

VERBATIM PROCEEDINGS  
DEPARTMENT OF PUBLIC HEALTH

CT HEALTH INFORMATION TECHNOLOGY  
AND EXCHANGE STRATEGIC PLAN

DR. THOMAS AGRESTA, ACTING CHAIRPERSON

DECEMBER 19, 2011

101 EAST RIVER DRIVE  
EAST HARTFORD, CONNECTICUT

POST REPORTING SERVICE  
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RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
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1 . . .Verbatim proceedings of a meeting in  
2 the matter of CT Health Information Technology and  
3 Exchange, held at 101 East River Drive, East Hartford,  
4 Connecticut on December 19, 2011 at 4:34 P.M. . . . .

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6  
7  
8  
9 ACTING CHAIRPERSON THOMAS AGRESTA: So I'm  
10 going to call to order the meeting. We do have a quorum,  
11 Marianne just informed me that the Commissioner is kind of  
12 tied up and will make it if she can a little bit later so  
13 we're going to go ahead and start.

14 So the first order of business is just to  
15 review and approve the minutes for the November 21st Board  
16 meeting.

17 MALE VOICE: Move we approve the minutes.

18 MALE VOICE: Second.

19 ACTING CHAIRPERSON AGRESTA: Any  
20 discussion? Okay, all in favor?

21 VOICES: Aye.

22 ACTING CHAIRPERSON AGRESTA: Alright --

23 MS. MEG HOOPER: Any opposed?

24 ACTING CHAIRPERSON AGRESTA: Any opposed?

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1 Any abstentions?

2 DR. STEVEN THORNQUIST: Me, I wasn't here,  
3 I can't vote.

4 ACTING CHAIRPERSON AGRESTA: Alright, so if  
5 you're not here you can't vote.

6 MS. HOOPER: Thank you Dr. Thornquist.

7 ACTING CHAIRPERSON AGRESTA: And the next  
8 is kind of go through HITE/CT business, so the first order  
9 of business is the Treasurer's report and --

10 MS. HOOPER: We did deposit that.

11 ACTING CHAIRPERSON AGRESTA: -- okay, so  
12 the Treasurer's report, I don't have a full Treasurer's  
13 report this month. We're in a transition phase with  
14 accountants at DPH but I am pleased to say that unlike  
15 last month when I gave the Treasurer's report where we  
16 were in deficit and awaiting funding from DPH, we actually  
17 have deposited the first large sort of transfer of funds  
18 to HITE/CT. So we had \$1.6 million and change transferred  
19 over to our account about three weeks ago, two weeks ago.

20 MS. HOOPER: Yes.

21 ACTING CHAIRPERSON AGRESTA: And we've  
22 subsequently spent a good portion of that paying that  
23 right back out to our vender Axeway and to outstanding  
24 bills that we had with our legal counsel and with our

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1 Interim CEO. But we still have a remainder in the account  
2 that's sufficient to pay for the CEO Interim, Chief  
3 Technology Officer, the next payment that's required from  
4 our vender, and it's sufficient to get us through  
5 comfortably to the next transfer of funds, which is  
6 anticipated in March of 2012. So I'm happy to say that we  
7 are fiscally sound at the moment.

8 MS. MARIANNE HORN: Did we have somebody  
9 else call in?

10 MR. MARK MASSELLI: Hi, it's Mark Masselli  
11 how are you today?

12 MS. HORN: Hi Mark, welcome.

13 MR. MASSELLI: Thank you.

14 ACTING CHAIRPERSON AGRESTA: The next  
15 standing order of business, the Executive Committee  
16 decided that at each meeting we'd like to hear directly  
17 from our CEO and to have the CEO give a report as he or  
18 she so desires, and so David.

19 MR. DAVID COILBERTSON: Okay, well I'm  
20 three weeks into the job and I'm starting to get a better  
21 feel for what this is going to take and understand the  
22 players involved. A lot of stakeholders. I'm very  
23 pleased with kind of where the project is at this point.  
24 There's been a lot of work done by the Committees, a

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1        tremendous amount of work done by the Committees. And  
2        Lori in her role in the interim has really brought us to a  
3        point where we're ready with our vender partner to  
4        actually implement some of the technologies that we've  
5        been talking about. And that allows us to then start  
6        focusing on testing out and bringing up sites, which  
7        ultimately for us is going to be the key in bringing  
8        people, bringing providers on to the Health Information  
9        Exchange and looking at what it's going to take to  
10       actually do that.

11                        As you'll hear in the Committee reports,  
12        I've sat through a lot of the Committees as Lori has, and  
13        again, a lot of progress has been made on some of the key  
14        things that have to be in place before we can even start  
15        to bring the right organizations up on the HIE. And  
16        you'll hear about some of those today. I think our  
17        biggest challenge or my biggest challenge is going to be  
18        trying to stay ahead of the cash flow for this  
19        organization. Obviously we have -- the budget was put  
20        together very carefully and we did the best we could do,  
21        but there's a requirement for us to generate a certain  
22        amount of revenue by -- within the next four or five  
23        months, six months, that's going to be very important for  
24        us to have enough cash flow in order to sustain.

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1                   So I think our effort has got to be in  
2 bringing the technology up, getting it to work, getting it  
3 tested, the Business and Operations Committee is going to  
4 be key because that's really how you make it work within  
5 all the things that have to make everything work together.  
6 Not only within our organization but within -- the  
7 provider organization has to start dealing with this new  
8 thing called an HIE and providing guidelines and training  
9 and how to do that. So I think my focus right now is just  
10 understanding what it's going to take to start to generate  
11 the interest and the cash flow so that we don't run into a  
12 problem once we -- you know, four or five months into this  
13 project we need to start generating some revenue. So  
14 that's going to be our biggest challenge.

15                   MR. DANIEL CARMODY: So question, we know  
16 that Axeway had responsibility within this to help  
17 generate the cash flow from the standpoint of getting  
18 providers signed up and signed on in working with the REC.  
19 So I guess my question is, are they solely focused on the  
20 technology piece or do we think there's enough work being  
21 put forth to create that pipeline so that it's not just  
22 you, and it was never intended just to be the CEO or the  
23 CTO, to focus on that?

24                   So if they're not doing that then I think

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1 that we need to understand what they are and what they are  
2 not doing in order to help generate that cash flow.

