that I would  
8 encourage you to look at and then when we talk about the  
9 RFP I can be a little bit more specific about where I think  
10 we can strengthen things.

11 CHAIRPERSON MULLEN: So I know this is my  
12 second meeting, but I just need help from the group because  
13 my impression was that we were discussing the consent model  
14 -- and thank you for your presentation. I thought we had  
15 gotten to a certain point already with regard to the  
16 direction we were going in.

17 So I just need to hear -- I need to  
18 reconcile your presentation with my understanding of our  
19 having come to a certain point with an opt in -- or I'm  
20 sorry, an opt out model. So somebody help me with this.

21 DR. BUCKMAN: Well, I'll give you my  
22 understanding. My understanding is that point came to  
23 happen before HITE/Connecticut was formed, before this  
24 group right here was formed. So that's my understanding,

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1 is that all that was done before this Board actually  
2 existed, before this quasi public existed.

3 MR. KEVIN CARR: Well, the Committee started  
4 meeting and put together a recommendation and then expanded  
5 to include more consumer representatives at that time.

6 MS. ANDREWS: Any consumer could join.

7 CHAIRPERSON MULLEN: So we have two  
8 Committees --

9 MR. CARR: It cleared the consumer  
10 representatives at that time and so there has been some  
11 debate I believe around what the right approach is for the  
12 consent around patient care. I don't -- what I'm hearing  
13 is that at the population health set of use cases around  
14 public health reporting or certain types of quality  
15 reporting, other types of use of data that are not direct  
16 patient care related, that there's not necessarily a debate  
17 that that should happen automatically.

18 It happens today in the paper world  
19 automatically and it should continue to occur that way.  
20 The debate really is around that other set of use cases and  
21 really around patient care where you're specifically  
22 querying other providers and receiving data without the  
23 patient's consent and I think that the NHIN direct is  
24 another question which is a different set of technologies

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1 and a different consent model. But the patient care set of  
2 use cases I think is the one that's more under debate.

3 MS. BOYLE: So just on the history, the  
4 actual history.

5 CHAIRPERSON MULLEN: Yes, yes, thank you.

6 MS. BOYLE: Okay, so we had an Advisory  
7 Board that was formed by legislation and that Advisory  
8 Board was doing work related to the Strategic and  
9 Operational Plan. There was something very similar to  
10 this, actually a shorter version of it, that a presentation  
11 was given to the Advisory Board on the consent model. That  
12 model got incorporated into the Strategic and Operational  
13 Plan, that Advisory Board then voted on that Plan, adopted  
14 that Plan with the consent model, then we shifted to the  
15 legislation change.

16 We shifted to the HITE/CT Board and that's  
17 how we got to this issue of, you know, did we actually  
18 approve.

19 DR. AGRESTA: But the HITE/CT Board  
20 authorized this middle of the Plan --

21 (Indiscernible -- talking)

22 CHAIRPERSON MULLEN: One person -- sorry,  
23 one person.

24 DR. AGRESTA: Sorry -- yes, they approved

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1 the S&O Plan.

2 MR. STEVEN THORNQUIST: I think we've  
3 actually approved the consent model in the Plan as put  
4 forward.

5 DR. AGRESTA: Twice.

6 MS. ANDREWS: Well, I was not -- there were  
7 no consumer members on the original task force and I was  
8 brought in -- basically asked by the Speaker to come in  
9 around this specific issue. I did not know then that I was  
10 -- and I've asked actually in I think it was December or  
11 November to bring this up as an issue on the agenda. And I  
12 certainly -- it was not part of the discussion. I don't  
13 think I missed a meeting.

14 I don't think that was a specific policy  
15 decision that was -- I mean, if it was then I'd just go  
16 back to legislation to fix this. It's not -- it has to be  
17 -- I don't feel as a member of this quasi public whatever  
18 it is, that I had a clean vote on the consent model.

19 MS. MATTIE: May I ask a question? Other  
20 than the patient autonomy issue, what's the argument for  
21 opt out? Is it less administratively burdensome, would it  
22 facilitate the exchange of data and why is opt out the  
23 shining star? Could someone possibly educate me on that  
24 because it seems like there's a whole lot of issues around

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1 it.

2 You know is it a dollar issue, an  
3 administrative burden issue?

4 MR. LYNCH: Several things the Committee  
5 considered. One, there's research that show that people  
6 will not, I'll call it represent themselves, given a choice  
7 in many situations like this. So example were opting in or  
8 opting out of being a blood donor -- or not -- an organ  
9 donor on a license plate for example. The research showed  
10 that given the consumer in this case for being a blood  
11 donor on the license plate, if it was an opt in only 15/20  
12 percent would do it.

13 But if the language was switched to be an  
14 opt out only five percent or so would opt out of being a  
15 blood donor. So places felt okay, it's much more  
16 efficient, etc., than to have an opt out than an opt in.  
17 So from that perspective, efficiency. The other  
18 perspective is the perspective of changing your mind from a  
19 consumer perspective by having the data flow into the HIE  
20 but then have to have the opt out, then I think the  
21 opportunity exists downstream, etc., the data could still  
22 be retrieved instantly etc., without a lot of time delays  
23 etc., for patient care purposes.

24 Third, a lot of input from the medical

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1 community about the workflow issues and the efficiencies,  
2 etc.

3 MS. BOYLE: Just if I could add one more  
4 thing. I think the model that follows the law right now, I  
5 think that was on one of those slides, so it's a paper  
6 world now. But basically HIPPA allows the sharing of  
7 information from physician to physician. For example for  
8 treatment, unless the patient requires or requests a  
9 restriction and is accepted by the private provider, this  
10 model follows the existing law.

11 So I think that the thought was it was also  
12 already just formalizing an electronic world the process  
13 that the law already follows.

14 DR. BUCKMAN: Well, let me comment on that.  
15 While HIPPA technically may allow that, from a practical  
16 standpoint that is not how this medical system works  
17 especially in this state. If my patient was treated in the  
18 hospital and I'm seeing that patient for a hospital follow-  
19 up, it says right on the discharge instructions hospital  
20 follow-up with your primary care physician, you must see  
21 them in two days, okay.

22 The patient shows up in my office, I don't  
23 have those records, okay. I can't get those records that  
24 same day while the patient is there in the office. It's

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1 impossible. Even though HIPPA clearly allows that, it's  
2 impossible, okay. Because the hospital's attorneys said  
3 no, you have to have a release signed by the patient, in-  
4 hand, and then you can -- then that goes to medical records  
5 who has to approve it, copy out the records, fax them to  
6 you, maybe we'll have it to you in a day or two.

