

VERBATIM PROCEEDINGS  
DEPARTMENT OF PUBLIC HEALTH

HEALTH INFORMATION TECHNOLOGY  
AND EXCHANGE STRATEGIC PLAN

THOMAS AGRESTA, CHAIRMAN

AUGUST 15, 2011

101 EAST RIVER DRIVE  
EAST HARTFORD, CONNECTICUT

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HEARING RE: DOIT/HITE  
AUGUST 15, 2011

1 . . .Verbatim proceedings of a meeting in  
2 the matter of DOIT/HITE, held at 101 East River Drive,  
3 East Hartford, Connecticut, on August 15, 2011 at 4:31  
4 p.m. . . .

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6  
7  
8 CHAIRPERSON THOMAS AGRESTA: All right.  
9 I'd like to welcome everybody to the August 15th Board of  
10 Director's meeting for HITE-CT.

11 What I'd like to do initially is sort of  
12 call the meeting to order and recognize that this is our  
13 first time being televised, and, so, that must mean that  
14 Health Information Technology is moving up in the world,  
15 or there's not much on the legislative agenda, so,  
16 therefore, we've kind of got the front seat.

17 I want to welcome the Connecticut  
18 Television Network to this meeting and the public that has  
19 the opportunity to view this operation from that.

20 First, I'd like to kind of do some  
21 introductions, so we can kind of go around the room and  
22 introduce ourselves and our role on the HITE-CT Board, and  
23 HITE-CT stands for the Health Information Technology  
24 Exchange of Connecticut, and that is a quasi public agency

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1 that was created legislatively in July of 2010 or June of  
2 2010.

3 My name is Tom Agresta. I'm a family  
4 physician. I'm the Vice-Chair and Treasurer of the HITE-  
5 CT Board, and let me just go around to the right.

6 MS. MARIANNE HORN: I'm Marianne Horn. I'm  
7 an attorney at the Department of Public Health, and I'm  
8 providing some assistance here to the Health Information  
9 Technology Exchange.

10 MS. VICTORIA VELTRI: I'm Victoria Veltri.  
11 I'm the State Health Care Advocate, and I'm an ex officio  
12 non-voting member.

13 MR. STEVE CASEY: I'm Steve Casey. I'm  
14 with the Department of Administrative Services now, no  
15 longer DOIT. We are now called the Bureau of Enterprise  
16 Services and Technology.

17 MR. MARK HERSCHKEL: My name is Mark  
18 Herschkel. I'm from the Department of Social Services. I  
19 represent the Commissioner on this Board, and at the  
20 Department I oversee the Electronic Health Record  
21 Incentive Program and, also, the Medicaid information  
22 system.

23 MR. JOHN LYNCH: I'm John Lynch. I'm with  
24 Pro Health Physicians. On the Board, I am the Chair of

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1 the Business Operations Work Group. I'm also acting Chair  
2 at the moment of the Legal, the Policy Work Group, and  
3 member of the CEO Search Committee.

4 MS. LORI REED-FOURQUET: I'm Lori Reed-  
5 Fourquet, and I'm the Executive Director for HITE.

6 DR. KEVIN CARR: I'm Kevin Carr. I'm an  
7 internal medicine physician. I'm appointed by the Senate  
8 Majority Leader as a Health Information Exchange Advisor  
9 and currently employed by Accentra.

10 MS. BARBARA PARKS WOLF: Barbara Parks  
11 Wolf. I'm with the Office of Policy and Management.

12 MS. BETTYE JO PAKULIS: Bettye Jo Pakulis,  
13 Chief of Staff for Lieutenant Governor Nancy Wyman, and  
14 I'm representing Lieutenant Governor Wyman this afternoon.

15 MS. BRENDA KELLEY: Hi. I'm Brenda Kelley.  
16 I am the State Director of AARP in Connecticut. On this  
17 Board, I co-Chair the Special Populations Committee, and  
18 I'm a member of the Legal and Policy Committee.

19 MR. PETER COURTWAY: Peter Courtway. I'm  
20 with the Board of Directors and Chairman of the Technical  
21 Committee, currently actively doing the contracting for  
22 the technology for the exchange.

23 MR. DANIEL CARMODY: Dan Carmody. I'm with  
24 CIGNA Health Care. I am the Secretary on the Board of

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1 Directors, and I represent the Health Services industry.

2 MR. KATE WIMKELER: My name is Kate  
3 Wimkeler. I'm a Secretary of DPH.

4 MS. MEG HOOPER: I'm Meg Hooper with the  
5 Department of Public Health and the acting HITE  
6 Coordinator for the State of Connecticut. Chris  
7 Ramone(phonetic) is not able to make it today, and she  
8 does send her regrets.

9 CHAIRPERSON AGRESTA: Okay. The first  
10 order of business for the meeting is to discuss and accept  
11 the minutes from July 18th.

12 A MALE VOICE: So moved.

13 MS. KELLEY: Second.

14 CHAIRPERSON AGRESTA: Any discussion?

15 MR. CARMODY: My only discussion was there  
16 was one -- at one point, didn't we put a dollar amount as  
17 a cap for what we could hire the temporary help for the  
18 interim CEO? I wanted to make sure that that was spiked  
19 out. I think we gave them a cap of about 20,000.

20 CHAIRPERSON AGRESTA: That is correct.

21 MR. CARMODY: We have no other point where  
22 that's documented, so I'd like to make sure it's  
23 documented.

24 MS. HOOPER: And you're on the interim

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1 hiring recommendation, is that correct, Daniel?

2 MR. CARMODY: Yes.

3 MS. HOOPER: And --

4 MR. CARMODY: Maybe you could just put some  
5 wording in there that talked about moved to transfer funds  
6 for temporary staff to a maximum of 20,000. I think we  
7 put a top on it.

8 MS. HOOPER: Understood. Any issues there?

9 Do we need a motion and a second to amend the minutes?

10 We do.

11 A MALE VOICE: So moved.

12 A MALE VOICE: Second.

13 CHAIRPERSON AGRESTA: Any other  
14 discussions? All in favor?

15 VOICES: Aye.

16 CHAIRPERSON AGRESTA: Opposed? The ayes  
17 carry it.

18 MR. CASEY: Now that was for the amendment?

19 CHAIRPERSON AGRESTA: Now for the actual  
20 acceptance of the minutes, any other discussion? All in  
21 favor?

22 VOICES: Aye.

23 CHAIRPERSON AGRESTA: Any opposed?

24 MR. HERSCHKEL: Abstention.

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1 CHAIRPERSON AGRESTA: An abstention.

2 MS. PAKULIS: Another abstention, please.

3 CHAIRPERSON AGRESTA: And one abstention.

4 MS. HOOPER: Thank you. Two abstain, and  
5 those abstaining are the Lieutenant Governor's office and  
6 DSS.

7 CHAIRPERSON AGRESTA: Okay, so, the minutes  
8 have passed. And the next order of business is to go  
9 through the Treasurer's report, so, as being the Treasurer,  
10 I'll kind of share with you you each have a copy of the  
11 Treasurer's report.

12 Currently, we have \$48,673 in cash and  
13 cash equivalence, and our current liabilities are \$5,000,  
14 which leaves us a fund balance of \$43,673.

15 Also of note, there is an executed  
16 Memorandum of Agreement for transfer of funds that is  
17 pending and should be occurring within the next day or so  
18 for transfer of funds for \$116,000 to support the Interim  
19 Director Position, the secretarial support, as was adopted  
20 and passed at the last Board of Directors meeting. My  
21 understanding is that is occurring, is awaiting  
22 essentially the final transfer of funds.

23 We do have some general administrative  
24 expenses currently for our insurance, both for the cost of

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1 the Director's insurance, as well as obtaining that  
2 insurance at \$11,067, or 8,000, rather, \$260, and paid  
3 expenses of \$11,067 for legal expenses, so that is how we  
4 have our \$43,000 funds available.

5 Any comments or questions currently on the  
6 Treasurer's report? Hearing none, I'm going to pass the  
7 mike over to John Lynch to talk about recommendations for  
8 an audit policy.

9 MR. LYNCH: In your packet, you'll see the  
10 first draft of an audit policy. We're going to be  
11 recommending a procedure, in essence, along with this.

12 We need a 30-day notice procedure in order  
13 to put notice in the Public Law Journal, and that should  
14 go into place before the Board fully votes on all policies  
15 and procedures, so we'd like to have you okay this to go  
16 out to the Public Law Journal, and it will have full month  
17 of potential revisions that would come in as part of that  
18 process.

19 At the same time, we're recommending that  
20 procedure for all of the other policies and procedures  
21 that we are developing. We have a meeting tomorrow  
22 morning, for example, to begin work on the, or continue  
23 work on the authentication policy, and we'll be working,  
24 also, on the DURSA agreements, etcetera, so we believe the

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1 process should be that we should start noticing all of  
2 those procedures in the Law Journal, give the public 30  
3 days' notice.

4 Hopefully, we can get that in in time that  
5 we can vote on a number of policies at our next meeting,  
6 but, in the meantime, would encourage you, as we try to  
7 get the first drafts of these things out, get your  
8 comments, questions back to us in that time frame, such  
9 that we can finalize all those comments and get the full  
10 policies to you at the next Board meeting.

11 CHAIRPERSON AGRESTA: Yes?

12 MS. HORN: If I may, I spoke with our legal  
13 consultants today, Shipman & Goodwin, just to clarify what  
14 this process should be for our quasi public state agency,  
15 and they are looking at our policies and are going to make  
16 a final determination about whether they fall within the  
17 definition of procedures that need to go through this Law  
18 Journal process, but looking at it in initial discussions,  
19 I think they probably will.

20 There may be some of these things that  
21 we're developing that might not meet that standard to this  
22 whole 30-day publication and public notice, but we will  
23 stay on top of that and move the process along as quickly  
24 as we can.

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1 I do want to make clear that as the Board  
2 is looking at this first audit policy and giving any  
3 comments either today, or, if you have additional  
4 comments, that they should go to Lori to be incorporated,  
5 and then we will bring them forward to the full Board  
6 meeting next month for a final adoption, because we can't  
7 get into public meetings that take place off the record.

8 We can't have e-mail exchanges, we can't  
9 have groups of people having discussions, and we can't  
10 have bits and pieces of things floating around out in the  
11 public, so I just want to remind everybody of those. I  
12 know you all know about that.

13 So we're clarifying this as we go, but I  
14 think these probably will fall within the procedure  
15 definition and the process that John described, is one  
16 that I think we can stay on top of those 30-day notices  
17 and will give the public an opportunity to weigh in on the  
18 policies that will be on the DPH website in total, and  
19 we'll get everybody's comments.