3 MR. COILBERTSON: To date my -- and Lori  
4 can correct me, but I don't see that they've been doing  
5 much in that area. I've had a conversation with them  
6 about that and they're willing to work with us to see what  
7 they can do. I don't know how much they have dedicated in  
8 terms of resources to support that, but that's discussion  
9 --

10 MR. CARMODY: Well let's put it this way,  
11 my -- and I'll just be very honest. I don't think we  
12 should make another payment until we get that clearly  
13 understood because that was not the basis in which the  
14 budget was put together. The basis in which the budget  
15 was put together is that there was a sizeable amount of  
16 people in working with the REC to help drive adoption.

17 Now granted, that still required the  
18 technology to be moving forward so that we actually had  
19 the technology to actually show them and implement. I  
20 mean don't get me wrong, but there were two sides to that  
21 coin. And the only reason why the budget floated in  
22 pencil was because that we believed that there was a level  
23 optimism as well as resources being put forth by the  
24 vender in order to make that happen. So if that is not

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1 the case then we have to have a sit down.

2 MS. LORI REED-FOURQUET: So the scope of  
3 work stated was the phase one -- phase 1A and phase 1B,  
4 was indeed focused on getting the technology up and  
5 running.

6 MR. CARMODY: Yup.

7 MS. REED-FOURQUET: They're in the process  
8 of developing the scope of work, the statement of work for  
9 our next phase. And that next phase does include -- one  
10 of the technology pieces that we bought from them was a  
11 campaign -- the ability to make a campaign to those  
12 potential stakeholders. So I'm expecting that will be in  
13 and a very short part of it is one of the multiple  
14 provider directories that we'll be seeing with information  
15 technology.

16 MR. CARMODY: Plus the tie-in with the REC  
17 I mean because again, we were sort of like -- the goal is  
18 even though the REC was responsible for talking about what  
19 they needed to do on the implementation. And I'll see  
20 Scott Cleary again today but I thought -- again, was that  
21 three-legged stool.

22 If the REC was already touching however  
23 many physicians they were -- they had people on the ground  
24 with the easy registration process. Because if those

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1 things don't come together then the budget does not --

2 MR. COILBERTSON: Well -- I mean, and  
3 that's the piece that I'm not sure has come together yet.

4 MS. HOOPER: No, I don't think the REC has  
5 met with Axeway yet.

6 MR. CARMODY: Okay, so again --

7 MS. HOOPER: So we would encourage that to  
8 happen.

9 MR. COILBERTSON: Well that -- yeah, I mean  
10 it's really trying to -- we've got bring that piece  
11 together and that's what I was saying is that technology  
12 is one piece and I think that's moving forward fine.

13 MR. CARMODY: I just didn't want -- I mean,  
14 the way as I listened to your report-out I got the  
15 impression like it's David against the world and --

16 MR. COILBERTSON: No, no --

17 MR. CARMODY: -- there's -- it really is,  
18 you had a support mechanism within that scope of work and  
19 I just wanted to make sure that they were living up to  
20 that because that allowed us to be real. And if they  
21 didn't come to the table with those resources yet --  
22 you're right, we are going to have -- I mean, not that  
23 there's not going to be pressure on the cash flow because  
24 we have to make that happen, but that truly would have

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1 made it even more difficult to --

2 MR. COILBERTSON: I think to clarify what I  
3 was trying to say is that has not happened yet. A plan  
4 hasn't been developed yet. I don't know what resources  
5 they're bringing to table. I am not sure that the current  
6 project manager is fully up on what that's going to take.  
7 I don't know if they have additional resources to help  
8 with that. I mean, there are certain skill sets that are  
9 different than technology skill sets to do what we just  
10 talked about and so they're going to have to bring some  
11 new people to the table that I haven't met yet, so.

12 ACTING CHAIRPERSON AGRESTA: And I think  
13 what Dan is alluding to is that when we were negotiating  
14 the contract we very clearly defined this as the stage  
15 that needed to occur after sort of the technical  
16 infrastructure was up and going. And it was the  
17 expectation that they would bring resources to the table  
18 to help with that and that was put into the contract.

19 How do you operationalize is really part of  
20 stage two scope of work, which the intention was that that  
21 was actually being sort of worked on as we speak right  
22 now.

23 MR. CARMODY: It had to be happening  
24 incongruently because if you --

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1           ACTING CHAIRPERSON AGRESTA:  -- yeah, and  
2           so the stage two statement of work I think is probably  
3           something that we need to look at and making sure that  
4           that gets laid out.

5           MR. COILBERTSON:  I don't think we've -- we  
6           haven't seen that --

7           MS. REED-FOURQUET:  No, last week --

8           MR. CARMODY:  Yeah, I just think -- and  
9           again, so if we can make -- I mean obviously, that's what  
10          needs to take place because that's what makes it real and  
11          so if we're not doing it in tandem then we will quickly  
12          run into an issue because everything was based upon the  
13          adoption rate.

14          MR. COILBERTSON:  Ahum.

15          MR. CARMODY:  So if the adoption rate is  
16          not there and they were the ones who talked about they  
17          were in it with us, we'll run out of cash.

18          ACTING CHAIRPERSON AGRESTA:  Well, we can  
19          --

20          MR. CARMODY:  I don't need an accountant to  
21          tell me that.

22          MR. JOHN LYNCH:  I think part of the  
23          problem is there was a series of things that all have to  
24          be done in parallel.  So for example, even in the test

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1 participation agreement it talks about whoever signs up  
2 might get 50 percent off of what? So we need to have that  
3 whole process of setting what the rates are going to be  
4 and if we're going to get the REC involved, in many ways  
5 that Business Operations Committee has to kind of work  
6 with Axeway to figure out what is the process actually  
7 going to be to actually train the REC, etc.

8 So there is a lot of connections that have  
9 to be made in parallel all at the same time.

10 MS. REED-FOURQUET: Yeah, and they're going  
11 to give us the trainers but we have to bring the trainers  
12 to the table that we want to architect into our schemes so  
13 we don't want to jump too quickly into delivering that if  
14 we have other --

15 MR. LYNCH: And from the testing process is  
16 where we will find out some of these workflow issues. So  
17 we need to get the testing process going to help define  
18 those workflows, to be able to train, but we need the  
19 rates for what's the person who's volunteering to do,  
20 etc., so it's --

21 ACTING CHAIRPERSON AGRESTA: It sounds like  
22 what we need is sort of a standard logic map.

23 MR. COILBERTSON: Standard what?

24 ACTING CHAIRPERSON AGRESTA: Logic map,

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1 sort of when does what need to happen in what order in  
2 order to facilitate that most effectively happening.

3 MS. BRENDA KELLEY: Yeah, what John just  
4 said makes me feel I haven't totally lost my mind. So we  
5 haven't really developed a rate schedule yet is that what  
6 I'm hearing?