7                   You know, so while HIPPA may say yeah,  
8 that's it, that's not how we work. And I think what we're  
9 getting at is expectations so if that's not how we work,  
10 even though HIPPA allows it, to say that that's how we're  
11 going to do it, no one expects it.

12                   CHAIRPERSON MULLEN: Just having been on all  
13 sides of trying to get or send information, I think what  
14 all of us who've practiced medicine have to remember is  
15 that this conversation is going to highlight a lot of other  
16 problems in the system that aren't necessarily going to be  
17 fixed or caused by this, so.

18                   DR. BUCKMAN: Totally.

19                   CHAIRPERSON MULLEN: Maybe I should add this  
20 to my list of things we can think about at the Department  
21 of Public Health but that's part of our reality of trying  
22 to take care of patients also.

23                   DR. BUCKMAN: Exactly.

24                   DR. AGRESTA: But in our patient's

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1 expectation, our patient's expectation is that we have that  
2 information and if we can't retrieve it on demand -- I  
3 mean, I can tell you practicing now they want me to get  
4 that information ASAP and if we can't retrieve it then we  
5 have some challenges in meeting not only their expectations  
6 as well. And I think that's really a little bit greater.

7 DR. BUCKMAN: Yeah, one thing too John maybe  
8 said was that the opting out policy allows the information  
9 to flow in advance. They way I believe we were talking  
10 about the -- the way they were presenting an opt in policy  
11 was that the information would still flow because it's  
12 there for public health use.

13 (Indiscernible -- talking)

14 MR. CARR: It's all clarified. There are  
15 states that have implemented a policy that all types of  
16 data could flow to the Health Information Exchange for the  
17 purpose of either quality reporting or for public health  
18 reporting and the data transmission occurs at the time that  
19 the data is created, goes to the Exchange. And then on top  
20 of that there's a different consent approach for retrieving  
21 the information for the purposes of patient care.

22 So there's the data -- all the same data  
23 would go in and for -- it would be exactly the same model,  
24 you'd get the exact same types of data into the Health

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1 Information Exchange in both models it's just that one, for  
2 the purposes of patient care you would have to have a  
3 consent and be able to retrieve the data. And I would  
4 again point us to make sure that we don't include direct  
5 messages in that because that's a totally different process  
6 but if we're retrieving data --

7 MR. MASSELLI: Ellen, would that be  
8 acceptable to --

9 MS. ANDREWS: Yes, that's what we  
10 envisioned.

11 MR. MASSELLI: So you would say that would  
12 be fine. Have all of that data up there even though you  
13 might have a breach of security or something else on top of  
14 that --

15 MS. ANDREWS: That could happen, yes.

16 MR. MASSELLI: But everything -- nobody  
17 could stop that from -- under Kevin's model no patient  
18 could opt out of --

19 MS. ANDREWS: But not getting it out, right.  
20 And we also had to break the glass opportunity so that if  
21 you do go in and you're unconscious and the doctor -- and  
22 you just haven't had an opportunity to opt in or out, the  
23 doctor could break the glass. I just want to address the  
24 workflow at doctor's practices.

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1                   We did integrate the language with the HIPPA  
2 form already so there shouldn't be any other -- any new  
3 workflow burdens on staff. The issue of changing your  
4 mind, you're going to have to deal with that either way.  
5 People are going to have a right to opt in and opt out or  
6 opt out and opt in, and there's a -- I understand the issue  
7 around organ exchanges. This is a huge area of literature  
8 around whether people default or don't and the individual  
9 mandate gets all boxed up in this.

10                   But probably the closest direct, on-point -  
11 - Care Review Journal Health Affairs had an article on  
12 Massachusetts' opt in and 88 to 92 percent, depending on  
13 which town you pick, all choose to opt in. So it's very  
14 viable, you can have a well populated exchange. You do  
15 have to do a good job of education but we have to do that  
16 either way.

17                   CHAIRPERSON MULLEN: Okay, the other thing  
18 that we have to do is I think what we've been doing and  
19 what you've been doing, which is to continue to bind the  
20 work together as a cohesive Board. And this conversation  
21 actually I think is a move in that direction but it will  
22 only be so constructive if we get to the point where we end  
23 up thinking we had a presentation and then we're going to  
24 debate two different models.

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1           So, we've come to a point of saying there's  
2 some other conversation that needs to be had and I think  
3 it's been respectful and people have been listening but we  
4 have to figure out what to do next. I mean, the options  
5 could be -- I know you have your hand up but I don't want  
6 to forget what I was going to say. The options could to  
7 push forward a vote, which probably would make it hard for  
8 me to come back next month and make it hard for everybody  
9 to think they're collaborating.

10           Another option would be to sort of just  
11 throw up our hands and say forget it and go back to the  
12 drawing board, which I don't think is going to get us very  
13 far. Meg is shaking her head no, no, no in the back. And  
14 then there's the recognition that there's some of what  
15 everybody said that's more palatable to some around the  
16 table than to others, but technically when it comes down to  
17 the end is what are we going to do for the people of  
18 Connecticut and getting this Exchange going in a way that  
19 serves meaningful use, improvement of care, quality and  
20 everything else that we're here for.

21           And along the way at some point I'm going to  
22 be able to sit back like this right behind Dr. Agresta  
23 because DPH is going to have less and less of an upfront  
24 role in this. But I can't do that yet but I can affirm

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1 that you're going in the right direction and we need to --  
2 not in the interest of time because I have a lot of time,  
3 but in the interest of moving forward declare where the  
4 Board should go next with this. Are you going to answer  
5 this question?

6 DR. BUCKMAN: Yes.

7 CHAIRPERSON MULLEN: Okay.

8 DR. BUCKMAN: I wanted to ask a question of  
9 Peter first. Peter --

10 CHAIRPERSON MULLEN: Wait a minute, you said  
11 yes.

12 DR. BUCKMAN: Yes, but I need to ask Peter a  
13 question first.

14 CHAIRPERSON MULLEN: Oh, okay.

15 DR. BUCKMAN: Is there any reason why the  
16 RFP can include language asking either system to be able to  
17 be implemented?

18 MR. COURTWAY: The language in the RFP is  
19 quite agnostic in this regard. What it does ask for is the  
20 capability of the vender and what their configuration is to  
21 allow different configurations. It doesn't say one way or  
22 the other way --

23 DR. BUCKMAN: So it doesn't matter.

24 MR. COURTWAY: -- it's going to say show us

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1 all the different options that are available by your  
2 technology or your technology that you're --

3 DR. BUCKMAN: Alright and timeline uses, we  
4 need to be able to say which way we want to go by June or  
5 by May?

6 DR. AGRESTA: You've got to say by May.

7 DR. BUCKMAN: By May, so my motion is that  
8 we send this issue back to the appropriate Committee for  
9 presentation and vote at our May meeting.