20 MR. COURTWAY: Considering that we have  
21 quite a number of policies and they're being documented,  
22 is the intent to, you know, hold in our meetings to try to  
23 get those ratified to get the 30-day, or is this a matter  
24 of the Legal Policy subgroup meets and says this is a

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1 policy ready to go that it gets noticed and comes back to  
2 the Board afterwards?

3 MR. LYNCH: It won't be a policy when you  
4 say ready to go, like it's final. That's part of the  
5 process here. We're giving notice that they have 30 days  
6 to comment on proposed policies.

7 MR. COURTWAY: Um-hum.

8 MR. LYNCH: And just looking at the  
9 calendar, we probably don't have 30 days, because I think  
10 the 12th is our next meeting. The 19th? All right, so,  
11 we probably have enough time to get 30 days in there  
12 potentially, depending how long it takes to get into the  
13 Law Journal.

14 We want to avoid the process, where if we  
15 have to go live, depending on what the Technical Committee  
16 comes up with as a signed contract of when we're going  
17 live, etcetera, we're starting to get data even in as part  
18 of the testing of that process, we want to make sure we  
19 have a policy started in place to help protect everything.

20 MR. COURTWAY: So out of the committee  
21 comes the draft, it goes for public comment, public  
22 comments get incorporated, and it comes to the Board for  
23 ratification?

24 MR. LYNCH: It goes back to the Legal and

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1 Policy to accept any final changes kind of thing, if it  
2 came in as comments, etcetera, and then to the full Board.

3 MR. COURTWAY: Okay.

4 MS. HORN: But the Legal and Policy  
5 Committee has been tremendously flexible and has been  
6 meeting much more often than their regularly monthly  
7 scheduled meetings, so I think they have a lot of interest  
8 in getting these policies, but it's a lot of work.

9 MR. COURTWAY: But as they come out of the  
10 committee, are we looking for this Board to regularly  
11 approve it, so that it then goes into the journal?

12 MR. LYNCH: Basically, I think I'm looking  
13 for authorization that the Legal and Policy Committee has  
14 authorization to submit proposed policies to the Law  
15 Journal, without coming through here first.

16 We would go through the 30-day notice, get  
17 the comments in, make any changes, corrections, and then  
18 go with Legal and Policy to adopt and send them here  
19 immediately for the full Board to approve policies. The  
20 full Board has to approve all policies and procedures.

21 MR. COURTWAY: I think that that's fine,  
22 per se, but I think the only question I would ask is that,  
23 if you're going to submit it to the Law Journal, that you  
24 do it contemporaneously to everybody else, so that we can

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1 see the policies as they come through.

2 MS. HOOPER: John, is it this document that  
3 we have submitted to the Board, both e-mail and in hard  
4 copy, today?

5 MR. LYNCH: That's the first proposed  
6 policy, yes.

7 MS. HOOPER: So is this something that will  
8 another proposal regarding the --

9 MR. LYNCH: Well, tomorrow, we'll be having  
10 an authentication policy. We're working on it. I  
11 believe, now that we understand the new process, we're  
12 working through -- this is the first one we're working  
13 through or understanding what the process is.

14 We will notice a whole series of policies  
15 that we'll be working on and hope to have available over  
16 the next 30 days for approval, and we'll probably do that  
17 every month, such that we'll work on a series of policies.

18 CHAIRPERSON AGRESTA: Yeah. I think one of  
19 the challenges in doing that is one of the obvious things,  
20 and that is that taken in isolation, without understanding  
21 the full completeness of the policies that need to be in  
22 place for the HIE to function in its most effective  
23 manner, there can be a risk that those that don't  
24 understand the full complexity and the number that will

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1 need to be in place and how they interplay with each  
2 other.

3           You know, we'll make comments based on what  
4 another policy will actually have to cover, and, so, I  
5 think we need to be careful in how we represent that both  
6 to the public and to the Board of Directors, as well, so  
7 that they understand the full spectrum of policies and  
8 what they might cover.

9           I'm not sure how to do that, John. I'm  
10 just aware that, you know, an isolated policy out there  
11 always poses the risk that it's going to be muted and is  
12 lacking the full necessary, you know, pieces of data,  
13 information, you know, workflow, all the other things that  
14 are required, and I know there are large numbers of  
15 policies that need to be kind of brought through this  
16 process.

17           I'm also aware that we're still awaiting  
18 final legal counsel, and that what I'd love to do is be  
19 somewhat flexible in thinking about, you know, utilizing  
20 technology that might be present in order for us to gather  
21 data and information and comments and to post things, as  
22 well.

23           And, so, I think it's a good idea to start  
24 this this way, but I'm not sure that we want to always

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1 kind of stay this way. We may kind of adopt a much more  
2 logical framework, as to how we review and publish and  
3 provide feedback on policies.

4 MS. VELTRI: I just wanted to point out  
5 that a lot of times, when agencies put proposed  
6 regulations in the Connecticut Law Journal, that they have  
7 a description, they have a note piece, in which they say,  
8 you know, the Department is now revising regulations  
9 related to sections blah, blah, blah of this regulation.  
10 This will affect or is tied to these other regulations.

11 You can craft that in your note or  
12 introductory piece I think for the reg., for the proposed  
13 reg., if it does, in fact, make it into the Law Journal,  
14 so that you're not leaving it hanging out there, and  
15 you're telling people that it's part of something else.

16 CHAIRPERSON AGRESTA: It's part of future  
17 policies that are going to be addressing the following  
18 types of issues perhaps.

19 DR. CARR: The two things that kind of came  
20 up in my mind when I was reading through these is how are  
21 exceptions to the policy want to be handled, because I'm  
22 just going through, and I think all the recommendations  
23 are --

24 My biggest concern is, you know, I'm in the

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1 middle of doing an implementation right now, and if I  
2 think back to the eight hospitals that we're visiting  
3 right now, only one of them would be able to meet all  
4 these requirements in Q1 of next year, and, so, how are  
5 the other hospitals here going to look at this and say,  
6 hey, I'm never going to be able to meet these requirements  
7 by Q1?

8 Can I get on board a little bit earlier  
9 with a different approach that's similar that gives you  
10 the same outcome?

11 And then the other one was the financial  
12 implications of the policies, so there's a requirement in  
13 here to do an annual audit, so should we pay for that  
14 audit? And I'm not sure. I don't think that's the Legal  
15 and Policy Committee's job to do that, but like how do we  
16 handle some of those other costs over --

17 MS. HOOPER: We do have the audit in the  
18 budget, audit expenses. (Multiple conversations)

19 MR. CARMODY: Not to say that you don't  
20 have included higher to audit policies and procedures.  
21 Typically, sometimes you have those. I'm not sure what  
22 we're required to do under the grant. Are we required to  
23 have an operational on it, or just have a financial on it,  
24 or even any audit?

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1 MS. HOOPER: Under the cooperative  
2 agreement and our contract with the HITE-CT, it will be a  
3 financial audit, so this is distinct, but we never did set  
4 with the Board of Directors, as to the audit line for the  
5 cost, but, again, the Board is reviewing that.

6 MR. LYNCH: Dan, part of the issue here is  
7 that we're trying to build the trust of the community, and  
8 we have to strike that right balance, and the audit is  
9 seen as part of the challenge that the better we do the  
10 audit the more we can potentially open up a little bit.

11 You don't want to have all the doors  
12 totally locked, barred, etcetera. You'll never get  
13 anything done, so we've got to somehow strike the  
14 appropriate balance of audit and access, and these are all  
15 valid questions.

16 I think part of the work group has  
17 discussed some of those issues, and there's a real need to  
18 make sure we get the consumers out there comfortable with  
19 the process, and we think that the audit will be critical  
20 to be done yearly, etcetera, so I think we have to find a  
21 way to make that happen.

22 MR. CARMODY: As a CPA, I understand the  
23 need for an audit, so I was more thinking in terms of he  
24 was talking about security. Sometimes you're talking

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1 about you get to a website and there's cyber  
2 certifications that you go through.

3 They're not necessarily really an audit.  
4 It just talks and attests to the fact that this site has  
5 been certified. Again, it's also goes back to what are we  
6 providing for services? So to the extent that no one has  
7 access into it, because there's no portal and we're  
8 talking about a different type, you know, who is seeing  
9 what type of certification, so I think we probably just  
10 need to explore.

11 MR. LYNCH: Again, for everybody's sake,  
12 remember that we will have patient type information  
13 flowing through. The audit is really more to make sure  
14 that we're following our other policies that we'll be  
15 developing, in terms of processes and procedures, who can  
16 get access, who cannot get access, etcetera.

17 So the audit is really meant to be that  
18 comfort zone, where, yes, we'll go in and we'll audit  
19 across the board to make sure that we're, you know, all of  
20 the members who sign up to participate are following the  
21 procedures we set into place, and that the patient,  
22 themselves, they can get access to their own records, so  
23 we're trying to make sure that those things are indeed  
24 followed to bring that comfort level.

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1 MR. CARMODY: John, I think that those are  
2 all really important things. I think it's also a  
3 different aspect, when we think about it from the HITE-CT  
4 organization standpoint.

5 The HITE-CT organization standpoint, as  
6 each policy is being considered, each one of those  
7 policies has some potential financial implication to the  
8 cost of running the organization and has some potential  
9 staffing implications and potential outsourcing type  
10 implications.

11 And I'm cognizant that we need some process  
12 by which we think about that, and, you know, it's almost  
13 like when legislation is proposed, there's a third party  
14 off to the side that analyzes it and says, you know, what  
15 are the implications? What are the cost implications?

16 I'm not sure how to do that in an  
17 organization like this, but I recognize that we can  
18 develop a number of policies that all of the sudden, you  
19 know, create for us barriers that financially we can't  
20 meet, and there might be policies that are absolutely  
21 required to build public trust, or because they just are  
22 required legally, or because we believe very strongly  
23 they're required and are going to cost something, but we  
24 haven't anticipated that yet, and so, therefore, we need

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1 to then build it into our budget in our ongoing support,  
2 so I'm not sure how to do that.

3 MR. LYNCH: I think part of this that we  
4 need to get something in place, and we'll learn as we go.  
5 These policies aren't going to be perfect day one out of  
6 the box, and some of those things we may have to tweak in  
7 further revisions downstream, but until we get people  
8 reacting to them and realizing some of this stuff, we may  
9 never get to that point of raising those valid questions.

10 CHAIRPERSON AGRESTA: Maybe we want to put  
11 it at the end of, you know, our comments, just build into  
12 our comment sheet, you know, some means by which even the  
13 Board of Directors can weigh in and say, gee, I think this  
14 has these types of implications financially, it has these  
15 type of implications from a business and operations  
16 perspective, and it will help us, I think, as we kind of  
17 move forward to refine what our business model is, as  
18 well.

19 MR. CARMODY: I think, also, as you look at  
20 that data use agreement and as people connect into it,  
21 there's a responsibility once you get into that agreement,  
22 and, so, maybe it's not auditing each transaction, but  
23 understanding how you validate the data use.