7 ACTING CHAIRPERSON AGRESTA: Brenda, you  
8 have to speak up a little bit.

9 MS. KELLEY: We don't -- we haven't  
10 developed a rate structure yet?

11 MS. REED-FOURQUET: We've worked with rate  
12 model but we haven't finalized that model and so actually  
13 David, I'm assuming you're coming to -- including in this  
14 -- the plan to try to bring to the next Board meeting a  
15 proposal for acceptance of what that rate model will be so  
16 we can work through it over the next few weeks.

17 MS. HOOPER: Lori, can you talk just a tiny  
18 bit louder when you talk? You don't have to repeat what  
19 you said, but.

20 MS. REED-FOURQUET: Yes, okay.

21 MR. CARMODY: Well, included in the build-  
22 out of that budget was an assumption around -- based upon  
23 the tiered staging around what implementation would be, as  
24 well as what annual would be. I mean, that got us into

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1 that general budget that you saw that was presented,  
2 again, to the extent that there's increments and  
3 decrements or just modifications that's great, but  
4 generally the framework.

5 MS. KELLEY: Well, was Axeway's job to fine  
6 tune this, you know, develop the document?

7 ACTING CHAIRPERSON AGRESTA: No.

8 MS. KELLEY: -- none of that, so that's a  
9 piece we have to do --

10 ACTING CHAIRPERSON AGRESTA: -- yes.

11 MS. KELLEY: -- and then they can hopefully  
12 use that to --

13 ACTING CHAIRPERSON AGRESTA: Yeah, they  
14 helped us understand the implications of any given -- of a  
15 number of different potential ways of laying out rates  
16 when we were in the contract negotiation phase with them  
17 in that they did do diligence of kind of defining a number  
18 of ways they've seen it work but also it really was kind  
19 of back to the Finance Committee and --

20 MR. CARMODY: Yeah, I mean there's a rate  
21 model here that just talks about what the -- not that you  
22 agree to anything that I'm going to point you but what the  
23 one-time implementation cost would be, what the annual  
24 cost would be, then we got optional. So this fed into the

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1 budget and needed to be calendarized in a way to talk  
2 about timing of cash flows but there was some general  
3 assumptions of simplistically beginning of the year, end  
4 of the year, how realistic. And then the way we looked at  
5 this was we determined that this was -- again, the thought  
6 process in which we felt comfortable that this was  
7 realistic.

8                   So that's why I think it's important that  
9 because they helped us develop what they had seen that  
10 they put the resources behind us along with whatever we  
11 needed to do to make this reality. Otherwise the funding  
12 just drops out.

13                   MS. REED-FOURQUET: Yeah, we worked with  
14 them to get the baseline model from what's left to do.  
15 It's not a huge amount of work, but what is left to do is  
16 for us to fine-tune that with a customer-basing stem if  
17 you will. The hospitals for instance are listed, they are  
18 still under bed size. It's broken down on bed-sized what  
19 comes to us but that's not how the hospitals want to get  
20 the breakdown for instance.

21                   The grouping of the number of providers --  
22 you know, grouping of one to nine comes to us but that's  
23 not necessarily how we'll group them going back out. So  
24 it's not that we don't have the bulk of the work done but

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1 we do need to tune in and prepare for what's going out.

2 DR. THORNQUIST: That's my recollection  
3 because I remember there were some problems when presented  
4 to the different groups --

5 MS. REED-FOURQUET: Yeah.

6 DR. THORNQUIST: -- with willingness to  
7 sign on with that specific structure. The general concept  
8 was approved but as I recall, there was a lot of fine-  
9 tuning still needed.

10 MS. REED-FOURQUET: Yup.

11 ACTING CHAIRPERSON AGRESTA: Yeah, and  
12 Steve I would imagine that whatever what structure we come  
13 up with there will be some groups who say that isn't --  
14 you know, I mean this is going to be a bit of a moving  
15 target but one that we have to settle on at some point.

16 DR. THORNQUIST: I understand that, but it  
17 was supposed to come back as I recall with some more  
18 specifics for review and it hasn't.

19 ACTING CHAIRPERSON AGRESTA: Yeah.

20 MS. REED-FOURQUET: But not from the  
21 vender. From the vender we were good and we said that we  
22 would do the rest of that internally.

23 MR. COILBERTSON: Yeah, our contract we  
24 have already agreed to wait. We're going to pay the

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1 vender, now the question is what are we going to charge  
2 and how does that differential generate enough revenue to  
3 sustain our operating costs. And where is the -- where do  
4 you place the majority or how do you make that cost  
5 distribution equitable and also such that it incentivises  
6 the right type of organizations to want to join.

7 You know, I think the concern is always  
8 going to be on the smaller providers and how they're going  
9 to react to whatever kind of rates --

10 MR. CARMODY: Yeah, I would imagine that  
11 this rate structure no matter what it is, it's going to be  
12 wrong. But it's going to be viewed -- I mean the general  
13 though process is that it was -- if you started getting  
14 over a certain dollar amount that was more than whatever  
15 their licensing was for an EMR or a typical cable bill  
16 that turned into issues that were problematic, and so I  
17 think -- you know, that was contemplated now we just to  
18 have to like you said more fine tune it.

19 But whatever you come out with there will  
20 always be the naysayers that will say I'm not happy, it's  
21 not the right amount, it's too much, it's too little. At  
22 some point it's going to be this is what we need it to be,  
23 you know. I think you'll fine-tune it over time, but  
24 whatever you do the hospitals won't be happy, whatever you

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1 do the smaller --

2 DR. THORNQUIST: No, I understand that but  
3 it has to be at least acceptable. And while you've got  
4 the concept -- you know, as you put it we do need to be  
5 able to -- there's a certain baseline we have to be able  
6 to achieve. But it also has to be -- in addition to the  
7 capability to get this going is the marketability of  
8 getting this going.

9 And if you make the threshold too high,  
10 it's like a chemical reaction. If the activation of  
11 energy is too high you're not going to get a reaction and  
12 you will not get product. So it has to be something that  
13 you can get people to buy into up front even if there's  
14 backend costs that they end up paying. And so it's not  
15 just the acceptability to us that you have to pay  
16 attention to.

17 MR. CARMODY: Understood.

18 ACTING CHAIRPERSON AGRESTA: I agree.

19 DR. THORNQUIST: Yeah, I think it's -- I  
20 don't want to micromanage or anything else but basically  
21 put forth a request I guess for our CEO that at your  
22 meeting one, we have a rate structure proposal; two, that  
23 we have a very high level project plan with critical path  
24 items. I mean, I'm not looking for the minutia of a

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1 project plan but enough so that we can see what's the  
2 critical path that we need to be moving forward and on to  
3 make sure we get the right things done in the proper  
4 order.