10 MS. MATTIE: Well, may I just say something?

11

12 CHAIRPERSON MULLEN: I have to address Dr.  
13 Agresta.

14 MS. MATTIE: Oh, I'm sorry.

15 DR. AGRESTA: I want to recognize that  
16 there's been an enormous amount of work done by the Legal  
17 and Policy group. It has been incredibly challenging I  
18 think to try to move through all this and I think that in  
19 order to make it effective for them it might be wise to  
20 move it to another Subcommittee, actually how to take a  
21 debate in that Subcommittee so that they can come back with  
22 it.

23 Perhaps the Business and Technical  
24 Subcommittee or some other place with some guidance

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1 perhaps? Lisa, I'm going to defer to your thoughts for  
2 that. I just know that it's very -- I know that you  
3 couldn't --

4 MS. BOYLE: I'm sorry, but I can't endorse  
5 that. I think we need to bring this to a head, we need to  
6 move on with the HIE -- whatever way we're going, this  
7 Board needs to make a decision.

8 CHAIRPERSON MULLEN: I agree with you and I  
9 think that there's some other conversation that has to go  
10 forward for people to feel good about making a decision and  
11 that's where Dr. Agresta is going right now.

12 DR. AGRESTA: Yeah, I'm hearing enough  
13 around the room that I feel like we need to make it happen  
14 by our next Board meeting. We need to put it on the agenda  
15 for a vote and we need to vote one way or the other so that  
16 we do move on because we can't keep bringing it back.

17 MR. MASSELLI: But it shouldn't delay our  
18 action --

19 DR. AGRESTA: It shouldn't delay our action  
20 and I think that we need to be respectfully communicating  
21 with each other around this issue as well including  
22 anything that occurs outside of our Board meetings so that  
23 the legislative agendas that are brought forth or anything  
24 like that, we need to be able to be respectful of each

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1 other in kind of moving forward as a group. And that's how  
2 I would -- and so I kind of see it a little bit.

3 MS. KELLY: I think that the conversation  
4 that should occur needs to have -- and I think it's been a  
5 weakness of both the e-Health process and the process here.

6 I think the e-Health process, which I was a part of it and  
7 I think we did a fantastic job, but it was primarily  
8 exclusively, almost exclusively, consumer. There's lots of  
9 issues here that -- and I think the other Committee was  
10 mostly providers, you know.

11 And the reality is in this new age, in this  
12 new thing we're building, if it's going to work we have to  
13 consider all the parties and their perspective. It's great  
14 for me as a consumer to say I want these things. But there  
15 may be reasons that I don't know that it either can't be  
16 delivered or maybe it should be exactly what I want. And  
17 so I think whatever we create should be -- there definitely  
18 has to be consumers because these are my health records,  
19 you know, what I'm talking about, your health records.

20 But I think we all -- it shouldn't be just  
21 shifted to another Committee. We should think about what's  
22 the composition of people that should be sitting around the  
23 table having this discussion. The immediate problem is the  
24 RFP and I want this to go forward in the worst way, because

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1 I'm a very big advocate. But when I looked at the RFP, I  
2 don't see even what you adopted in here.

3 MS. BOYLE: No, it's not in there.

4 MS. KELLY: And it behooves to question are  
5 we asking venders about this or not? What is the --  
6 because this is what's confusing me because I have legal  
7 responsibility by being on this quasi public agency. If  
8 this thing goes up this fall, who's responsible for working  
9 all this out? What's the vender's role and where -- and  
10 you know, the budget.

11 The budget worries me, you know, because if  
12 in fact we spend most of our money, which it sounds like  
13 ONC wants us to do putting this up, who's going to be left  
14 to work out these issues and that's what scares me and why  
15 I probably won't vote for this tonight. Not because of  
16 even the issues I'm bringing, I don't even see the things  
17 that you adopted reflected in the RFP.

18 CHAIRPERSON MULLEN: So I think if we can  
19 resolve how we're going to finish out getting the consent  
20 model done -- and I'm not ignoring you, I'm really not.

21 MS. BOYLE: No, no.

22 CHAIRPERSON MULLEN: We can get into a more  
23 substantive discussion about the RFP, I would like us to be  
24 able to do that. So we have put out here that there's not

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1 a vote tonight on the consent model, we've said that. I  
2 think everybody honors that but we can't end the  
3 conversation without a plan and a plan to bring it to  
4 closure and the willingness to come back and then say there  
5 were people who were authorized to come back to us with  
6 recommendations because that's how we're going to keep  
7 moving forward.

8 And that's how we're going to have something  
9 that feels good to you, feels good to all of us, in the RFP  
10 which Peter has already said is relatively agnostic in this  
11 area. It's sort of a hole, we need to do that work to get  
12 it in there.

13 MR. COURTWAY: Not into the RFP.

14 CHAIRPERSON MULLEN: Well okay --

15 MR. COURTWAY: We need to get through that  
16 process --

17 CHAIRPERSON MULLEN: Right, okay.

18 MR. COURTWAY: -- before we actually can  
19 figure and -- you know, before we actually finish the  
20 selection.

21 CHAIRPERSON MULLEN: Okay, so can we mainly  
22 finish agenda item No. 4 with a plan? And we can exercise  
23 a motion --

24 DR. AGRESTA: I'm trying to think of the

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1 best motion.

2 MR. THORNQUIST: Well, he had talked about  
3 pitching this to another group. What group do you want to  
4 pitch it to? Is there a standing Committee or do you, as  
5 was suggested, want to create a separate small group to  
6 talk about this? I don't know -- I mean, who would have  
7 representation of both consumers, providers and some  
8 technology because we're going to need all three of those  
9 in there?

10 CHAIRPERSON MULLEN: And Legal.

11 MR. THORNQUIST: And Legal, to make that  
12 decision.

13 MR. LYNCH: I think the current policy has  
14 always been open and anybody who showed participated, etc.  
15 So it's been open, there have been other people on there  
16 who participated so I don't have a problem with the current  
17 Policy Committee doing that. It can have that. Ultimately  
18 it's not like there's a representation of X, Y and Z body  
19 on any of our workgroups.

20 So to me that's the most appropriate place  
21 but the problem is it gets into additional subject matter  
22 that may be other policy groups in the future, which is  
23 consumer education which we haven't really -- one of the  
24 reasons I've requested a designation to talk about other

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1 workgroups, we desperately need to talk about where does  
2 consumer education fit because it fits in every one of our  
3 Committees in some sense but we need to talk about that  
4 because that's part of what's missing here is how do we  
5 address the education, whatever model we come up with.