24 Every physician in here is a covered

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1 entity. Your health plan is a covered entity under HIPAA.

2 There's requirements that say if you don't meet these  
3 HIPAA standards as a covered entity, you know, the  
4 Department of Health and Human Services can come in and  
5 audit you.

6 Now they don't audit a lot of people. Now  
7 they try to increase the level of -- a way to collect if  
8 somebody thinks that there's a breach, so I think we want  
9 to hit the right balance, because, you know, with the  
10 number of people (coughing) covered entity, you have  
11 certain requirements that are expected of you, and you  
12 need to maybe try to see if we can leverage them.

13 DR. CARR: So I wonder if, if I summarized  
14 your thoughts, with each one of the policies we can have a  
15 set of assumptions and then staffing for further  
16 organization, so that as we go forward it's easier for  
17 somebody like yourself to look at those and say, hey, you  
18 know, we'll have these one or two people, or five people  
19 going forward. That might help to answer that staffing  
20 question.

21 MR. LYNCH: Good suggestion.

22 CHAIRPERSON AGRESTA: Would you want the  
23 Legal and Policy Committee to take that on, or is that  
24 something that's beyond what you feel comfortable with, or

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1 will it slow you down, or should we have some other  
2 internal mechanism by which we try to do that?

3 MR. LYNCH: I'm not convinced that other  
4 work groups will necessarily have all the details to be  
5 able to guess at that. On the other hand, we don't  
6 necessarily have all the answers, in terms of costs,  
7 ourselves either, but, certainly, we should be able to  
8 make some statement, as suggested here, that, you know, in  
9 terms of implied staffing, implied types of expenses or  
10 something, so that if people are currently reviewing these  
11 and say no way, or right on, or whatever.

12 CHAIRPERSON AGRESTA: Okay.

13 MS. HOOPER: Angela, if you have any  
14 questions and if there's anybody else on the phone?

15 MS. ANGELA MATTIE: Well, Meg, I'm hearing  
16 part of the conversation, but just in terms of it sounds  
17 like when you develop a policy and procedures manual, and  
18 some of this may have already been parts of it, but what I  
19 might suggest is can we prioritize the policies that we  
20 must have in place immediately, and then perhaps focus on  
21 that, and then, in addition to the policy language I think  
22 Tom mentioned, are there any requirements for -- what are  
23 those requirements? What are the operational requirements  
24 associated with the policy?

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1                   And then perhaps it's not just the Legal  
2                   and Policy Committee that does all of the policies. I  
3                   mean this is a tremendous undertaking, but then, once we  
4                   hit the heavy hitters that we must have, then are there  
5                   other committees that can take on policy development?

6                   And then have we looked at the ONC website?

7                   I'm sure a lot of this has been done or in process in  
8                   other states.

9                   MR. LYNCH: Angela, a couple of answers for  
10                  you. One, we're starting off with policies that have been  
11                  developed elsewhere, so we are using that source. We're  
12                  not doing them from scratch.

13                  Number two, in many ways we have  
14                  prioritized already. That was one of the reasons we  
15                  brought audit to the front very first, because we felt  
16                  that was one of the more critical ones to make sure and to  
17                  bring the comfort there, so, yes, we will be prioritizing  
18                  the flow of these.

19                  MS. HOOPER: Were you able to hear that,  
20                  Angela?

21                  MS. MATTIE: I'm sorry?

22                  MS. HOOPER: Were you able to hear? John  
23                  Lynch responded that, in fact, this policy has been --

24                  MR. LYNCH: Prioritized.

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1 MS. HOOPER: Prioritized. And, in fact,  
2 was drawn from other state examples, so what you've been  
3 able to put forward as a recommendation was embraced by  
4 the Legal and Policy and will continue to.

5 Is there anyone else on the line?

6 MS. KELLEY: Just a quick question to  
7 piggyback on what you brought up. It seems to me like  
8 there's two issues. There's the issue of the cost to  
9 HITE-CT, but it sounds to me like you were bringing up  
10 also the issue to the providers that are going to become  
11 linked into HITE-CT.

12 And it seems to me that if we're going to  
13 do this flagging of potential cost implications, then we  
14 should do the double flagging, because we're rapidly going  
15 to be approaching negotiating with hospital doctors,  
16 etcetera, and that is going to be essential to be able to  
17 articulate what's going to be required of them.

18 And then, as a consumer, who is not a  
19 doctor or a hospital, I'm becoming increasingly concerned  
20 about the fact that I do not think we should be beginning  
21 something that we're not doing, you know, at least the  
22 minimum that we should be doing, like in the case of the  
23 audit policy, to provide people with comfort, you know,  
24 that we are holding their data secure.

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1                   So I really would like to see us, either at  
2                   this meeting or at subsequent meetings, talk, revisit  
3                   financing this operation, you know, so that we generate  
4                   the resources to be able to do what I think we're going to  
5                   rapidly see we're going to need to do, but we don't have  
6                   the money to do just with the federal funding.

7                   And I don't personally believe it requires  
8                   legislation to do that.

9                   MS. HOOPER: Is there a motion or a  
10                  consensus to move forward? I'm sorry. I don't think  
11                  there was a motion.

12                  MS. PARKS WOLF: I just had a comment on  
13                  it. This audit policy, to Tom's point maybe, the  
14                  corrective action that would be applied by it, is that a  
15                  separate policy, or is that part of it?

16                  MR. LYNCH: We didn't spell out --

17                  MS. PARKS WOLF: -- policy?

18                  MR. LYNCH: No.

19                  MS. PARKS WOLF: If you find something with  
20                  the audit, then what do you do?

21                  MR. LYNCH: We haven't totally spelled out  
22                  ramifications across the board for not only audit, but  
23                  other components, if there are found to be.

24                  CHAIRPERSON AGRESTA: That needs to be a

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1 separate policy. That's why I said there's a lot of  
2 interrelated policies that even just reading through here  
3 and knowing what other states have done, having set it up,  
4 there's a lot of interrelated components, and, so, that's  
5 part of our challenge.

6 We need to keep moving, and you need to  
7 know what the interrelated stuff is, but it's hard to  
8 catch up in the middle.

9 MR. LYNCH: Yeah. Lori points out, also,  
10 that a lot of these things will be in procedures, which  
11 you'd also have to develop, so we might have a policy that  
12 says one thing, but then we're going to have to develop  
13 step-by-step kind of procedures of how we would go through  
14 something like that.

15 CHAIRPERSON AGRESTA: So being cognizant of  
16 the time and the rest of the schedule we have to cover, I  
17 think we've kind of framed a number of different issues  
18 that I think we might be able to put into a motion that  
19 permits us to move this one forward, but understand how to  
20 amend and kind of make the process a little bit more  
21 effective moving forward. Does anyone want to frame that?

22 MR. CARMODY: So I make a motion that the  
23 Legal and Policy Committee is able to submit to --

24 MR. LYNCH: To the Law Journal.

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1 MR. CARMODY: To the Law Journal ahead of  
2 the Board of Directors, so long as that the Board of  
3 Directors gets a copy of the policy contemporaneously for  
4 30-day comment.

5 A MALE VOICE: Second.

6 CHAIRPERSON AGRESTA: Any discussion? All  
7 in favor?

8 VOICES: Aye.

9 CHAIRPERSON AGRESTA: Any opposed? Any  
10 abstained? The ayes have it. All right.

11 The next order of business is Privacy and  
12 Security Officer nominations.

13 MR. LYNCH: Yes. As part of that same  
14 audit policy, we're recognizing that we need to have a  
15 Privacy and Security Officer in place, and, therefore,  
16 we're proposing an interim solution.

17 In a long-term, we believe that since we  
18 have outside legal counsel, sometimes typically a Privacy  
19 and Security Officer might be the legal counsel, but it's  
20 an outside legal counsel.

21 Other places will have their Chief  
22 Technology Officer as the Privacy and Security Officer, so  
23 we're proposing that, in a long-term, when we hire a Chief  
24 Technology Officer, that that will be the Privacy and

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1 Security Officer, and, therefore, in the interim,  
2 basically a nomination that Steve Casey fulfill that role  
3 as a Board member, just similar like you did with the RFP  
4 process.

5 He did a super job on that, so we'd like to  
6 make a motion that Steve Casey be the interim Privacy and  
7 Security Officer until we hire a Chief Technology Officer,  
8 at which time the Chief Technology Officer by that role  
9 will assume that position.

10 MS. HOOPER: Is there a second?

11 MR. HERSCHKEL: I'll second that.

12 CHAIRPERSON AGRESTA: All right. Mark  
13 seconded it. Any discussion?

14 MR. COURTWAY: I just wanted to have some  
15 clarity here. Is it that if the exchange is up and  
16 running, you know, before we hire the CTO, that Mr. Casey  
17 will have operational responsibility to the CEO for  
18 fulfilling the Chief Security Officer, a Privacy Officer?

19 MR. LYNCH: Well, to fulfill that role, in  
20 the sense that if we get any I'll call it complaints, or  
21 any questions, etcetera, that come through, they should be  
22 routed directly to Steve Casey, who would further  
23 determine how to resolve it.

24 MR. COURTWAY: Okay.

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1 MS. HOOPER: Other nominations or  
2 discussion on this?

3 MR. COURTWAY: I'm just not sure what the  
4 time commitment actually is, which is part of the question  
5 of the operations part of it.

6 MR. CASEY: That was my question to Meg.  
7 In short-term, I don't think it's going to be that much,  
8 and hopefully we'll be hiring somebody in a permanent  
9 position after awhile.

10 Temporarily, I can handle the  
11 responsibilities for the few months.

12 MR. CARMODY: And I don't have any problem  
13 with it, per se. I'm just outlining and understanding  
14 what the role is.

15 MS. HOOPER: Can we have a second before we  
16 have a discussion? (Multiple conversations)

17 MR. CARMODY: Was it seconded? Just  
18 understanding what it is, I think that's sort of where my  
19 question is. If anybody has a question, they come to  
20 Steven. How are you going to interact with the interest  
21 of legal counsel?

22 MR. CASEY: I'll work with the resources  
23 available, as I always do.

24 MR. COURTWAY: So it's basically putting

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1 you on --

2 MR. CASEY: Pointed context.

3 CHAIRPERSON AGRESTA: And I guess probably  
4 from my perspective one of the things that needs to get  
5 fleshed out in a little bit more detail and maybe one of  
6 the things that Steve can help participate in is what are  
7 the roles and responsibilities of the Privacy and Security  
8 Officer and laying out how they might report in the  
9 future.

10 I do think those are very valid questions.  
11 Define them in much greater detail is probably going to be  
12 very helpful, even as we get into negotiating with another  
13 individual to take on another role.