5 MS. HOOPER: Is that a motion John or just  
6 a request --

7 DR. THORNQUIST: Well essentially I'm not  
8 trying to make it a motion or micromanage, I'm just trying  
9 to suggest that --

10 ACTING CHAIRPERSON AGRESTA: I actually  
11 think that's things that are reasonable and David and I  
12 have discussed those as things that kind of are really  
13 needed for him to operate anyway.

14 So, I think that's very reasonable for us  
15 to see what -- I'm going to turn over next kind of getting  
16 into the operating procedures, a request that we can  
17 actually let our CEO do this operating procedure. So we  
18 have to actually formally design as a Board -- the way our  
19 By-Laws were structured we have to formally design the  
20 authorization for the CEO. And I'm going to let Bruce  
21 kind of describe the process that we agreed to in the  
22 Executive Committee so that we can allow our CEO to  
23 operate in an interim fashion.

24 And then we also then have to sort of put

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1 before for public comment the operating procedures for  
2 HITE/CT. And so we need to kind of create an opportunity  
3 for both an interim operating procedure for our CEO and  
4 then public comment and then the Board has to finally  
5 approve full operating procedures for the CEO. So, Bruce.

6 MR. BRUCE CHUDWICK: Thank you Mr.  
7 Chairman. We prepared a few documents for you because the  
8 By-Laws have some general provisions in there as to what  
9 the Authority is authorized to do and what the CEO is  
10 authorized to do. There's no specificity in that that is  
11 enough to have David run the origination.

12 So in looking through this, there are  
13 really two things we need to do that I would request you  
14 to do today. One is to take a look at the operating  
15 procedures, quasi-public agencies in Connecticut operating  
16 procedures for how they interact with the public in their  
17 general business operations. State agencies adopt  
18 regulations, quasi's adopt procedures under the general  
19 statutes. And what we've done is we've prepared those in  
20 a draft of those that as Tom mentioned, need to go out to  
21 a public comment period like your procedures have done,  
22 where they'd be published in the Law Journal, that they're  
23 available for inspection, and you would take written and  
24 oral comments from folks and adopt them after a 30-day

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1 public comment period.

2                   So they would probably not be adopted until  
3 February because it takes about a week or two to get into  
4 the Law Journal and the 30 days starts running from that  
5 time when they're published until public comment ends. We  
6 have drafted these in relation to some of the other ones  
7 we've seen in the State of Connecticut. And I think  
8 hopefully all of you received the chart that we had sent  
9 out that the comparison of the other quasi-public agencies  
10 in Connecticut, CHFA, CI, the CEFIA, the new spin-off of  
11 CI, the Clean Energy Finance Investment Authority, CHEFA,  
12 CDA, there are some other ones but these are the primary  
13 ones that have operating procedures in place. Some of  
14 them are very short and sweet, you know, three or four  
15 pages long. And some of them are very, very detailed.

16                   For instance CHFA's operating procedures  
17 are about 150 pages long because they have so much  
18 interaction with the public, people who are coming in for  
19 loans and refinancing both on the homeowner's side,  
20 residents as well as the developers of property. So they  
21 have very detailed operating procedures. But in essence  
22 what we need to do is put something in place where when  
23 you are interacting with the public, either you're buying  
24 goods or services, what are the rules of the road? How do

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1 people know if they're an outside vender, how they're  
2 going to deal with HITE/CT as an agency and what powers do  
3 the CEO have, what powers are retained by the Board and  
4 what's the general process for buying stuff, buying goods  
5 and services with the public?

6 And so the draft operating procedures we  
7 put together for you address those types of issues. And  
8 we base these primarily off of the CI and CEFIA operating  
9 procedures that are in place. And just to run through  
10 them very briefly, we talk about the adoption of the  
11 annual operating budget, the other quasi's have this in  
12 there as well. It provides it within 60 days or 60 days  
13 before the end of the fiscal year. CEO is to prepare a  
14 budget and bring it to you for adoption. After it's  
15 adopted any expenditure can be obviously paid by the CEO  
16 if it's a budget in a line item. Anything over \$10,000  
17 has to come to the Board for approval so if it's outside  
18 that threshold -- now that threshold of \$10,000 can be  
19 larger than that. It's up to you as a Board for your  
20 discretion to determine that amount but I think we based  
21 that on what we've seen in other quasi's.

22 Personnel policies on page 4 generally  
23 provide how the CEO is responsible for putting together a  
24 schedule of positions or a staffing level, that would be

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1 that HITE/CT would employ that would be approved by the  
2 Board. After that's approved then the CEO can then take  
3 it from there and hire people within budgetary  
4 appropriations. The procurement of goods of personal  
5 property is on page 7, the purchase/lease acquisition  
6 policy for personal property. Your enabling legislation  
7 allows you to buy personal property but interestingly not  
8 real estate. That's just the way it was drafted. There's  
9 one spot in the legislation that talks about disposing of  
10 real estate but there's no powers of the agency HITE/CT to  
11 buy real property, but that you probably will not need  
12 that at any point in time.

13 But you need to buy personal property,  
14 office equipment, anything like that that needs to be  
15 acquired. And the way we drafted the procurement  
16 procedures is that the authority would give the CEO the  
17 power for anything up to \$25,000. He could go out on his  
18 own and either through a sole source procurement or  
19 bidding it, however he determines is in the best interest  
20 of HITE/CT to acquire personal property. If it's over  
21 \$25,000, he needs to get three bids so you have some sort  
22 of competitive process over that threshold. Contracting  
23 for professional services, we've modeled this very much  
24 along the lines of what the new CEFIA has in place right

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1 now, that's the spin-off from Connecticut Innovations  
2 where there's three thresholds.

3 Under \$50,000 the CEO can do on his own,  
4 \$50,000 to \$100,000 the CEO plus the Chairperson. And in  
5 talking with David he made a good suggestion, and just  
6 review these for today's meeting, we should probably amend  
7 so that the Chairperson or the Vice-Chair/Treasurer in  
8 conjunction with the CEO could go out and buy anything  
9 between \$50,000 and \$100,000. It gives it a little more  
10 flexibility and the Commissioner may not be available for  
11 that, so -- but again, that's up to the Board. You can do  
12 that in any fashion. But we would -- it probably would be  
13 a good idea for the \$50/100 threshold be the CEO and  
14 either the Chairperson or Vice-Chair can sign off on that.  
15 Anything over \$100,000, well it basically goes out to bid.  
16 You need three qualified bidders and you have to come back  
17 with the lowest best -- you know, lowest responsible  
18 bidder would end up getting that with the approval of the  
19 Board.