6 DR. AGRESTA: So what I'm hearing is that it  
7 would be great if we had subject matter experts across a  
8 couple of different realms sit down and kind of maybe come  
9 back to this other group with a proposal. The subject  
10 matter experts have to be -- there has to be someone who is  
11 kind of aware of consumers and be connected to that.

12 There has to be somebody that understand how  
13 actual health information technology exchange works. You  
14 know, you have to be able to understand what's possible to  
15 actually implement within a technical framework because you  
16 can have the best consent policy in the world but if you  
17 can't implement it technically it's not really very  
18 helpful. I think there has to be somebody that understands  
19 the clinical workflow and am I missing --

20 MS. MATTIE: Legal --

21 DR. AGRESTA: -- the legal framework.

22 MR. CARMODY: The only thing I'd add Tom is  
23 that sometimes when I've heard the conversation develop  
24 tonight, we have to be cognizant of cost at the end of the

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1 day. When we started off with this Board we talked about  
2 keeping the layer associated with administration to a  
3 minimum. And so what we'll find -- you know, I heard like  
4 we're going to do PHR pieces and whatnot. That's adding on  
5 to what the original adoption of what our strategy was,  
6 which was three main technical IT assets. And even when we  
7 get to that there's still going to be a layer of operations  
8 that we're going to need to be cognizant of.

9 So what we'll quickly find is that people  
10 are willing -- they like services but they're unwilling to  
11 pay for them and we haven't talked about how we're going to  
12 pay for this yet. And part of the RFP process was to help  
13 guide us in a modular way as to what our costs are going to  
14 be. So if we put in things into the what we are and all of  
15 a sudden it starts to build, what I'm concerned about is if  
16 we're going to get ahead of ourselves as to what can  
17 actually do.

18 MR. WOLLSCHLAGER: So I heard what you said  
19 Dr. Agresta, and I -- having staffed the Financial  
20 Committee I support your comments. Would you entertain a  
21 motion to -- would you like to try to turn that into a  
22 motion of some sort Dr. --

23 DR. AGRESTA: Yeah, right so anyone want to  
24 help me create the motion here?

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1 MR. MASSELLI: Well, we've got to create a  
2 Committee, four members of the Board who will come together  
3 and -- from the various disciplines, consumers, HIT-  
4 knowledge based medical side to -- who's the fourth one  
5 there?

6 MR. WOLLSCHLAGER: Legal and Financial --

7 MR. MASSELLI: Legal and Financial --

8 MR. WOLLSCHLAGER: -- so that's five.

9 MR. MASSELLI: -- Legal and Financial to  
10 come back with recommendations about the course of  
11 direction that the Authority should move on the consent  
12 issue. And they don't have to come back by consensus  
13 because --

14 MR. WOLLSCHLAGER: They may not have  
15 consensus.

16 MR. MASSELLI: They may not have consensus  
17 but they'd come back with the decision points that we have  
18 to address.

19 MR. WOLLSCHLAGER: So that's your motion, do  
20 we have a second?

21 MR. THORNQUIST: I'll second.

22 CHAIRPERSON MULLEN: Discussion?

23 MR. WOLLSCHLAGER: We have a second by Dr.  
24 Thornquist, discussion?

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1 MR. COURTWAY: Yes, I question the wisdom of  
2 taking this out of the Legal and Policy arena and there is  
3 a tremendous amount of work. These laws are somewhat  
4 complex. You know, I think that at the end of the day I  
5 think that what we'll find is that we're closer and talking  
6 about the same things and the same protections than what it  
7 sounds like at the meeting tonight.

8 MR. MASSELLI: But I think Dr. Mullen had  
9 the point earlier, which was it just needs to -- people  
10 need to be talking to each other and trying to develop that  
11 sort of understanding of each other and where they come  
12 from. And that may help to incubate for a month, hopefully  
13 not hardened positions but rather I think Dr. Agresta said  
14 it as well, we want everybody working together not outside  
15 of the box, inside the box saying let's not do an end run,  
16 let's try to keep it here, resolve it here and there might  
17 be some accommodations that need to be made.

18 And I just think that you're not going to  
19 get the perfect group but this might help us.

20 MR. COURTWAY: So this is -- and I agree but  
21 I would add those other domain experts under the rubric of  
22 the Committee so that it can play itself out because I  
23 think we can bring different experts to the table to talk  
24 about how it practically works.

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1 MR. MASSELLI: Yeah, and I'm just thinking  
2 about the geopolitics of the thing, making sure consumers  
3 have the same -- have a reasonable representation, so.

4 MS. BOYLE: Can we just look because I think  
5 -- who's on the Committee and maybe decide that we need to  
6 add something as opposed --

7 MR. MASSELLI: Sure.

8 MS. BOYLE: -- you know, because I think we  
9 could -- the list is in the presentation on page 2.

10 MS. KELLY: So just to -- and you know, and  
11 maybe it's some piece of this like maybe it's -- maybe we  
12 take away from some of this, but I think if we are trying  
13 to form a Committee that represents all interest and if  
14 there is a sentiment to use some of the existing Committee  
15 then maybe we look at the existing Committee and figure out  
16 if there's a way to -- what needs to be added or taken  
17 away. And some of these people are more involved than  
18 others.

19 MS. ANDREWS: Can I just say something about  
20 sort of the process of the Committee? I know I'm listed  
21 there but I'm not actually a member of the Committee. I  
22 never agreed to be on the Committee. I heard about this  
23 all happening from someone who doesn't want their name  
24 used. It was not -- I did not find out about it in a

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1 public process. The decision was already made before I  
2 came to the public forum, the recommendation had been sent  
3 in, then they invited me to come and meet with this  
4 Committee and they had already made up their decision.

5 It was clear that it wasn't going to change.

6 I don't think going back to that same group is going to  
7 get you a different answer.

8 CHAIRPERSON MULLEN: So my question is  
9 honoring the history that you just reported, can we move  
10 forward? Can we move forward?

11 MS. KELLY: As the other consumer  
12 representative, I believe we should do it with Legal and  
13 Policy. I think what has gotten us into some trouble here  
14 is just -- it's unfortunate because there was a group and  
15 then this group got created, alright. I also didn't come  
16 on right at the beginning. There was a delay in my  
17 appointment, alright.