14 And I'm not 100 percent sure that it would  
15 end up being the Chief Technology Officer as we move  
16 forward. That makes a lot of sense in many ways, but  
17 that's a little bit down the road, in terms of trying to  
18 figure out that information now.

19 MS. VELTRI: I have a concern, and I hate  
20 to bring it up, because I think in the real world it would  
21 be a really good idea, but in the state world I don't know  
22 if there's any problems with someone assuming  
23 responsibility that would otherwise be a paid position.

24 I'm just raising what I think might be

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1 something that might have to go through ethics.

2 MR. CASEY: We have representatives of the  
3 Board here, who set the state hours on this quasi public.  
4 I could ask the Ethics Commission that question.

5 MS. VELTRI: I just don't want there to be  
6 any problem.

7 MS. HOOPER: We certainly appreciate the in  
8 kind donation for any time dedicated.

9 MR. CASEY: Another in kind donation, but  
10 I'll double check with Ethics.

11 MS. HOOPER: So there is that motion. Are  
12 there other nominations and/or concerns?

13 CHAIRPERSON AGRESTA: All right. All in  
14 favor?

15 VOICES: Aye.

16 CHAIRPERSON AGRESTA: Any opposed? Any  
17 abstentions? The ayes carry it. Steve gets to wear  
18 another hat.

19 The next is committee reports, and I'm  
20 cognizant that, you know, we're doing pretty good for  
21 time, but I want to make sure that we kind of move through  
22 and do this effectively, so we've got committee reports of  
23 the Executive Committee, and I will present the Executive  
24 Committee.

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1                   The Executive Committee met once on Monday,  
2                   July 25th. At that point, we discussed the statement of  
3                   work and guidelines for reporting for our interim CEO and  
4                   came to a conclusion that came out of our Board of  
5                   Directors meeting here and then was passed on to the  
6                   Executive Committee.

7                   And the statement of work for Lori, as the  
8                   interim director, is that she is going to work with DPH,  
9                   work with the Executive Committee and Board of Directors  
10                  to develop the contract around the HIE system vendor, that  
11                  she would be appointed employ assistance in the process,  
12                  both clerical and otherwise, that she participate in  
13                  committee meetings, report to the Chair and Vice-Chair for  
14                  her work, that she would provide biweekly updates to the  
15                  Executive Committee and monthly updates to the Board of  
16                  Directors, which she will do later in the Executive  
17                  Session for our group, and review and recommend  
18                  sustainability models, so we did add some roles to her --  
19                  tasks to her role, and that she would prepare a short-term  
20                  work plan for what she was trying to accomplish.

21                  That was the public section of the  
22                  Executive Committee, and then we went to Executive Session  
23                  to discuss the personal search committee and for the CEO  
24                  search, and that was the extent of the Executive

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1 Committee.

2 We had a meeting scheduled for last Monday,  
3 but were unable to gather a quorum, so we will reconvene  
4 shortly.

5 Next, I believe we have listed to kind of  
6 go through Business and Operations Committee.

7 MR. LYNCH: Business and Operations has not  
8 met. I'm looking at August 31st, Wednesday morning at  
9 8:30, as the next meeting. We have an agenda of several  
10 things we need to be moving forward on.

11 We need to be talking about communications,  
12 evaluation metrics, business processes. Lori has already  
13 begun to circulate a laboratory use case that we'll be  
14 looking at for exchanging lab, and we're talking about  
15 value cases, and one of the value cases is starting to  
16 percolate up a little bit to be probably handed over to  
17 the Finance Committee to look at is the fact that, as  
18 physicians and the hospitals get their physicians up on an  
19 electronic health record, they may need a redundant kind  
20 of back up, so, for example, if your EHR system goes down,  
21 you might need a way to still get access to patient  
22 records, so you can still be treating your patients  
23 without being in the blind, or if you have a scheduled  
24 downtime.

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1                   Every so often, you've got to bring your  
2 system down to bring it up-to-date with new updates,  
3 etcetera. At least you could have a backup. We think  
4 that may be a value case that could be a value to help  
5 encourage the physicians and others to be part of HITE,  
6 because the physician portal could be seen as that value  
7 of the redundant backup.

8                   In case your system fails, you could always  
9 go to that portal. We think that there would be a value  
10 to that, so we're beginning to percolate some discussion  
11 around that, as well.

12                   CHAIRPERSON AGRESTA: Okay. Update from  
13 the Finance Committee?

14                   MR. CARMODY: So the Finance Committee  
15 hasn't met, but a couple of things that I think I would  
16 want to bring to its attention.

17                   I did have a conversation with John Brady,  
18 who is the CFO of CHA, and we talked about the need, that  
19 as we move from sort of the model of master patient index,  
20 master provider index, record locator, those three core  
21 capabilities, and we've started to talk about services,  
22 and I think we talked about this at the last Board  
23 meeting, there's a need for us to actually talk with CHA.  
24 They're going to be the consumers of the services.

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1                   Otherwise, what we have as mile markers is  
2 we have some of the information that has come from the  
3 vendors. We can look and see what's happening in other  
4 states, but we really need to talk to our local community,  
5 that if we're looking at the hospitals around, you know,  
6 what is it that we're going to offer as services, and, so,  
7 the conversation -- and he agreed that the conversation  
8 needs to really transpire fairly soon, because we're going  
9 to be looking for them, at least initially as the  
10 sustainability model, then we need to get in front of  
11 them, as to what those services are.

12                   So even as we stand today, if we polled and  
13 we went around the room and I said what are the services  
14 that we're going to provide, I'm not quite sure how well  
15 each Board member would fare, including myself, around  
16 what those services would be, you know, what are core  
17 services, what are buy up services.

18                   I've talked with Peter, and I've talked  
19 with Lori just earlier this afternoon, around the need for  
20 us to put together a very short, concise deck that says  
21 this is what we're offering. This is what we're not.  
22 This is what the cost of these services are.

23                   And we then need to get in front of whether  
24 it be the various constituents of the CHA and/or others

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1 and get them to weigh in on is the model that we're  
2 proposing something that's going to work here, and will  
3 they accept that, and would they pay for those services,  
4 and I think that that's important.

5 John was very amenable to that. He thought  
6 that that was a good idea. I put some e-mails out to him  
7 today. This was my first day back from being away for a  
8 week. I'm trying to see sometime in September, early  
9 September, that we could get in front of a group, and then  
10 what I think we need to decide is who sort of are going to  
11 be the presenters to that group on behalf of the Board of  
12 Directors to say that this is what we're thinking.

13 I think we need to do that in short order,  
14 especially when we look from a chronology standpoint of  
15 when we would like to sign something, if it's by the end  
16 of September, and having time to react to what that other  
17 constituency would look like, so I'm waiting to hear back  
18 from him.

19 I just wanted to bring that to the group,  
20 that I think that that's something that we need to move  
21 forward on.

22 I'd also recommend, if folks haven't, and  
23 I'm not sure if this is on everybody's desktop reading,  
24 there's an e-Health Initiative. It's a group out of

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1 Washington, and it's titled Staying Alive, Determinates of  
2 HIE Sustainability.

3 It's a specialty health report, and it  
4 talks about what of the 243 HIEs that were identified in  
5 the country, and it looks at a maturity model of I think  
6 from one to seven, and it talks about only 18 are  
7 sustainable, and it talks about what makes them  
8 sustainable.

9 And I think it's important to look. It's a  
10 very easy read. It's not complicated. It's not talked  
11 about, you know, a fancy finance chart, but it just talks  
12 about some of the things I think we need to settle on, so  
13 that when we say this is what we can offer you, that  
14 people agree, and that we can actually put that in front  
15 of folks to say yes, no, or maybe.

16 If we don't, then I think what you're going  
17 to find is that we hate to get us to a point where we're  
18 actually going to take a vote on a contract and not know  
19 that the constituents that we're going to first look to to  
20 say support us, because we're going to provide you  
21 services, come back and say no.

22 They looked at subscription models, which  
23 we've talked about and I think some of the vendors have  
24 come to. They talked about transaction models, which were

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1 less, maybe less favorable, only because of it was sort of  
2 by the joint type of concept.

3 You also didn't get it as a diverse base,  
4 which meant that in order to get the economy to scale,  
5 you're going it on the transaction basis, it may be a  
6 little bit more difficult, because you had a lot more  
7 people carrying to load.

8 It talks a little bit about opt-in, opt-out  
9 models. I know some folks were interested was there any  
10 correlation or not to what was taking place on these  
11 sustainable HIEs.

12 They also looked at what it meant to  
13 provide services. Now I will say that, and shortly just  
14 before I went out on vacation, it was unfortunate, one of  
15 the longest standing HIEs in the country, which was  
16 CareSpark, actually closed its doors.

17 COURT REPORTER: One second.

18 MR. CARMODY: And to conclude, I said they  
19 closed its doors, and they did offer and they were trying  
20 to get a subscription model, and that was one of the  
21 oldest ones in the country, and they had a captive  
22 audience from the standpoint of it was mostly state and  
23 federal government.

24 We're talking rural Tennessee, up in the

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1 northeast corner, and, so, you're talking about the model  
2 that was supported mostly by government, the Department of  
3 Defense, and they weren't able to get services off the  
4 ground, so a service model is very important, because I've  
5 seen and talked to the people in Atlanta, and it's  
6 important that if we are going to go over the service  
7 model, that we understand what services people are willing  
8 to pay for.

9 So I would ask you to go out and take a  
10 look at it. If you can't get it, I can give you a copy.

11 MS. KELLEY: Can you give us the full  
12 title?

13 MR. CARMODY: Yup. It's called Staying  
14 Alive, Determinants of an HIE Sustainability. It's  
15 published by the e-Health Initiative.

16 CHAIRPERSON AGRESTA: Dan, we'll e-mail it.

17 MR. CARMODY: Okay. That way, you can read  
18 it, and, actually, it gives a nice appendix, where they  
19 talk about our core services and whatnot, and we have to  
20 decide. Once we put that package together, I think, one,  
21 everybody should feel comfortable that these are our  
22 services that we're thinking of, and then --

23 CHAIRPERSON AGRESTA: Any comments?

24 MS. KELLEY: Well I'm happy we're moving in

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1 this direction. I'm a little concerned about the  
2 timeline, because you said that the meeting would be some  
3 time in September, but that we want to be signing people  
4 up at the end of September. It seems like a lot, to my  
5 understanding.

6 MR. CARMODY: I think, from the timelines  
7 that we've talked about, we need to understand when we  
8 thought we would want to sign a contract with a vendor.  
9 Now that's not signing people up, per se. That's just, if  
10 we move forward, what that would look like, and, again,  
11 we're working off of some of the timelines that we've  
12 discussed previously, so end of September was sort of the  
13 more latest.