20 State contracting requirements, those are  
21 in the other quasi's operating procedures. No surprise  
22 that anybody that's contracting with HITE/CT has to follow  
23 all the State contracting procedures that we have listed  
24 in here. And currently Axeway has those in their

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1 contract, Lori has those in her contract, we have ours in  
2 the contract as well. We sign-off on all affidavits and  
3 certifications, we comply with all the State contracting  
4 provisions.

5 MR. COILBERTSON: Excuse me, just a  
6 thought. The ability to leverage State contracts, does  
7 that need to be addressed in here? In other words, if for  
8 example Best has a contract for technology services and  
9 it's an existing State contract, can we just leverage that  
10 State contract rather than completing for those services?

11 MR. CHUDWICK: That's commonly done by  
12 municipalities. They use the "State bid" that DAS puts  
13 together for when they're buying sand and salt for roads  
14 and so forth. We could build something like that into  
15 there. That's a good suggestion, so that any State  
16 contract Hite/CT could sign on to and that would not  
17 require a competitive bidding process because it's already  
18 been through a competitive bidding process at the State  
19 level.

20 MR. STEVE CASEY: Would you want to extend  
21 it to the Western States Coalition --

22 MR. CHUDWICK: You could, however the Board  
23 wants to define that.

24 MR. CASEY: We use that -- and we now use

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1 that, we use the general services agreement, GSA --  
2 general services administration , any federal contract we  
3 use those.

4 ACTING CHAIRPERSON AGRESTA: So Steve, can  
5 you give an example of how that --

6 MR. CASEY: Sure, for software it's the  
7 ADOBE, that's shrink wrap right off the GSA contract. It  
8 doesn't have to go out to bid, it's already gone out to  
9 bid, there's a federal pricelist for that. We used to  
10 issue a contract for that ourselves.

11 ACTING CHAIRPERSON AGRESTA: Okay.

12 MR. JOHN GADEA: If I could Tom, what we  
13 did was we took our vender and provided that statute to  
14 the State of Rhode Island and they avoided the whole RFP  
15 process in Rhode Island, grabbed the contract through  
16 their statute, which is a sister to ours, and was able to  
17 jump into the vender and bypass the entire --

18 ACTING CHAIRPERSON AGRESTA: So that would  
19 permit us to do the same thing with contracts that Rhode  
20 Island for example had. So this gives us a lot more  
21 flexibility and freedom to kind of do things that make  
22 sense for the --

23 MR. GADEA: Well, the key thing is what  
24 Steve said. I mean, you could be tied up for a year plus

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1 on an RFP if nobody else has ever done it before. Now all  
2 of a sudden you just basically bypass -- not bypass but  
3 you're able to deal with that and cut that timeline down  
4 substantially.

5 MR. CASEY: You leverage the existing  
6 contracts out.

7 MR. COILBERTSON: And the reason you want  
8 to do that, we're extremely small so we're not going to  
9 get competitive pricing. The State is going to get  
10 competitive pricing because they're buying a much bigger  
11 volume so it's better that we jump on their competitive  
12 pricing. Nobody is going to cut us a deal, I mean, we're  
13 not big enough.

14 MR. GADEA: I don't even know if we're  
15 limited to Connecticut. I don't know how you folks -- but  
16 there might be a contract that another state has that is  
17 more appealing to us. That might have to be taken a look  
18 at.

19 MR. CHUDWICK: You know, the key has got to  
20 go through some sort of bidding process by someone. We  
21 could draft it that way. Let me try and find some  
22 examples of the language we could put in there because  
23 that's a good idea. I think it doesn't make any sense to  
24 have to go out for three bids if there's a State bid

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1 already in place for some other state agency or quasi-  
2 governmental agency in Connecticut or elsewhere that's  
3 been through that process and gives you the lowest  
4 responsible bidder's price.

5 MR. RONALD BUCKMAN: So essentially you can  
6 write this so it would apply to any bidding process that  
7 has already occurred in a municipality, any state agency,  
8 any federal agency.

9 MR. CHUDWICK: Yes. We could draft that,  
10 put that in here and we'll see what public comment comes  
11 back and if the Board has other concerns or wants to  
12 tighten up the language before you adopt in February, you  
13 could do it at that point, okay.

14 So anyway, these are for your consideration  
15 but again, we've used the other State quasi as a model.  
16 The threshold for dollar amounts are really up to you, but  
17 we started with that as a beginning point, so. One other  
18 note in the final section, this is item number 10, funding  
19 source and procedures for general applicability to grant  
20 assistance. When you go and look at the other quasi's,  
21 this is really where the guts of what they do falls. For  
22 instance when you look at Connecticut Innovations,  
23 Incorporated, or this new entity CEFIA, this is the  
24 section where it talks about how entities can get grants

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1 or loans or loan guarantees from those entities to  
2 provide, you know, economic development in the State of  
3 Connecticut.

4 And it lays out the very detailed process  
5 about how that's done. I wasn't sure what to put in here  
6 for you at this point in time, for Hite/Connecticut,  
7 because actually you do have grant making ability. In  
8 your statute you do have the ability to provide grants to  
9 entities. When I thought a little a bit about that I  
10 thought about well, does grants mean waiving some of the  
11 adoption fees or those types of things that you're going  
12 to be doing with outside third parties? That's something  
13 we may want to flush out over time as you mature as an  
14 agency, but for right now I've left it very broad where  
15 you can provide those types of grant assistance in  
16 accordance with the statute based on coming back to the  
17 authority and a process that you would develop in the  
18 future.

19 So it's very open-ended at this point, but  
20 at least it addresses the ability to do that.

21 MR. COILBERTSON: Yeah, I felt that was  
22 important because we can't be changing people's -- we  
23 can't have different prices for different people but if  
24 there are certain target populations that we want to

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1 target, we could maybe do it through a grant process.  
2 They pay the same rate but they can also apply for a grant  
3 or assistance, that way we'd set some of our dollars aside  
4 for that purpose. But it's another way to get to the same  
5 thing without charging people different rates.

6 ACTING CHAIRPERSON AGRESTA: And this  
7 permits us to also act -- to receive grant funds and then  
8 pass them on as well. You know, go after via co-  
9 partnering and granting process if there federal grants  
10 available and we could then distribute them in some  
11 fashion as well.