18 So it is true what Ellen says, we were  
19 handed something, there wasn't much discussion, it was said  
20 this is the way it is, it's been decided. It was said  
21 today that we voted to send the policy -- the future plan  
22 forward. I never voted on that because I hadn't been  
23 appointed at the time, alright. I was asked to be part of  
24 the Legal and Policy Committee. I've been one meeting by

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1 phone. I was at the last meeting and I participated and  
2 people I think were respectful, and I followed up with some  
3 of the materials I distributed today because I just wanted  
4 to be clear the perspective I was bringing.

5 So I think that some of this is unfortunate  
6 because we had one group, we now have a different group and  
7 I believe that we're all smart, professional people and I  
8 think this is the right configuration. Maybe we need to  
9 add something but I do think it needs to be a mixture of  
10 consumer and provider because there are different  
11 perspectives and I've learned a lot from hearing the  
12 doctor's perspective and the clinic -- you know, the  
13 hospital's perspective. I've learned as much from that as  
14 I have from talking to other consumers and I think the  
15 right answer is going to be all of that.

16 I do want to say to what Dan said, I'm  
17 really scared about the money too. And what I don't want  
18 to end up with because we don't have any money, that we've  
19 created a system that isn't going to be protecting my  
20 health quality down the road. So I do agree that -- but we  
21 can't say we're not going to do something because we don't  
22 have the money. You know, the Policy has to drive what we  
23 create not the other way around or we're going to end up  
24 taking steps backwards, which is not what we're trying to

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1 do here. We're trying to improve health care for all of  
2 us.

3 CHAIRPERSON MULLEN: Okay, and this is the  
4 discussion that's followed the motion and the second okay.

5 MS. KELLY: I oppose the motion and say we  
6 should work through the existing Committee and add whoever  
7 it is that we need to add to that Committee.

8 MR. CARMODY: I guess that the only thing -  
9 - that the conversation is is I would also like to see it  
10 stay with the Legal and Policy Committee. Maybe they need  
11 to go back and put in -- and maybe sit down if they want to  
12 add a couple more on the consumer side, just to look  
13 through and see if you can challenge the policy overview  
14 like in how you approached it to see if -- I think part of  
15 it is going to get into timing and then workflow and those  
16 are going to -- if you put the money aside for a minute  
17 it's going to be timing and workflow what we can get up and  
18 running fairly quickly.

19 I mean, if we start to impose new processes  
20 I think that will be a concern. Breaking or having  
21 contradictions of federal law, what works and what doesn't  
22 work -- I mean, maybe just -- like with a fresh set of  
23 eyes. And my only question to raise is that if people  
24 start to get so entrenched, I mean if we -- if they came up

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1 with anything other than looking at opt out policy could  
2 you accept that if you went through and looked at it. So  
3 if you're going to be on the Committee, I think everybody  
4 who goes back to the table has to go okay, let's just go  
5 back and challenge it to see if he had that perspective and  
6 then see where you come out.

7 I'm not quite sure either way -- I mean,  
8 there's going to be pros and cons if people are so  
9 impassioned either way you're never going to get to the  
10 compromise. And you may never agree in total but I think  
11 maybe an earring with different viewpoint to maybe press on  
12 those and say hey, maybe that was a solid foundation.

13 MR. MASSELLI: You know, just as maker of  
14 the motion the purpose here was to bring five members of  
15 the Authority together because we have to work together.  
16 We have now heard from our other members who've been on the  
17 Committee, they're not Authority members, and we've had had  
18 their input. And I don't think we need to revisit it. It  
19 seems like we have an obstacle to overcome, which is  
20 understanding this, and we're going to have to work  
21 together and this is important.

22 And so my -- if I had to name five right now  
23 it would be Ellen, Dan, Tom, Lisa and Brenda probably  
24 because it sort of has a representative group. It's

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1 Authority members and we have to come up with this and it's  
2 not about a vote because right there it looks like it may  
3 be three to two, but it's about trying to come and find  
4 some common ground. And we already have heard, and Lisa's  
5 done a great job with everybody else, we know their  
6 opinion. But now we're in a different phase of our  
7 operation. We're the Authority, we have to come and see if  
8 we can break bread with each other and deal with difficult  
9 issues. So that's why I want to keep it there and I  
10 appreciate everything -- and that's no knock on anybody on  
11 the -- who's been on that Committee but it's about a new  
12 phase that we're in and it's an important issue.

13 MR. WOLLSCHLAGER: Other discussion on the  
14 motion?

15 DR. BUCKMAN: I would just add in looking at  
16 the list there I see one private practice, one M.D. on the  
17 list. I don't know if that M.D. is an active participant  
18 in --

19 MS. BOYLE: Yeah, he is. He was actually a  
20 consumer representative to the Advisory Board just for --  
21 that's how he was appointed to the Advisory Board.

22 MS. KELLY: We're all consumers but --

23 MS. BOYLE: Yeah, just in terms of his  
24 initial appointment.

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1 CHAIRPERSON MULLEN: Okay, so --

2 MR. WOLLSCHLAGER: So we have a motion that  
3 was seconded, to form a five person Committee --  
4 Subcommittee members of the HITE/CT that would represent  
5 the consumer, HIE technical knowledge, clinical, legal and  
6 financial expertise to take on -- to review the issue of  
7 consent policy and come back with recommendations to this  
8 body next month. Is that accurately reflected?

9 MR. MASSELLI: Yeah, and you've heard my  
10 side recommendation but --

11 CHAIRPERSON MULLEN: Well, you can delegate  
12 that to the co-chairs.

13 MR. MASSELLI: Yeah, delegated to the co-  
14 chairs.

15 MR. WOLLSCHLAGER: Alright, so it would be  
16 probably more a work group than a Subcommittee --

17 MR. MASSELLI: Absolutely, yeah.

18 MR. WOLLSCHLAGER: Alright, so you want to  
19 take a vote on this or do roll call if you folks need it or  
20 we just -- all in favor say Aye?

21 VOICES: Aye.

22 MR. WOLLSCHLAGER: Opposed?

23 MS. BOYLE: I'm going to abstain.

24 MR. WOLLSCHLAGER: Abstained.

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1 MALE VOICE: Opposed.

2 MR. WOLLSCHLAGER: We have four -- the Ayes  
3 have it. And we'll leave it to maybe this body to decide  
4 who's going to be on that but I would defer maybe to the  
5 Executive Committee to figure that out and we'll go with  
6 yours. Okay, so now we're down to 10 minutes for a half  
7 hour presentation and 15 minutes worth of public comment.

8 MR. COURTWAY: Okay, now for something less  
9 controversial. The 92 pages that you received last week,  
10 just to put it in context in regard to the different policy  
11 issues is that the RFP is not meant to embody any  
12 particular policy. It's not meant to give any particular  
13 direction of how we implement the exchange and that's why  
14 Brenda when you read, you didn't see anything in there  
15 about what we're really doing or what our actual  
16 requirements are because what I found in looking across all  
17 of the health information exchange technologies that are  
18 out there, is they all have different strengths and  
19 weaknesses and they're all in different stages of  
20 development.