14 And hearing back from our constituents, or  
15 hearing back from the people that we're going to sell  
16 these services to in early September, we're allowed time  
17 for us to digest that and figure out what that meant or  
18 not, and then decide is the end of September reasonable?

19 If our product doesn't hunt, then you don't  
20 have to worry about the end of September, because then we  
21 can look at it and go this isn't going to fly, and we have  
22 to go back to the drawing board.

23 CHAIRPERSON AGRESTA: Dan, do you have a  
24 recommendation for the next steps, how we might actually

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1 specifically take those, or a motion?

2 MR. CARMODY: I actually probably have two.

3 One is we have to develop that short, concise, you know,  
4 three to five-page PowerPoint. These are our services,  
5 this is what it's going to cost, so I think we have to do  
6 that, because that is sort of our sales brochure, and get  
7 that in front of some folks that get them to react to  
8 that.

9 MS. HOOPER: And if we stay on that, who  
10 would you like to be involved in that?

11 CHAIRPERSON AGRESTA: Why don't we phrase a  
12 motion?

13 MR. CARMODY: Well my motion will be I  
14 think the Board needs to create a -- I don't know who the  
15 right committee is to create the sales brochure, so I'm  
16 going to look to the CEO or the interim CEO to talk about  
17 where should we go, what committee, or -- I'm trying to  
18 formulate what the motion is, but I have to figure out  
19 what committee should actually create that brochure.

20 I'm not quite sure that you need a motion  
21 to do anything.

22 CHAIRPERSON AGRESTA: Okay.

23 MS. REED-FOURQUET: I mean it certainly is  
24 going to need finance input. It needs operational input.

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1 It needs technical input.

2 MR. CARMODY: Maybe it's the Executive  
3 team, only because maybe that represents the touch points,  
4 and then we get it out. I think, whatever we do, I think  
5 it then needs to be floated, even on an interim basis,  
6 because between now and the next Board meeting it needs to  
7 get out to the rest of the Board members, so that they can  
8 look at it.

9 CHAIRPERSON AGRESTA: So we have an  
10 Executive Committee meeting next Monday. Would it make  
11 sense for this to be one of the agendas and for this group  
12 to endorse the Executive Committee to begin this process?  
13 Can we create a motion out of that?

14 MR. CARMODY: I motion that the Executive  
15 Committee create possibly a promotional brochure relative  
16 to services that the Connecticut HITE will provide.

17 A MALE VOICE: Second.

18 CHAIRPERSON AGRESTA: Any comments,  
19 questions, concerns? Brenda?

20 MS. KELLEY: Initial conversation is with  
21 the Connecticut Hospital Association, but, potentially,  
22 the people that would be consuming this service, the group  
23 that would be consuming, would be the State of Connecticut  
24 through the Medicaid program I would assume, and then

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1 potentially individual position. Would it all come  
2 through hospitals?

3 MS. HOOPER: No, not at all.

4 MR. CARMODY: No. I think that --  
5 (multiple conversations).

6 CHAIRPERSON AGRESTA: No. I think you're  
7 absolutely correct, Brenda, that when we create the sort  
8 of services, all of those stakeholders need to absolutely  
9 be thought of, and the way we would engage with them and  
10 discuss the benefits need to include all those  
11 stakeholders.

12 MS. KELLEY: There needs to be some  
13 fairness around how you approach things, depending on who  
14 the stakeholders are.

15 CHAIRPERSON AGRESTA: Absolutely, but we  
16 need to start the process, and, so, how we start the  
17 process I think --

18 MR. COURTWAY: I think the Technical  
19 Committee with the Connecticut hospitals, you know, has  
20 joined together with the Hospital Association is a natural  
21 first step, and the contracting process and the thought of  
22 how you sustain this it really is a tier model, so even,  
23 you know, when we take a look at the hospitals, probably  
24 not each hospital will be charged the same amount to

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1 participate, so it is a good model for quite a range of  
2 things.

3 In addition to that, we do need to go into  
4 the physician practice side and price out what the value  
5 of the services are to practices, to the insurance  
6 carriers, to the State of Connecticut, so there is a wide  
7 variety.

8 This is a way to capture and make sure  
9 we're able to capture what will be the beachhead, if you  
10 will, because if we are able to bring in the hospitals in  
11 the state, where most of the data is flowing and where the  
12 exchange is going to be most useful from a physician  
13 practice, physician practices may not be all individually  
14 connected, but those that can connect will likely connect  
15 with hospitals for the exchange of data. It provides  
16 early value into the use of exchange and will give us a  
17 real boost moving forward.

18 So, you're right, it doesn't stop there,  
19 but it's a great place to start.

20 MS. HOOPER: You had a second point, Dan?

21 CHAIRPERSON AGRESTA: Well I think we've  
22 got to vote. We have to vote on that, or have any further  
23 discussion.

24 MR. LYNCH: Actually, a recommendation,

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1 that you send out your initial model with the Finance  
2 Committee you worked on to the Executive Committee, so  
3 that we use that as a starter.

4 MR. CARMODY: The budget, the adopted  
5 budget --

6 MR. LYNCH: You came up with a model quite  
7 awhile back of how you might allocate and think about  
8 that.

9 MR. CARMODY: I will tell you this. I'm  
10 not quite sure that that model supports where we're at  
11 right now. That model was a shared model that required --  
12 it would have been the basis maybe to some legislative  
13 action around how you would then say this is how we want  
14 to generate a revenue stream.

15 That's very different than the shared  
16 service model that we're now talking about and saying this  
17 is what we believe the services are going to be and who is  
18 going to consume the services.

19 If you were going to go and say we needed  
20 to create a revenue stream and based upon some various  
21 data points that is anecdotal. One of the things you'll  
22 see in the e-Health Initiative slides are it's very  
23 anecdotal.

24 You can either impose it to say you believe

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1 there's value, but we haven't proven it yet, or, under the  
2 services model, we have a service we want to offer you,  
3 and this is what I would charge you for that service.

4 So, well, I can share it with you, and it's  
5 up on the website.

6 MR. LYNCH: I'm not quite sure we're  
7 talking apples-to-apples anymore. It's not a bad place to  
8 go to find out things. Like one of the examples would be  
9 is, you know, I think this is why it's very important to  
10 generate this document that says these are the services,  
11 this is the cost of the services, and this is why we think  
12 it's important.

13 It is putting a lot of that initial look at  
14 this at the administrative piece on exchanging data for  
15 health care professionals and facilities, so that is not a  
16 shared model, where it's across the entire constituency.

17 I think we have to evolve. I think that  
18 this effort needs to evolve over time. In order to bring  
19 in those other constituents, I think you have to look at  
20 what a shared cost savings model would be, and I think  
21 I've raised that before.

22 Now that's a model under a shared cost  
23 savings model, sort of like that state ACO-ish. I hate to  
24 use that as a term, but that concept, but that's going to

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1 require the hospitals, the physicians, the payers, not  
2 just the health insurance carriers, but the actual  
3 employers, to sit down and talk about how do you generate  
4 a cost savings model and redistribute, of course taking  
5 off a portion of this enablement piece. I think that's  
6 going to take a lot longer to do.

7 CHAIRPERSON AGRESTA: So I think our task,  
8 though, at the Executive Committee may not be to actually  
9 develop the cost model on Monday. It's really to develop  
10 the service, you know, what do we think are the core  
11 services, and what's the message, and it may be that's  
12 what we have to try to take away, so I think that's what  
13 we have as a motion.

14 I'm conscious of time, so I don't want to  
15 cut off comment, but I want to make sure that we have the  
16 ability to have our, you know, we have outside partner  
17 updates that we need to get to, and we need to have an  
18 Executive Session. Any further comments? All in favor,  
19 say aye.

20 VOICES: Aye.

21 CHAIRPERSON AGRESTA: Any opposed? Any  
22 abstentions? Okay. Is there a second thing that you  
23 need?

24 MR. CARMODY: I think we can discuss it at

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1 that same session, because I think we have to decide who  
2 is going to do the presentation.

3 CHAIRPERSON AGRESTA: Okay. That we can  
4 bring to the Executive Session and bring back. That makes  
5 sense. The Legal and Policy update?

6 MR. LYNCH: Yeah. I think we had most of  
7 our activity already with the audit policy. We have a  
8 meeting tomorrow morning at 8:30. We'll be taking up the  
9 authentication policy and the DURSA agreements, and, as a  
10 result of the vote, we'll be trying to get our notices out  
11 to the Law Journal.

12 CHAIRPERSON AGRESTA: Thank you. Short and  
13 sweet. Brenda for Special Committee?

14 MS. KELLEY: Yes.

15 CHAIRPERSON AGRESTA: Special Populations.  
16 Excuse me.

17 MS. KELLEY: Yes. We met on August 3rd,  
18 had quite a number of people participate. One of our  
19 things that we did is we looked at a statement of consumer  
20 principles that was put out by a national group, called  
21 the Consumer Partnership for e-Health, and we used that as  
22 the basis for discussion and managed to get through the  
23 first principle with some agreement with minor  
24 adjustments.

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1 I don't need to report on that yet, because  
2 we'll wait until we get it done, but that was an  
3 accomplishment.

4 We also did receive a number of  
5 applications to be on the committee, and we decided before  
6 the meeting, actually, we went through the resumes that  
7 had come in, and we matched them to the criteria that ONC  
8 puts out, as to who should be on the Special Populations  
9 Committee, and I'll read that, so everyone knows.

10 It's medically underserved. Newborns and  
11 children in foster care, elderly, people with  
12 disabilities, people with mental health and substance  
13 abuse issues and persons in long-term care, and, ideally,  
14 we're looking for either consumers or people that  
15 represent consumers, although I think, also, people that  
16 serve those populations, but it is looking at consumer  
17 issues, so, ideally, we want consumers.

18 And we realized that a lot of the resumes  
19 that come in did not match to this group, so we did send  
20 some resumes, them meaning Mark Maselli, myself, Sarju and  
21 Lori, were the ones that did this initial review, to the  
22 Commissioner to look at, but we also at the meeting made  
23 another call for people to apply, and there were some  
24 people at the meeting that had not yet applied, and, also,

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1 to spread the word to other groups.

2 I also did a kind of a comprehensive search  
3 of my contacts, and, so, we did an expanded message.  
4 Sarju sent it out to a large number of people with a new  
5 deadline of August 19th, so, hopefully, we will get a  
6 broader array of people.

7 We made it clear that the meeting is an  
8 open meeting, but we ideally would like to have at least  
9 some people that represent each of these categories, so  
10 we're meeting what ONC is looking for.