12 MR. CARMODY: So we created a shared  
13 service model where we said, we're going to provide an  
14 application and provider index for the state insurance  
15 exchange. So this provides enough flexibility in order  
16 for us to be able to do it?

17 MR. CHUDWICK: It does, yes, within your  
18 enabling legislation. So if the Board -- I'm sorry.

19 MR. LYNCH: Do you want to read the  
20 proposed motion for us?

21 MR. CHUDWICK: We hadn't put together a  
22 motion. There's a separate section -- a separate item on  
23 the agenda after this which deals with an interim  
24 authority for David to act. This will be the permanent

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1 authority to move forward but we do have a 30-day public  
2 comment period.

3 DR. THORNQUIST: This is the one that  
4 requires public comment.

5 MR. CHUDWICK: That's right.

6 DR. THORNQUIST: So you just want us to  
7 authorize publishing this --

8 MR. CHUDWICK: Exactly.

9 DR. THORNQUIST: -- with the modification  
10 you already mentioned and possibly this additional  
11 language about leveraging.

12 MR. CHUDWICK: Exactly.

13 MS. HOOPER: Bruce, do we need a motion for  
14 that?

15 MR. CHUDWICK: I think it would be  
16 appropriate for the Board to say let's move forward and  
17 we'll publish --

18 MALE VOICE: So moved.

19 MALE VOICE: And I will second that.

20 DR. THORNQUIST: Discussion?

21 ACTING CHAIRPERSON AGRESTA: Discussion?

22 MR. LYNCH: I think we want to make sure  
23 that do we give a limit to the interim, you know like 90  
24 days or something, or is there a problem with that?

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1 Is it unended until we get the final vote on the full one?

2 MR. CHUDWICK: Well, it would be until we  
3 get the final vote on the full one, right.

4 ACTING CHAIRPERSON AGRESTA: If there were  
5 some adjustments that needed to take place John, I would  
6 imagine that we would have to -- we could adjust it, you  
7 know. If we learned in the interim timeframe while we  
8 were waiting for the final that we needed to make  
9 adjustments, take a vote of the Board to adjust it.

10 MR. LYNCH: And the motion, I think,  
11 included that we would incorporate building the state  
12 contracting in and those types of things right?

13 MR. CHUDWICK: I'll draft those into this  
14 draft before we put a notice in the Law Journal so that  
15 when someone comes and looks at it it will have what's  
16 been discussed tonight.

17 MR. LYNCH: And the -- I assume the process  
18 will be the same as our other policies, that the notice  
19 will go in, will notice a Legal and Policy Committee  
20 meeting where we can have public comments. And after the  
21 30 days Legal and Policy will review and recommend back to  
22 the full Board for the February meeting.

23 MR. CHUDWICK: That's right, we just want  
24 to make sure we only publish once, let the 30-day period

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1 start just once. I think we had a little bump in the road  
2 last time, we published three times.

3 MR. LYNCH: Publish it once but build in --  
4 I think we're saying assign this to the Legal and Policy  
5 to carry out that 60 day process of the notice review and  
6 coming back.

7 ACTING CHAIRPERSON AGRESTA: That would be  
8 very -- yeah, that makes a lot of sense. Learn from our  
9 past --

10 MR. CHUDWICK: Right.

11 MS. HOOPER: So it's to post this with the  
12 changes on specifically ability to grant funds, some  
13 clarification there?

14 MR. CHUDWICK: No, to enter the contracts  
15 -- other State contracts --

16 MS. HOOPER: Other State, right, and that  
17 would be it for the amendments correct?

18 MR. COILBERTSON: And the Co-Chair.

19 MR. CHUDWICK: And the --

20 DR. THORNQUIST: And the Co-Chair/Treasurer  
21 or the Vice-Chair, sorry, has authority for the \$50,000 to  
22 \$100,00.

23 MR. CHUDWICK: Right.

24 MS. HOOPER: Without the current

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1 configuration that's in the By-Laws that the CEO reports  
2 to the Commissioner and to the Chair and the Vice-Chair.

3 DR. THORNQUIST: Those are -- but this is  
4 different than reporting.

5 ACTING CHAIRPERSON AGRESTA: No, this is to  
6 approve a purchase. To sign-off on a purchase.

7 MS. HOOPER: Correct. So to approve as  
8 part of the --

9 DR. THORNQUIST: Well, we want to make it  
10 reasonably flexible and if you make it both, which is --  
11 there's a difference between reporting and getting  
12 approval for a purchase.

13 MS. HOOPER: Oh, alright.

14 DR. THORNQUIST: And if we make it both,  
15 that's going to make it harder.

16 MS. HOOPER: Speaking of -- go ahead and  
17 vote on this one. She is here at the table.

18 MS. HORN: Just vote yes.

19 MS. HOOPER: And this is for -- can you be  
20 clear on that so we have it on the record? The amendment  
21 includes --

22 MR. CHUDWICK: The amendment includes in  
23 section eight under procurement procedures for purchases  
24 between \$50,000 and \$100,000, it would require the

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1 approval of the CEO and either the Chairperson or Vice-  
2 Chair/Treasurer and also under that section it would  
3 include additional language allowing Hite/CT to enter into  
4 contracts with other state contracts or public agencies --

5 DR. THORNQUIST: Previously bid contracts.

6 MR. CHUDWICK: -- previously bid contracts.

7 DR. THORNQUIST: Yeah, with State and other  
8 entities, I don't know how you want to word this but --

9 MR. CHUDWICK: Yeah, we'll do --

10 DR. THORNQUIST: -- just that some of these  
11 are regional organizations and whatnot.

12 MR. CHUDWICK: Right, we'll find some  
13 wording that captures entire --

14 DR. BUCKMAN: Or these all inclusive as  
15 possible, the broadest range of contracts that we can --

16 MR. CHUDWICK: At the same time you want to  
17 make sure there's some -- you know, there's --

18 DR. THORNQUIST: There's some review.

19 MR. CHUDWICK: -- there's some review. You  
20 know, the State of Wyoming, if they don't go through a  
21 true competitive bidding process do you want to tie in  
22 with their -- if there's any question of that --

23 DR. BUCKMAN: Couldn't you put in the  
24 language that a contract that was entered into through a

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1 bidding process?

2 MR. CHUDWICK: Right, that's what you want  
3 to do.

4 DR. BUCKMAN: And then it doesn't matter  
5 what level of government it's in.

6 MR. CHUDWICK: We'll get some language that  
7 --

8 DR. THORNQUIST: He mentioned Rhode Island  
9 piggybacking out of something in Connecticut. There must  
10 be a neighboring language in Rhode Island, not that we  
11 necessarily want to follow the legal precedence of Rhode  
12 Island, but that may be of help.