21 So rather than preclude any of the  
22 particular vendors who are in the market space the idea is  
23 to cast a wide net to say what are your capabilities, what  
24 can you do in this configuration models, whether or not

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1 it's consent, whether or not it's release, whether or not  
2 it's data aggregation, whether or not it's what they can do  
3 with PHR, what they can do with registries and whatnot,  
4 it's meant to get the broad capabilities of the venders who  
5 are in the marketplace. And I am expecting that we will  
6 get a fairly wide response from the marketplace. I think  
7 that in the days after the RFP is led it's all about  
8 getting to the next stages, which are the definitions of  
9 what lens will we look at those responses in, what do we  
10 think we're going to do with some of these policies and  
11 what flexibility do we need to have built into this in case  
12 the policies change because you don't buy something today  
13 for something you're going to do tomorrow.

14           You buy something today for something that's  
15 going to be the flexibility, handle a traumatically  
16 changing landscape of policy and process inside of this  
17 nation as it moves forward. So you don't see a lot of  
18 details in there. I know that we did send it out last  
19 week. All of the responses that were received from Board  
20 members so far have been accepted and are built into the  
21 next round of the RFP ready to go. And what I'm looking to  
22 do is to check your minds in terms of what you saw, what  
23 questions you have, are they in regards to structure or why  
24 it's structured that way so that we can get the final RFP

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1 out the door in time for our March 30th dates.

2 So Brenda, I know that you had some  
3 questions about what you didn't see. I'd like to try to  
4 answer those questions that were slated for this timeslot.

5 MS. KELLY: Yeah, well my concern was that -  
6 - I understand what you're trying to do, I think. And that  
7 is have a fairly open-ended thing so we can really get an  
8 idea of what people are capable of doing.

9 MR. COURTWAY: Right.

10 MS. KELLY: And so I think that to do that  
11 on the issues -- the consumer issues, then you need to have  
12 a little bit more language that would allow -- tell the  
13 vendors that you want them to talk about that.

14 MR. COURTWAY: Okay.

15 MS. KELLY: Alright, and there was one  
16 particular thing -- I didn't see a lot. These little flags  
17 are where I thought you came close to talking about it, but  
18 the place that kind of got me -- upset is probably the  
19 wrong word, but if you look at page 6 right at the  
20 beginning and you're talking about meaningful use and you  
21 say these goals may evolve to include support for  
22 additional meaningful use stage one goals and additional  
23 meaningful use requirements including but not limited to,  
24 providing patients with an electronic copy of the health

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1 information record, sending reminders to patients,  
2 recording advance directives, etc., etc., okay.

3 First of all, the tone got me a little bit -  
4 -

5 MR. COURTWAY: Okay.

6 MS. KELLY: -- but I think it's a difference  
7 of perspective. I'm a patient so I'm saying you shouldn't  
8 be doing that for meaningful use you should be doing that  
9 because this is what I as a patient need. And even if they  
10 never put it in meaningful use, you should be doing it. So  
11 that was just my little red flag that went off.

12 But those are the kinds of things I think we  
13 should be asking, but then there's to talk about later on  
14 when you have the questions later on in the RFP. Those  
15 kinds of questions.

16 MR. COURTWAY: So if we changed the language  
17 to please describe your capabilities of doing this --

18 MS. KELLY: That's right, that's right.

19 MR. COURTWAY: -- so the reason why we tie  
20 it to meaningful use is that stage two and stage three are  
21 still unknown and we want the venders to commit to their  
22 adherence to whatever is coming and say I think we can  
23 cover that in a different area and make it clear that  
24 please describe your capabilities.

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1 MS. KELLY: And I understand that right now  
2 we want doctors to be able to come to meaningful use and in  
3 order to come to meaningful use they have to have a system  
4 to hook into. So I do understand that that's driving  
5 things and that's okay. But the consumer tone needs to  
6 also be driving. So I do think asking some of those  
7 questions other places at -- you're asking the vender to  
8 respond to it would start to get at what my concern is.

9 MR. COURTWAY: Okay.

10 MS. KELLY: The other issue is in John's  
11 presentation, which I thought was excellent, to do some of  
12 the things that Ellen has pointed out on the opt in versus  
13 opt out, if it's true that technology isn't capable of  
14 doing some of those things that speaks even more to asking  
15 the vender what of those things can they do, you know, or  
16 would envision being able to do in the future.

17 So that would, I think, strengthen the RFP  
18 and I don't think it would be that hard quite frankly. But  
19 right now there's not much there other than this little  
20 beginning introduction where you raise the issues question.

21 I don't really see it coming through later on.

22 MS. BOYLE: I thought I saw something in  
23 there about the ability to segregate the data.

24 MR. COURTWAY: Ahum.

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1 MS. BOYLE: Like there is, right? I don't  
2 know exactly where now but I think it's in there somewhere.

3 I don't know, you probably know it better than I do but --

4 MS. KELLY: Here it is. It is there, it is  
5 there. And so it's on page 31. I went through -- I did  
6 this very quickly so I may not have picked up everything  
7 but there are a few little comments. But the overall gist  
8 of it isn't there I guess is what I'm saying.

9 MR. COURTWAY: So we'll strengthen the  
10 describer capabilities so that it's clear that we're  
11 interested. Whether or not we purchase or not gets back to  
12 Dan's question of how much of this is actually affordable  
13 with the business model but we'll put that in there.

14 On the issue of the consent options, the  
15 reason why we haven't steered down one path or the other  
16 or we haven't given specific use cases is the technical  
17 group felt that it was all about the configurability of the  
18 system. So although it's already in there, I sort of hid  
19 it in there, you can't really cross-reference it. One of  
20 the things that we do ask for is the configuration manuals  
21 for the Exchange itself.

22 So in the configuration manual is the actual  
23 documents that you're going to get if you bought the  
24 product. That's where you'd be able to see for sure that

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1 if you put this check mark, this check mark and this check  
2 mark, this is the level of protection it would provide.  
3 That there's a check mark for opt in and check mark for opt  
4 out, a check mark for specially protected, a check mark for  
5 not this particular provider or only this class of  
6 providers, because they will tell you from the HIE  
7 landscape they are all over the board and really the devil  
8 is in the detail so it's more looking at how they actually  
9 can figure it that will inform us. And in that review  
10 process for the RFP, that's why policies need to be blended  
11 and harmonized in time for that review so we can see if the  
12 configuration is going to actually support it.