11 We decided that we needed a lot of  
12 meetings, because our thinking is is that it would be a  
13 terrible mistake to not have a patient bill of rights, but  
14 it goes well beyond the patient bill of rights, because we  
15 need consumer-friendly education materials, and we also  
16 need, because we have decided an opt-out to be the way  
17 we're doing things, and that still is controversial, and  
18 that comes up at each of our last two meetings, but we  
19 keep saying that is what the Board has decided, but we  
20 cannot begin the system if people are not able to exercise  
21 their opt-out rights and know what that means and how they  
22 do it and so forth.

23 So we decided we needed to be on a fast  
24 track to try to develop consensus on a patient bill of

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1 rights and start putting in place the opt-out procedures  
2 and the consumer education materials, so we have three  
3 meetings in September that are scheduled.

4 One is looking a little questionable now,  
5 based on Lori's schedule and my schedule, but tentatively  
6 now we have three dates. If we have to drop one, we will  
7 replace it probably with a date. I think we accomplished  
8 a good deal at the first meeting and the second meeting.

9 I will say, and we can talk about this in  
10 Executive Session, is that I'm very concerned about two  
11 things. I'm concerned about staffing capacity, because I  
12 know the Health Department has to pull back, and there's a  
13 limit to what Mark and I are going to be able to do on our  
14 own.

15 Certainly, Lori was at the meeting and was  
16 very helpful, but I'm cautious about saying she can do  
17 things unless I'm sure she can. And it's not just  
18 staffing the committee, which is fine, but it's developing  
19 all of the educational materials that I think are going to  
20 be there.

21 And then the second issue is budget, and I  
22 know from looking at the budget that it's very limited,  
23 and I do have some ideas, as to how we can do some of  
24 those in a limited way, but that would require, I think,

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1 more cost to the people that are opting in or joining us,  
2 you know, your issues of topic at the hospitals.

3 If we cannot develop, because of our  
4 budget, comprehensive materials that we hand people, then  
5 we could develop PDFs that people have to use, but then  
6 that's going to require, you know.

7 That's just one idea, but that will require  
8 more cost on their side, so I think both staffing of the  
9 committee and, also, the development of the consumer  
10 education materials is something that we need to address  
11 early on.

12 We're assuming, I'm assuming, and I think  
13 Mark is assuming that we need to have these things in  
14 place by the time the consumers start having their  
15 information being put into the HITE-CT. Any questions?

16 CHAIRPERSON AGRESTA: I think you're doing  
17 a wonderful job, Brenda. I really do.

18 MS. KELLEY: We're at a very elementary  
19 stage.

20 CHAIRPERSON AGRESTA: Yes, but I think you  
21 have all of the key issues outlined. Thank you.

22 MS. HOOPER: Technical is Peter?

23 MR. COURTWAY: The Technical Committee has  
24 not met since the last session, but I've been

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1 concentrating with Lori and counsel on the negotiation of  
2 the contract, which is part of the (high-pitched noise).

3 We are planning on noticing the Technical  
4 Committee not for next week, but the week after, with the  
5 next pieces being picked up and taking a look at the  
6 domain policy.

7 The other policies are being developed to  
8 make sure that they could be technically implemented  
9 within the contract and the framework, so that we're sure  
10 that we have a match up and a policy that could actually  
11 be proceduralized with the technology we're acquiring.

12 I imagine we'll be, you know, back on a  
13 roll and regularly scheduled meetings at that point to  
14 march us forward.

15 CHAIRPERSON AGRESTA: All right. Now we  
16 have an opportunity to hear from partners to HITE-CT and  
17 the folks who are kind of going to work with us, and we're  
18 very excited to invite you to present. So, first, we have  
19 the evaluation project, and I think Minakshi Tikoo is  
20 going to share with us, and, hopefully, we can actually  
21 project what she has to share.

22 MS. MINAKSHI TIKOO: The contract was  
23 awarded from the Department of Public Health to the  
24 University of Connecticut Health Center to conduct an

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1 evaluation of the HIE project that has been funded.

2 The evaluation period -- the contract was  
3 awarded to us last July in 2010, and the contract period  
4 goes up to 3/14, which is March 14th, 2014.

5 What we decided to do, given the limited  
6 resources, was to use a mixed method approach to evaluate  
7 whether or not this project ultimately meets the goals  
8 that it has set out for itself.

9 We have designed five sub-studies to  
10 accomplish that. One is a lab survey, one is a pharmacy  
11 survey, a physician survey, a consumer survey and a  
12 stakeholder interview.

13 What I have for you is I'm giving you like  
14 a brief outline of how we have approached the survey and  
15 where we are with the surveys right now. We are in the  
16 first stage, which is baseline data, because we didn't  
17 have very good baseline data for the State of Connecticut,  
18 so the first wave of the survey is actually going to be  
19 used as a baseline data in Connecticut.

20 So the first survey to be conducted was the  
21 lab survey, and it was a base survey. All the surveys  
22 actually have gone through the IRB process and have been  
23 approved by the University of Connecticut IRB, so the  
24 State will have the opportunity to publish this, both in a

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1 peer review journal and other places as the State sees  
2 fit.

3 So the web survey was done. The first  
4 mailing was in April. The last mailing reminder went out  
5 in June, and we received 15 responses to the 24 surveys  
6 that were sent out. The rate is 62 or 63 percent. Still  
7 not very good.

8 The limitation of the survey, actually, is  
9 something that we need to kind of review and see what we  
10 might be able to do, because all the labs that we have  
11 surveyed are hospital-based, and we were able to recruit  
12 help from the Connecticut Hospital Association, and,  
13 hence, we got the rate, but I think one of the concerns we  
14 are hearing in the national discussions that are going on,  
15 about how do you measure these things, is that the labs  
16 that are not hospital-based are the small labs, what are  
17 they doing, as far as adoption of standards.

18 So I think this is something we are  
19 vigilant about, and we are participating in the national  
20 quorum. Discussions are being held, and we're hoping that  
21 if we learn something or get to a point where we can  
22 actually have contact information, where we can send out  
23 the surveys, we will do an addendum to this survey, but,  
24 at this point in time, we have only 15.

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1                   In the pharmacy survey, a little  
2 complicated. The lists have to be generated using  
3 multiple sources, and we got the list from the Department  
4 of Consumer Protection. A list was also received from  
5 Surescripts, and we also used a website to learn about e-  
6 prescriptions.com to get the list.

7                   And we used algorithms to, you know,  
8 unduplicate all these lists, and we came up with 697  
9 unduplicated pharmacies for the State of Connecticut, and  
10 the breakdown is like 535 represent actually chains, seven  
11 are franchise and 145 are independent.

12                   Right now, the survey, the pharmacy survey  
13 is in the field, and we have the web mailing went out in  
14 July, and we also started using telephones.

15                   What we have to do, actually, the reason  
16 for delay is we find out that we needed to use multiple  
17 methods. One method would not suffice, so we actually  
18 went back to our IRB, and we have permission to actually  
19 call people, mail people, and do web page, so that we're  
20 trying to get as much traction on the collection of data  
21 as we can.

22                   The response that we received to date are  
23 32 responses, and these are via the telephone, and only  
24 two via the web, and what we are finding, after talking to

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1 pharmacies, is that the pharmacies usually are very busy,  
2 though they're very willing to talk to us, so we follow-up  
3 with what's a good time for them and we're calling them.

4 It's only been in the field for about two  
5 to three weeks, so we're going to continue to do that, but  
6 the good thing, again, as we realized through the  
7 discussions that are happening actually on the pharmacy  
8 evaluation, is that the most important piece is to get  
9 information from the smaller independent pharmacies,  
10 because the Surescripts data gives us a good idea about  
11 other pharmacies that are chain pharmacies about their  
12 adoption of standards, where they are, how are they using  
13 the e-prescription system.

14 In that sense, we are doing well, because  
15 we are getting the representation from the small  
16 independent pharmacies, and they're very willing to talk  
17 to us, so that we think is a good thing for us, because we  
18 will get enough data about adoption of standards from the  
19 Surescripts data file that is available to the State  
20 through its ONC contact, so we have that file and will be  
21 able to do performance measurement based on that data.

22 You know the limitation, like I said,  
23 there's very few want to take it on the web, but, you  
24 know, some of them said, well, why don't you send us a

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1 link, and then we follow-up, so we're trying to do  
2 everything possibly we can to get the response rate to be  
3 higher.

4 The physician survey list, again, had to be  
5 generated using multiple sources. We received a list from  
6 the Department of Public Health. The list was also  
7 received from the Department of Social Services, and we're  
8 waiting for a list that ONC has promised the Department of  
9 Public Health, which is called the escan(phonetic) a list,  
10 which is actually a national survey that is done by a  
11 private entity on behalf of the physicians, and they  
12 survey them routinely every year.

13 And we will also send out a request to the  
14 Connecticut Medical Society, hoping to unduplicate the  
15 list. We haven't received anything yet.

16 So using our three sources, we got a final  
17 unduplicated list. It was 18,642. The word on the street  
18 was that this is a high number, and there's only 8,000  
19 practicing physicians, or 6,000, but this is the list we  
20 have.

21 So what we did was we added the step, and  
22 we first decided to clean up the list before we actually  
23 sent out the survey, because that's an expansive portion  
24 of the study. So we sent out 18,642 postcards, and we

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1 have so far received 3,492, representing about 19 percent  
2 of the sample.

3 And based on that postcard, we asked them  
4 how the physician would like to receive the survey and if  
5 they would like to receive the survey. We got about 1,200  
6 of them came back, actually, address not known, or person  
7 not found, and, so, based on what the people responded,  
8 whether a telephone survey, a web-based survey, or a mail  
9 survey, that's the methodology we used.

10 The web-based mailing was done in mid July,  
11 telephone calling started early August, and the mail  
12 survey we are waiting the return list to be printed. There  
13 was a glitch in our regular process payments. That's how  
14 it works.

15 And the response we received to date are  
16 181 completed interviews of physician surveys have been  
17 received, and 24 of them are partial.

18 The limitation is the target population is  
19 not known, so this is something I think the State of  
20 Connecticut will have to work on a little bit more to know  
21 what is the population and what is the actual number of  
22 physicians that practice in the State of Connecticut.

23 It's kind of interesting, because when I  
24 started this evaluation, I didn't think this was something

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1 I'd be working on and not knowing what the population was,  
2 so we're working on it, and I think we've reached out to  
3 people, and I think, at the end of the process, it should  
4 be a known quantity, and this would be a benefit, not just  
5 DPH or HIT, but I think of the State I think in general.

6 So far, just the preliminary results,  
7 because I thought otherwise you might be bored, the age  
8 range of the respondents is between 31 to 83, the gender  
9 75 percent, so three percent of the survey respondents are  
10 male, 28 areas of certification are represented, 98  
11 percent of the people that completed were physicians,  
12 because we thought what if they're going to give it to an  
13 office manager. So far, looks like they have been doing  
14 it themselves.