13 MR. CHUDWICK: Okay, we'll do that.

14 ACTING CHAIRPERSON AGRESTA: We have a  
15 motion and a we have a second. Any further discussion?  
16 Okay, all in favor say Aye.

17 VOICES: Aye.

18 ACTING CHAIRPERSON AGRESTA: Any opposed?  
19 Any abstentions? Alright. I'd like to recognize that  
20 Commissioner Mullen is here.

21 COMMISSIONER JEWEL MULLEN: Could you say  
22 that louder? I don't know, is that going on the record  
23 Meg?

24 MS. HOOPER: No.

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1                   ACTING CHAIRPERSON AGRESTA: And then the  
2 next would be -- the next item is an interim, yes. Bruce  
3 will handle that too.

4                   MR. CHUDWICK: Yes, pending final with  
5 option those operating procedures we need -- or I suggest  
6 Hite/CT get some powers delegated to the CEO to do what  
7 needs to be done and we've prepared this resolution that  
8 walks through what Hite/CT is all about, the By-Laws in  
9 Section 601 and 405 talk about general powers that the  
10 Board has, the Directors have and that the CEO has.

11                   When we get down to the resolve clause,  
12 what this is intended to do is put in place those  
13 operating procedures on an interim basis so that the CEO  
14 can buy some goods and services in the interim time  
15 period. And so what I've done is just basically  
16 reiterated what was in the operating procedures for the  
17 purchase of personal property and for the purchase of  
18 professional services. We -- I think the same changes  
19 that we just discussed should be talked about as well  
20 here.

21                   DR. THORNQUIST: Yeah, but I think we'd  
22 have to see the language to vote on that so it might be  
23 best to bring as an amendment or another resolution at the  
24 next meeting because I don't know how you could amend this

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1 on the fly here today to incorporate that without having  
2 had the language you're going to look at --

3 MR. CHUDWICK: Well, what I would suggest  
4 is that we get to that language and put it in the  
5 operating procedures and if we need to amend this at the  
6 next meeting, but something has to be put in place so that  
7 David can function --

8 DR. THORNQUIST: No, I understand that but  
9 I think that certainly using the previously leveraged  
10 contracts would be an amendment we'd want to make sooner  
11 rather than later.

12 MR. CHUDWICK: Right, absolutely, but at  
13 the next meeting we'll do that. I think the ability of  
14 the CEO to enter into contracts between 50 and 100 with a  
15 Chairperson or Vice-Chair/Treasurer can be added in in  
16 this resolution, which is on the second page.

17 DR. THORNQUIST: Yeah, right.

18 MR. CHUDWICK: And the other resolution is  
19 to provide basic authority, which would be permanent  
20 authority, for the CEO to sign checks in addition to the  
21 Vice-Chair/Treasurer, which was adopted about a little  
22 over a year ago now, to approve expense reimbursements  
23 except his own expense report, which would be approved by  
24 the Chairperson or Vice-Chair/Treasurer. And finally, to

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1 execute and deliver any other forms, documents or  
2 instruments incident to the office of the CEO.

3 A prime example of that is one that we've  
4 been rustling with for the last week or two which is the  
5 sales tax exemption certificate that Axeway is looking for  
6 from Hite/CT. You are not subject to sales tax but their  
7 services would be taxable in Connecticut if you were a  
8 for-profit entity. They need a sales tax exemption  
9 certificate and we wanted to make sure the Board approved  
10 this resolution before David actually signs that on behalf  
11 of the Hite/CT Board because it's a pretty important  
12 exemption to take all those costs and have them be sales  
13 tax exempt in Connecticut, so. So that's the type of  
14 thing that will be wrapped in and any other employment  
15 filings and other things that David needs to do.

16 We talked about setting up payroll  
17 functions and other -- 457B plans for his plan and so  
18 forth, those types of things would be swept under that  
19 general authorization and be permanent, so. So that's the  
20 interim authorization that we would recommend to the Board  
21 be adopted this evening so you can continue to operate.

22 MALE VOICE: So moved.

23 DR. THORNQUIST: With the amendment of the  
24 Vice-Chair.

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1 MR. CHUDWICK: Yup.

2 ACTING CHAIRPERSON AGRESTA: I need a  
3 second.

4 MALE VOICE: Second.

5 ACTING CHAIRPERSON AGRESTA: Discussion?  
6 No discussion, all in favor say Aye.

7 VOICES: Aye.

8 ACTING CHAIRPERSON AGRESTA: Any opposed?  
9 Any abstentions? Thank you. Okay, now our Committee  
10 reports. The first Committee report is the Executive  
11 Committee and the Executive Committee did meet twice. We  
12 met on November 28th and we met on December 12th.

13 In the November 28th meeting we talked a  
14 little bit about the work plan that the Board had  
15 authorized us to finalize. We talked a bit about  
16 assignments for the CEO and have since given those to  
17 David and he has carried them out. We did some initial  
18 review of the budget and finalized the budget that the  
19 Board has authorized us to finalize. And then we had some  
20 public comment. So that was our November 28th meeting.

21 The December 12th meeting, we authorized  
22 the Interim CEO to have a contract extension as an Interim  
23 CTO, as the Chief Technology Officer as the CEO had  
24 requested that we do, and that the Board had authorized us

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1 to do, as well on your behalf. We finalized and updated a  
2 call for participation for pilot sites to participate in  
3 setting up the pilot functions for the HIE and authorize  
4 the CEO and the CTO to send that information out to all  
5 available and appropriate individuals and that has gone  
6 out and probably all of you have seen the call for  
7 participation. And I'm quite certain that Lori and David  
8 will fill us in a little bit about how that's going and  
9 what kind of feedback they're getting about that.

10 We discussed some issues that were related  
11 to some stakeholders that had asked to meet with the  
12 leadership of Hite/CT including the Connecticut Hospital  
13 Association and the Regional Extension Center and shared  
14 some of the information that they had provided back to us  
15 as offered guidance as to how they might best proceed in  
16 collaborating with us. And got -- that was pretty much  
17 it. There was a lot of work in those timeframes, so any  
18 comments? Any of the folks that were there that want to  
19 -- nope.