13 It gives us the flexibility for the future,  
14 but you will not see in the RFP the specific cases of how  
15 that will be. It's not designed to try to embark on that  
16 policy --

17 MR. WOLLSCHLAGER: Peter, I'm sorry if I  
18 could just in the interest of time here as I'm tracking  
19 this, you talked about trying to get to a place where you  
20 can meet the March 30th or April 1st deadline.

21 MR. COURTWAY: Yeah.

22 MR. WOLLSCHLAGER: Do you have an action  
23 item that you're looking for?

24 MR. COURTWAY: I do. I don't know whether

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1 everybody got their comments in to Laurie. I do see some  
2 comments directed I sent into Laurie. So far they've been  
3 accepted. Brenda, certainly we can add those  
4 clarifications there. Is there any other comment or  
5 concerns related to what is missing in the RFP?

6 MR. JOHN GADEA: I've got a question for you  
7 if you don't mind.

8 MR. WOLLSCHLAGER: Sure.

9 MR. GADEA: It's more technical, it's got  
10 nothing to do with the other matters but I was looking  
11 through this and we've had some experience with RFPs and  
12 the dates I see in here don't really -- they're not really  
13 conclusive dates. And it seems like it's somewhat open  
14 ended. Now Tom had brought up the issue of this is so  
15 massive it's going to have to be in phases, but even the  
16 phases aren't potentially requested nor are the timelines  
17 for those phases. At least the first phase request and  
18 what happens in the second phase is a whole other issue.  
19 But the question is, is the RFP for phase one or is it an  
20 RFP for phase two, three, all the way to the end?

21 And the reason I ask is because we've  
22 recently in our own Department had a situation -- luckily  
23 we've been on the sideline and it involved a hub system, an  
24 information hub, interstate as opposed to intrastate, and

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1 they had a consortium or a conglomeration of IT companies  
2 and software that had been using federal money to come up  
3 with this hub system that's been going on for seven years.

4 They've gotten friendly with the Feds, they've gotten  
5 friendly with certain states and it's always next phase is  
6 coming, we have to extend it, whatever. And now all of a  
7 sudden another organization has come out and said we can  
8 have it up and running in six months and it won't cost the  
9 states anything and now everybody is screaming that's not  
10 fair and that's this and that.

11 And so I don't really see anything in here  
12 and again, it just may be because I'm not seeing it but it  
13 seems to be rather open-ended.

14 MR. COURTWAY: It's designed to get to where  
15 the ONC wanted for us to be able to take any willing  
16 provider in the August timeframe to do the testing. So the  
17 dates predominately are driven around bringing the Exchange  
18 live in it's first adopted mode in the July timeframe to be  
19 able to bring the first phase up in August.

20 The RFP is meant to span all of the possible  
21 products that we would offer through the exchange but is  
22 not meant to commit to all of the products that are in the  
23 portfolio. So it's meant to cast again the wide net to say  
24 who of all of the players in the landscape give us the

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1 winds that we need and the future flexibility of where  
2 we're going. And we won't know what those future pieces  
3 are until after we get through more of the detail.

4 MR. GADEA: And you're absolutely right but  
5 one of the things that I'm a little paranoid about is if  
6 you pick the right vender, which I'm sure we will, and you  
7 get through a phase, let's say phase one, and all of a  
8 sudden you're ready to move into phase two but some new  
9 vendors come on the scene, are you bound by this RFP  
10 because you've basically put it out with the first vender  
11 and then plunge away from it and come up with any sort of  
12 new innovative technology to address that because you've  
13 already kind of had the RFP going out with the first  
14 vender.

15 DR. AGRESTA: Is that a contract issue or an  
16 RFP issue?

17 MR. COURTWAY: It's a contract issue.

18 MR. GADEA: Well I don't know, but does it  
19 need to be addressed in here so a vender doesn't get the  
20 idea that they get the whole kit and caboodle.

21 MR. COURTWAY: Yeah, I think that the RFP is  
22 clear that we're not committed to taking any or all so  
23 that's why an open-end and then the contracts we'll issue  
24 about who we commit and what period of timeframe will be -

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1 - you know, part of the contracting process.

2 DR. AGRESTA: But John, I think those a  
3 really excellent points that we need to be very vigilant  
4 about as we kind of even define how we're evaluating these  
5 things.

6 MR. WOLLSCHLAGER: Other questions for  
7 Peter?

8 MS. MATTIE: May I just -- just a few things  
9 and I apologize because I'm sure it's in here but there  
10 should be some easement regarding full disclosure about  
11 relationships with Board members or members of DPH and my  
12 concern as a Board member and here again, I apologize, I  
13 tried to be very dutiful to the reading, but I did  
14 something else this weekend.

15 MR. COURTWAY: We're covering the two --

16 MS. MATTIE: I know there's a general  
17 statement in here that we have complete autonomy in terms  
18 of setting up a Review Committee. I just want to be  
19 dutiful to the fact that we want to be unbiased in any of  
20 the decisions. We also want recommendations and we also  
21 want full disclosures about relationships and I just want  
22 to put that on the record.

23 MR. COURTWAY: Okay. Dan?

24 MR. CARMODY: The question was around I

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1 didn't see a lot in there about business process. If we  
2 start doing the number of matching on identification are  
3 they -- was the vender going to be responsible for dealing  
4 with all of that operational aspects of limitation. I  
5 didn't get that from looking at it but maybe I missed it,  
6 so.

7 MR. COURTWAY: Well, we should take a look  
8 and make sure that particular aspect is clear because what  
9 it's supposed to get us from the venders is if we outsource  
10 the whole thing to you what does that look like, you know,  
11 you ought to be able to get it up in that timeframe. If we  
12 do it inside what does that look like in terms of the  
13 number of FTEs or people --

14 MR. CARMODY: I saw that, I didn't see -- I  
15 saw where you went back and forth and said included in that  
16 but I didn't see like the number matching process, the  
17 government's process -- when you start taking those sources  
18 of data and having to match them all in, so never mind the  
19 fact that you have to do member matching on a regular  
20 basis, I didn't see that in there. So that would be my  
21 only question. I did see how you tried to say show me an  
22 all end piece, so just make sure that that's included.

23 MR. COURTWAY: Okay, we'll strengthen that  
24 component of it to make sure we have that.

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1 MR. CARMODY: So I hear that folks still  
2 want to be able to have an opportunity to provide you  
3 comment and that you're incorporating comments so it's  
4 still a fluid document.