15 A few things of interest to you. Methods  
16 of record storage, 43 percent of them are paper records,  
17 48.6 percent are computer-based records, and 40, 41  
18 percent are using EHR system, actually, and some have a  
19 combination.

20 Duration of EHR users in the main practice  
21 ranges from less than one year to greater than five years,  
22 so there is a spread for you.

23 The EHR influence on medication error, this  
24 is the opinion questions, what did they think EHRs are

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1 helping them do, and the majority of the people think that  
2 they have a positive impact on reduction of medication  
3 errors, and satisfaction with EHR, again, we see more  
4 people are happy and satisfied with their EHR, but there  
5 are also people that, 20 percent of the people that are  
6 not happy with the EHR they have.

7           Again, the study is designed as a repeated  
8 measure study, so we have to be doing it in multiple  
9 times, so that we will see change over time at the time  
10 that HITE-CT is kind of implementing a lot of policies and  
11 procedures and reaching out. Hopefully, we will see a  
12 change in the right direction.

13           Familiarity with the CT-HIT initiative,  
14 this I thought the Board would want to know. Most people  
15 are not familiar at this point in time, so I think, you  
16 know, I've heard the discussions here about reaching out,  
17 education. I think those are getting born out in the data  
18 that you're finding, so there is some thinking there of  
19 what the Board is thinking, in terms of its stakeholders  
20 and that the stakeholders are.

21           Just a few comments from the physician  
22 survey. It needs more promotion. I'm interested in  
23 learning more. Clearly, better efforts are promulgating  
24 the ideas and plans of the endeavor are needed, meaning to

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1 me at present that are both positive and encouraging, but  
2 at the same time negative comments.

3           Seems like publicity is in order, which is  
4 what you guys have been talking about. Only heard about  
5 this through the survey, because when we ask them  
6 questions, and on the phone we also give them information  
7 after we ask questions, because we don't want to influence  
8 their answers to whether or not they're aware of it, but  
9 we do ask them if they want to know more about the  
10 initiative, and then we have like a standard way of  
11 telling them what this initiative is about and where they  
12 can go and find information.

13           The last two pieces of the evaluation on  
14 one is a consumer survey. This is a randomly generated  
15 list that we have purchased from Genesis, which gives us  
16 household phone numbers, basically, and we started calling  
17 just this past week, and, so far, now we've gone up to I  
18 think -- I don't have it up there.

19           So this is just, you know, starting, and  
20 we're going to see some part of -- this, actually, is a  
21 piece of the survey that has not been done, because last  
22 week I got a call from the State of Alabama from the  
23 Medicaid authority, and the School of Public Health in  
24 Alabama had been recommended to go look at our study,

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1 which is doing the cost evaluation nationally, but they  
2 didn't have a plan, and ours is the only plan that's up  
3 and running, so Connecticut should be, regardless what  
4 they're doing, because I think you will probably see the  
5 consumer survey piece is not being done anywhere else, and  
6 that's actually important, because those are the  
7 constituents that we really do want to have impacted.

8 Last, but not least, is the stakeholder  
9 interviews. We started with interviews with the Board  
10 members. We have completed interviews with nine Board  
11 members. We got no responses from six. Nobody actually  
12 refused, and one had a cancelled appointment.

13 As a result of these interviews, we have  
14 been recommended by the Board members to go and seek out  
15 other broader stakeholders, so that we have done an  
16 addendum to our IRB, because we need approval, because  
17 initially we had said we would only talk to the Board  
18 members, because now we want to talk to other people and  
19 groups of people.

20 We're asking for amendment to the IRB, and  
21 when we have it, we'll be going out to other people to get  
22 their feedback. Any questions?

23 MS. HOOPER: Thank you for putting us as a  
24 model example for the U.S.

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1 MS. TIKOO: You're welcome.

2 MS. HOOPER: Do you have any questions for  
3 Minakshi? We had staff people answer the surveys. It  
4 really is the only way that we have data. The actual  
5 practicing physicians the Department has an on-line  
6 licensure system up and running now.

7 That really is the only way that we are  
8 able to ask physicians, nurses and dentists if they are  
9 indeed practicing the old paper forms. It was not asked.  
10 It was simply for a licensure database.

11 We all know that there are nurses, doctors  
12 and dentists that want to retain their license, but, in  
13 fact, not practice. There's also those that retain their  
14 licenses in two states, but they serve in New York, but  
15 they retain their license here.

16 We fooled Minakshi to let her think that  
17 the number was readily available, but, in fact, it was  
18 not. We're hoping, as the e-licensure system goes  
19 forward, that the Department will have all the health care  
20 workforce licensed, and that will give us some better  
21 information.

22 CHAIRPERSON AGRESTA: Thank you. I'm  
23 actually thrilled that you've gone through the IRB, so  
24 that this can actually get published, because I think it

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1 is an important example that we can set, but it also will  
2 allow us to gather a lot of information from other states,  
3 as well.

4 Next up on our partner updates, Mark is  
5 going to talk about the Connecticut Department of Social  
6 Services.

7 MR. HERSCHKEL: Thank you. This evening,  
8 I'd just like to update you mainly on the status of the  
9 Connecticut EHR Incentive Program in Connecticut.

10 Our program was officially launched back  
11 with CMS on July 4th. Now what that means is, as of that  
12 date, both hospitals and eligible professionals are able  
13 to register on CMS's centralized registration.

14 Registration of the system is a  
15 prerequisite to applying for the incentive payments at the  
16 state level. Today, as of this morning, our reporting  
17 tells us there's been 91 providers that have registered,  
18 six hospitals and 85 eligible professionals.

19 To apply for the incentive payments,  
20 providers must be registered in the system I just  
21 mentioned, the RNA system at CMS, and then open up an  
22 application in the State's mapper system.

23 The mapper system is what we're working on  
24 here in Connecticut. It's actually developed by HP

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1 Enterprise Services, who is our MMIS contractor, in  
2 collaboration with 12 other states.

3 On September 1st, we plan to open the  
4 system up to applications for incentive payments for  
5 providers, who adopt, implement, or upgrade certified EHR  
6 systems, and payments to eligible providers will begin as  
7 soon as the second week in September, assuming we get  
8 providers made eligible that quickly, but the intent is  
9 certainly to be able to pay as soon as we can determine  
10 eligibility.

11 In the meantime, DSS has been making  
12 preparations to accept the applications beginning  
13 September 1. We've been working with HP Enterprise  
14 Services on configuring mapper, testing it, integrating it  
15 with our MMIS system.

16 Prior to the formal program opening at the  
17 State level on the 1st of September, we are having HP data  
18 tests with several hospitals and EPs. This allows us to  
19 test the process with real data and refine our operation  
20 procedures and guidance.

21 We've also been preparing provider user  
22 guides in other publications. User guides for both  
23 hospitals and professionals are now available on the  
24 website HP maintains for us. That's [www.ctdssmap.com](http://www.ctdssmap.com).

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1 DSS staff have also been very busy working  
2 on draft regulations governing the program and on internal  
3 review procedures and pre-payment audit.

4 And I'd also like to mention that DSS is in  
5 discussions with UConn's Biomedical Informatics Division,  
6 forming a collaboration to strengthen the administration  
7 of a program.

8 We hope to bring BMI subject matter  
9 expertise to help insure maximum provider participation in  
10 the incentive program to strengthen our ability to  
11 collaborate with our HIE partners and to provide technical  
12 expertise as we develop mechanisms for reporting use and  
13 critical quality data in support of other DSS initiatives.

14 Finally, I'd like to mention that DSS is  
15 planning to participate in the Connecticut HIE summit,  
16 both sponsored by e-Health Connecticut, by this Board,  
17 this organization, the Department of Public Health and  
18 Capital Community College, and that's scheduled for  
19 October 20th. Thank you. Does anybody have any  
20 questions?

21 MS. HOOPER: Thank you, Mark. Any  
22 questions? Congratulations on signing up. Dr. Buckman?

23 DR. BUCKMAN: The number of providers and  
24 hospitals you have signed up, are they signed up

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1 specifically for the Medicaid side of the program?

2 MR. HERSCHKEL: Yes.

3 DR. BUCKMAN: Okay. That's a good number.

4 MS. HOOPER: Mark, will you send that to me  
5 via e-mail, so we make sure that we get reflected in the  
6 minutes?

7 MR. HERSCHKEL: Certainly.

8 MS. HOOPER: Thank you.

9 MR. CARMODY: Mark, what was the  
10 anticipated or what you think it's going to grow to, so we  
11 heard the numbers of what was signed up, but what was the  
12 expected? Was it compared to --

13 MR. HERSCHKEL: That's something we have to  
14 look at. I think there's some concerns that are in our  
15 planning, and I can't remember the numbers off the top of  
16 my head.

17 I think there may be a realization in some  
18 of our planning work earlier that we may have been under  
19 counting, or underestimating. It's actually something we  
20 want to look at going forward. Eventually, we're going to  
21 have to probably revise our estimates we give to CMS for  
22 the actual allocation of incentive payments.

23 I wish I knew more specific, but I can't  
24 remember what the numbers were.

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1 MS. HOOPER: All right. Those incentive  
2 payments and signing up are ready.

3 CHAIRPERSON AGRESTA: I think it's  
4 wonderful, and I think that, you know, making this as a  
5 public announcement now, you know, anybody that is  
6 eligible should sign up, because this is one of those  
7 things that will be of great value and will facilitate  
8 what happens across all these realms, and I'm very  
9 excited, so thank you.

10 Now I'd like to open it up for the Regional  
11 Expansion Center, e-Health Connecticut, and Scott is  
12 coming up.

13 (Off the record)

14 MR. SCOTT RUTH: Thank you, Tom. On behalf  
15 of e-Health Connecticut, I'd like to thank you and Meg and  
16 all of your Board members for your open arms and for this  
17 opportunity to collaborate, because, goodness, there's a  
18 lot of work that we need to do and should be doing  
19 together.

20 What I thought I'd do is suggest three  
21 specific areas where perhaps we can collaborate, but  
22 before I do that, maybe I'll just give you a brief  
23 overview of our charge with the feds, and then a little  
24 bit of a status report on where we are, and then get into

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1 those three areas of collaboration.

2 First, our charge. We have a four-year  
3 cooperative agreement with the Office of the National  
4 Coordinator. That started in April of 2010. That goes to  
5 April of 2014. Our commitment is to help 1,308, there's a  
6 precise number for you, 1,308 priority primary care  
7 providers get to be meaningful users of certified health  
8 information technology.

9 So, basically, there's a very specific  
10 requirement, as all of you know, that the feds have for  
11 what is meaningful use. It's 15 core components and five  
12 from a menu set, and it's our job as the Regional  
13 Extension Center to explain all that and then help  
14 priority primary care providers go on that journey and  
15 actually implement the technology.

16 What's a priority primary care provider?  
17 Basically, it's primary care providers in small practices,  
18 10 or fewer, as defined by the feds.

19 Also, it's primary care providers who serve  
20 vulnerable underserved populations, such as the federally  
21 qualified health centers and hospitals that serve a very  
22 large percentage of Medicaid or uninsured folks, so if  
23 hospitals have primary care clinics and they meet those  
24 criteria, they are priority primary care providers.

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1                   Anyway, we've got all those rules, and  
2 we'll be very happy to explain those to anybody who wants  
3 to know.

4                   The way the business model works is that we  
5 have the 6.4-million-dollar contract from ONC, and we turn  
6 around and we have hired, to a very open competitive  
7 process, direct assistance contractors that we deploy to  
8 go help our customers, that's the priority primary care  
9 providers, get the meaningful use.

10                   We have I think the number, Steve, is  
11 around 10 of these qualified organizations that we  
12 actually deploy, and then, as they deliver certain pieces  
13 of work and spend certain hours with the providers, we go  
14 ahead and leverage that federal subsidy to pay them the  
15 majority of their fee.

16                   We do collect a fee from the providers,  
17 themselves, and that depends on the scope of work, but  
18 it's between 450 and 750 dollars per provider.

19                   Okay, so, how is it going? Remember 1,308  
20 as our ultimate goal? We have 900 enrolled in the  
21 program, so we have 900 customers, who have signed the  
22 contract. We've deployed the direct assistance contract  
23 that is best for them, and we're off to the races.

24                   We get paid by the feds, based on three

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1 milestones. Milestone one is enrollment, so we've got 900  
2 providers, where we can basically receive a third of our  
3 per provider reimbursement number.

4 Milestone two is when those providers are  
5 actually live, using an electronic health record. Live  
6 means e-prescribing. And milestone three, of course, is  
7 use.

8 We have developed an on-line system, and I  
9 think this is one of the things that perhaps we can  
10 leverage together. The on-line system we have enables us  
11 to on-board these provider customers electronically, so  
12 we're out in the community basically describing the  
13 program, recruiting folks, but once they've decided to  
14 commit, they can come online, they give us their tax ID  
15 information, they give us their site information, their  
16 individual provider information, and all kinds of data  
17 about their practice.

18 We capture that in data, and now we're  
19 ready to roll. They actually sign a contract with us,  
20 which is customized to them, and that contract is  
21 automatically generated. They give us an e-signature  
22 online, but my point is we capture data about these  
23 providers in our system now.

24 As you think about it, this is one of the

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1 three areas of collaboration, as you think about,  
2 goodness, how are we going to reach out to the provider  
3 community and attract them to the HIE and help them plug  
4 into the HIE, you can use us to do an awful lot of that,  
5 number one, to carry the message, and then, number two, to  
6 know something about the providers, and maybe there's even  
7 something more we can do in your on-boarding process to  
8 leverage the system we have in place and the relationship,  
9 the trusting relationships that we have and are trying to  
10 build with those providers.

11 So that's kind of collaboration opportunity  
12 number one. It's just use us, since we and our direct  
13 assistance contractors are the boots on the ground in the  
14 field every day. Once you have your messages and once you  
15 have your sales pitch, once you have anything, you know,  
16 your policies and so on, you can use us to help spread the  
17 word.

18 Number two, and, Mark, you referred to it,  
19 we got an immediate opportunity for collaboration, and  
20 that's the conference on October 20, which is nine weeks  
21 from Thursday. It's going to be at the Capital Community  
22 College. They're going to be very proud to show off their  
23 campus and the collaboration that CCC has with us and with  
24 HITE Connecticut and DSS and DPH, so you're all invited.

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1                   We've got to get organized to get a little  
2 sign up process on our website. Probably, there will be a  
3 charge, perhaps, unless you're a priority primary care  
4 provider and already a customer of the REC. We've got to  
5 figure that out.

6                   Anyway, you're invited, and look forward to  
7 a great day. We'll probably spend mostly the whole  
8 afternoon and maybe into the evening, but, Lori, as you  
9 and I were discussing, maybe we do a couple of workshops  
10 in the morning, in addition, around e-prescribing, around  
11 Health Information Exchange, whatever agenda items we come  
12 up with.

13                   The third area is, in general, education,  
14 training. We are all about that, and we're working with  
15 our contractors, partners, UConn, the Connecticut  
16 Pharmacist Association, I see Marie Smith from UConn  
17 School of Pharmacy, to basically put together on-line  
18 training around meaningful use, about what is a certified  
19 EHR, about specific topics, like e-prescribing and  
20 medication therapy management and medication  
21 reconciliation, use of the computer, so from general to  
22 very detailed topics we're going to offer those online to  
23 our REC customers.

24                   And, working with UConn, we're going to

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1 offer an opportunity for providers, doctors, to basically  
2 earn continuing medical education credits. We have to  
3 figure out our business model around that, but that's  
4 going to be a capability that we offer and we think the  
5 best one to attract quite a few folks, you know, to the  
6 website to us as a Regional Extension Center.

7 And, again, as you think about the messages  
8 and the education you want to do, you know, again, just  
9 leverage, you know, let's work together for leverage and  
10 things that we have in place.

11 And then, on behalf of e-Health  
12 Connecticut, just a general offer to sit down any time,  
13 anywhere to figure out how we share resources and all that  
14 goes with it, because that's what we know we're all about.

15 So thank you for having me, and if there  
16 are any questions, I could certainly take those, otherwise  
17 -- Kevin?

18 DR. CARR: So for the providers -- so how  
19 would they get access or sign up for the subsidized  
20 services?

21 MR. RUTH: They can go right to e-Health,  
22 [www-dot-ehealthconnecticut-dot-org](http://www-dot-ehealthconnecticut-dot-org), and, all the  
23 information is there, and if they're so inclined, they can  
24 actually sign up and execute a contract, or they can call

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1 me or send me an e-mail, and that contact information is  
2 on the website.

3 DR. CARR: Okay. Thank you.

4 MS. HOOPER: Other questions for staff?

5 And we're very proud to have the partnership. Dan has  
6 been our liaison, and I'm sure that he's been hustling in  
7 relaying the information. We are talking about sharing  
8 resources as the staff and their locations are going  
9 forward. Any questions, other than thank you?

10 I don't think we're going to get -- e-mail  
11 me those.

12 CHAIRPERSON AGRESTA: All right. And, so,  
13 you know, I think that we've got some absolutely wonderful  
14 collaborations going forward, and this has been a very  
15 whirlwind year and a half, or I don't know how long it's  
16 been, but it's been a whirlwind time frame.

17 I think the collaborations are at a rich  
18 stage and have the capacity to really help us, and I think  
19 we need to think about how we leverage them, as Scott  
20 mentioned.

21 As we get into delivering messages and  
22 education and there's more than one budget, more than one  
23 group that can work collectively on these things, and I  
24 think we need to figure out how to do that, so I'm very

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1 pleased about that.

2 I think next on our agenda is to kind of  
3 open up for public comment before we go into Executive  
4 Session.

5 MS. HOOPER: And we would ask anybody that  
6 has comments from the public if you will step up?

7 CHAIRPERSON AGRESTA: Please come up.  
8 Yeah, come up.

9 MS. HOOPER: So that we can have that  
10 recorded.

11 A MALE VOICE: You want us to introduce  
12 ourselves?

13 CHAIRPERSON AGRESTA: If you're coming up  
14 to make a public comment, sure. So we do have members of  
15 the public here. Hearing no comments, I will release the  
16 public to go on their merry way and enjoy the evening.

17 MS. HOOPER: And I believe, also, the  
18 media.

19 CHAIRPERSON AGRESTA: We need to make a  
20 motion to actually enter -- the end the public component  
21 of this and to go into Executive Session.

22 DR. BUCKMAN: Move that move into Executive  
23 Session.

24 A MALE VOICE: Second.

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1 MS. HOOPER: May we ask for the -- well we  
2 have to have two Executive Sessions, so I'm sorry, Dr.  
3 Buckman.

4 DR. BUCKMAN: I move we move into Executive  
5 Session to review vendor contract and status pursuant to  
6 Connecticut General Statutes 1-210b 24.

7 MS. HOOPER: Thank you very much, Dr.  
8 Buckman. And was there a second?

9 MR. CASEY: Yes, there was.

10 MS. HOOPER: Thank you, Mr. Casey.

11 CHAIRPERSON AGRESTA: All in favor?

12 A MALE VOICE: Do we have an invite list,  
13 as well, for that?

14 CHAIRPERSON AGRESTA: I believe that we  
15 need to have an invite list for members who are not  
16 members of the Board. The CEO now is officially part of  
17 Executive Session.

18 MS. HOOPER: How would you like us to close  
19 up?

20 A MALE VOICE: Are you going into Executive  
21 Session now?

22 MS. HOOPER: Yes, sir.

23 CHAIRPERSON AGRESTA: So I would like to  
24 amend that, that we include DPH staff as part of that

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1 Executive Session.

2 DR. BUCKMAN: Accept the amendment.

3 CHAIRPERSON AGRESTA: All in favor?

4 VOICES: Aye.

5 CHAIRPERSON AGRESTA: Any opposed? Into  
6 Executive Session we go.

7 (Whereupon, the meeting moved into  
8 Executive Session.)

9 CHAIRPERSON AGRESTA: We have returned out  
10 of Executive Session at 7:05 or so, and we had a very  
11 fruitful discussion on the two agenda items, and I believe  
12 there's a motion to be put forward regarding the CEO  
13 search process. John, you want to --

14 MR. LYNCH: The motion has a series of  
15 steps. The first part of the motion is to close the  
16 search process for additional candidates as of Friday,  
17 August 19th.

18 The second component is that we have two  
19 candidates and that we propose to, for the next stage, to  
20 bring them to a teleconference interview process with the  
21 entire Board invited to the Search Committee meeting for  
22 that process to be held sometime in mid to late June,  
23 excuse me, mid to late September, and that DPH should be  
24 searching background issues relative to a candidate from

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1 out of country.

2 MS. HOOPER: Is there a second?

3 A MALE VOICE: Second.

4 MS. HOOPER: Discussion?

5 MR. COURTWAY: Do you want to keep it open  
6 for candidates that come in between now and August?

7 MS. HOOPER: Yes.

8 CHAIRPERSON AGRESTA: Any other comments?  
9 All in favor?

10 VOICES: Aye.

11 CHAIRPERSON AGRESTA: All opposed? All  
12 abstentions? Would anyone like to --

13 MR. CASEY: Move to adjourn. (Laughter)

14 CHAIRPERSON AGRESTA: All in favor?

15 VOICES: Aye.

16 CHAIRPERSON AGRESTA: All right, thank you,  
17 everybody.

18 (Whereupon, the hearing adjourned at 7:07  
19 p.m.)