5 MR. COURTWAY: Well, we need to --

6 MR. MASSELLI: Can we make a motion to  
7 approve the proposal -- well, I make a motion to approve  
8 the recommendation for the RFP with the comments --  
9 incorporating the comments that Angela and Brenda and Dan  
10 have made and leave it open to the discretion of the  
11 Committee. Peter, are you the head of the --

12 MR. COURTWAY: I am.

13 MR. MASSELLI: -- the discretion to add some  
14 subsequent comments that might come in prior to the RFP  
15 that we move forward on that timetable.

16 MR. WOLLSCHLAGER: Do we have a second?

17 MR. CARMODY: Second.

18 MR. WOLLSCHLAGER: Seconded by Dan.

19 Discussion? All those in favor?

20 VOICES: Aye.

21 MR. WOLLSCHLAGER: Opposed? Ayes have it.

22 MR. COURTWAY: I would like to receive any  
23 comments, you know, really by Wednesday of this week if I  
24 could. In all fairness we have still some work to do to

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1 finish it up so we can get this thing out in time.

2 MR. WOLLSCHLAGER: Great. Alright, so  
3 comments due to Peter by this Wednesday, close of business.  
4 Alright --

5 MR. CARMODY: Congratulations Peter, there  
6 was a lot of work.

7 MS. MATTIE: Thank you, it was a tremendous  
8 amount of work there, my goodness.

9 MR. WOLLSCHLAGER: So I don't know if we  
10 need a motion to extend this meeting in order to -- or do  
11 you just want to open it up to the public?

12 CHAIRPERSON MULLEN: Right, we didn't move  
13 to start late and I acknowledge that we started late, I  
14 think at least 10-minutes late, so I'm only saying that now  
15 because I don't want to convey the impression that we have  
16 abbreviated the time for public comment, okay. Thanks.

17 MR. WOLLSCHLAGER: Alright, so is there  
18 comments from the public we'll open it up now. We'll ask  
19 you to come up to the table so you can be on a microphone.  
20 Comments from the public? Yes sir, come up closer to the  
21 table.

22 MR. DOUG ARNOLD: My name is Doug Arnold and  
23 I'm the CEO of Medical Professional Services. I know a  
24 number of you, I served on the e-Health Connecticut Board.

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1 I'm one of the direct assistance contractors to the Rec  
2 and I'm heavily involved in health care IT in Connecticut  
3 and I'm leading the Direct project pilot in Connecticut.  
4 So I wanted to just give you a very quick snapshot of where  
5 we are in the direct project and specifically some of the  
6 substantial challenges we're facing and ask your input and  
7 assistance.

8 First thing you need to know is that the  
9 Direct Project in Connecticut is totally on a voluntary  
10 basis. There is no money allocated from ONC or anybody to  
11 do that. So it's all sweat equity by me and a bunch of  
12 other people. We are working with a number of  
13 organizations around this table, the community health  
14 centers, Middlesex Hospital, Quest Med plus labs and a  
15 number of technology vendors to work with us to help  
16 implement and facilitate point-to-point secure electronic  
17 exchange of health information between trusted -- basically  
18 provider-to-provider in support of the number of the use  
19 cases within meaningful use.

20 A primary care physician sends referral  
21 information to a specialist, labs send lab data back and  
22 forth. And we've had a number of technology companies,  
23 some of the biggest EHR providers in the country, who have  
24 been at the table and have participated in the planning

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1 around the Direct project. And we are one of the -- I  
2 think there's eight pilots in the whole country for the  
3 Direct project. And in the last couple of weeks it has  
4 come -- been made excruciatingly clear to me that there has  
5 been a lot of talk from a number of these big EHR venders  
6 about yup, we want to be involved, we want to help you, we  
7 want to help you facilitate the Direct protocols to enable  
8 exchange of information but when it comes time to really  
9 doing it, they're not doing it.

10 And it's causing a substantial amount of  
11 problems. For example, in Middlesex county approximately a  
12 third of the primary care physicians in Middlesex county  
13 are e-clinical works users including all the providers at  
14 the community health centers and a number of other primary  
15 care providers. And e-clinical works has been a  
16 participant or said they want -- they're going to be a  
17 participant in the planning for this Direct project. And  
18 every time it comes time for them to implement and to  
19 deliver on implementing the Direct protocols and  
20 facilitating a health information exchange or becoming a  
21 HISP, which is the health internet services provider, it  
22 gets pushed back. It's getting pushed back.

23 So two weeks ago I spoke with the CEO of E-  
24 Clinical Works, he said they were going to be ready at the

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1 end of April, two hours after that I spoke with the  
2 technical people at E-Clinical Works, they said at the end  
3 of May, probably more like the middle of the summer, and so  
4 we are substantially hamstrung for a number of physicians  
5 who are ready, willing and able and want to be able to  
6 share clinical information according to the Direct  
7 protocols, are getting hung out to dry basically by a  
8 number of these technology venders who see the Direct  
9 protocols as either a challenge to their business models or  
10 some other thing where this national health policy doesn't  
11 jive with their corporate strategy.

12 So I just wanted to -- I'll answer some  
13 questions. I don't want to take a lot of your time but I  
14 just want to make you aware that all the talk and all the  
15 agreements in principle on working groups, when push comes  
16 to shove it's not really working out as well as we hoped  
17 because the public policy and other stated goals of  
18 information exchange, when they clash with specific  
19 corporate policy of individual venders the public policy  
20 and stated goals become secondary to those corporate  
21 interests and it's creating a substantial problem for us.  
22 And I'm most jealous of my colleagues in Rhode Island who  
23 are the Rec -- the HIE and they got the beat the community  
24 grant with \$25 million to do and they're managing to ramp

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1 through a lot of things.

2 So I wanted to -- and I urge this  
3 organization to work with us to try to facilitate -- help  
4 point-to-point health information exchange as much as  
5 possible. We have a lot of physicians who are depending  
6 upon the outcome of what you are all about and the Direct  
7 project to be able to meet some of the requirements of  
8 meaningful use. And I look forward to and would encourage  
9 and offer in any way possible to work with this body to  
10 help institute and disseminate the Direct project and the  
11 Direct protocols to facilitate health information exchange.

12 MR. WOLLSCHLAGER: Thank you very much for  
13 the info as well as for the sweat equity.

14 MR. ARNOLD: Okay, you're welcome.

15 MR. WOLLSCHLAGER: Other comments from the  
16 public? Other comments, last chance? I'll entertain a  
17 motion to adjourn.

18 MALE VOICE: Move.

19 MALE VOICE: Second.

20 MR. WOLLSCHLAGER: All in favor?

21 VOICES: Aye.

22 MR. WOLLSCHLAGER: Thank you all.

23 (Whereupon, the meeting was adjourned at  
24 6:42 p.m.)