20 Committee reports -- well, the next is  
21 Business and Operations. Kevin is not on the line right,  
22 Kevin Carr? So having him not on the line, the Business  
23 and Operations Committee continues to be a little bit of a  
24 challenge. Kevin was participating with us at our last

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1 Executive Committee meeting and did start to take down  
2 some things that need to proceed. The Business and  
3 Operations Subcommittee, there are now names of people  
4 kind of being gathered and being forwarded. And Mark and  
5 John and David and I have started to talk a little bit  
6 about how to proceed with that process but this will be an  
7 area where I think we're going to have to put a lot of  
8 focus in the next few months.

9 So I don't know if anybody has any other  
10 comments or observations. Mark, do you have any -- other  
11 than the request to have some Tums?

12 MR. COILBERTSON: Well, I think this  
13 Committee will be the nuts and bolts of how this things is  
14 actually going to work beyond the technology. So, you've  
15 got the technology and then what do you do with the  
16 technology and how do you manage it? And that's the  
17 Business and Operations Committee, otherwise we'll have a  
18 really nice technology but nobody will know what to do  
19 with it so that's going to be really important.

20 ACTING CHAIRPERSON AGRESTA: So -- and that  
21 critical pathway that David is going to develop is going  
22 to be --

23 MR. COILBERTSON: That critical path, yeah,  
24 absolutely critical.

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1                   ACTING CHAIRPERSON AGRESTA: Finance  
2                   Committee?

3                   MR. CARMODY: So Finance Committee has not  
4 met. My plan is to put a meeting on the agenda through  
5 2012 to talk through the financial policies, I just  
6 haven't been able to get to that. I do think that we  
7 don't -- well, we don't have it on here. We could  
8 probably just give an update from the December 5th meeting  
9 at the Capital because I think that it did talk about sort  
10 of -- there was a meeting that was pulled together by the  
11 Lieutenant Governor's office that talked about how the  
12 State Insurance Exchange was sort of -- to give -- what  
13 they are doing and what they need.

14                   And the meeting was for a couple of hours,  
15 there's another meeting coming up in January and in  
16 February. And what was nice about the conversation that  
17 took place is that we were at the table, the REC was at  
18 the table, a variety of Commissioners that had been  
19 already talking on a regular cadence and it sort of  
20 demonstrated that there's a need for a lot of the same  
21 type of capabilities that we're producing. A masterpation  
22 index, a master provider index, and the State Insurance  
23 Exchange is not as far as we are. We're actually  
24 implementing the technology, they're looking to figure out

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1 what's the -- you know, they sort of know their  
2 capabilities. So I think the dialogue was one where when  
3 we start looking at the small pools of funds that we have,  
4 is this an opportunity for us to be leveraged and to  
5 deliver some of those shared services and help so that  
6 we're not going to reinvent the wheel time and time again  
7 as a small state.

8                   And I think that if we structure it  
9 correctly and the meetings proceed, I would assume that  
10 our hope would be that we could provide those essential  
11 services while they focus on other things. A good example  
12 was as a State Insurance Exchange that it's going to come  
13 up and ask each of the individuals that go to that website  
14 how to purchase insurance. We talked about it being a  
15 phase two or a phase three opportunity where we may want  
16 to implement a similar type of technical, that we would  
17 have a website that would be externally facing. Well  
18 guess what, if they're developing that because they have  
19 to on an insurance exchange, you know, maybe that's  
20 something that we could leverage that they need to do that  
21 was not a number one or a number two priority.

22                   So I think -- you know, again, as everybody  
23 starts talking foundationally of what the capabilities  
24 that they need to have, there's opportunities to leverage

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1 each one of these as we go forward. So I don't know who  
2 else -- well, why don't you add or subtract or clarify.

3 COMMISSIONER MULLEN: Well, add -- no,  
4 amplify. I was glad to sit there with this group of  
5 individuals we've been meeting with for almost a year now  
6 since I came, at least my year, almost first year here,  
7 and look around and sort of smile at one another at all  
8 our accomplishments and to recognize that we're at the  
9 table at the beginning.

10 And one of the other things that I would  
11 offer to this group is that since the Insurance Exchange,  
12 working with guidance from HHS, is looking at the  
13 essential benefits that must be covered. There's also an  
14 opportunity for us because everybody here wears more than  
15 one hat to give them information about what that might  
16 look like from your respective disciplines as  
17 practitioners or other types of providers because the last  
18 thing that we want is for somebody to say oh yeah, that's  
19 covered, and think about the technical aspects of creating  
20 a bronze, silver, platinum, gold levels of care, but still  
21 not have it be meaningful. And -- or whatever it is,  
22 still not linked to anything that we measure on the  
23 quality, side on the business side.

24 So, I mean think about that because we have

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1 the opportunity since we're at the table to contribute in  
2 any way that we think is useful. And now I'm looking at  
3 you guys because you were there too, to see what else you  
4 would want to add. I don't want -- it's not like I want  
5 to take it over but I think that there's a lot that we do  
6 have to offer.

7 MR. COILBERTSON: Yeah, I thought it was  
8 great to as a newcomer, to kind of see that there is some  
9 dialogue going on about the fact that we -- although the  
10 federal government continues to fund things in silos they  
11 want us to work together. So they want to throw it out in  
12 silos and come together here and there's always a tendency  
13 when you get money in a silo that it's so constricted that  
14 you really have to implement it in the silo.

15 It's our job to try to say let's break down  
16 those restrictions that may come. And even if that means  
17 we have to reach back to the federal government and say  
18 you know, you're kind of getting in our way by restricting  
19 these dollars in this way and they can and they will  
20 change, but you have to help them. And so that was very  
21 good.

22 MS. REED-FOURQUET: And it's been very  
23 refreshing, hearing that they're actually looking to  
24 collaborate on implementation of such new services and

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1 features. We all share the same patients, we all share  
2 the same provider pool, and so those in particular, some  
3 of the early features that we probably leverage from one  
4 another.

5 MR. LYNCH: I would also add quality  
6 metrics would be the leveraging point because we're going  
7 to both meet and discuss that.

8 MS. REED-FOURQUET: And there's certainly a  
9 difference between clinical data that we would be  
10 collecting or sharing rather for Health Information  
11 Exchange and the billing data type of information that's  
12 collect and the type of outcomes you'll get on a quality  
13 measure.

14 MR. CARMODY: And we just hit the tipping  
15 point because there was only a couple at our meeting after  
16 they went through and they disclosed it but I do think  
17 that there's still the opportunity to discuss or see where  
18 maybe over the next few meetings, where it goes around  
19 some level of an accountable care organization or quality  
20 effort where you start to give a reason for the technology  
21 and not that it's just the technology itself.

22 I know that we know that that needs to be  
23 out there and that may take a little bit tale to get that  
24 solidified but you start to see where all of that comes

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1 together.

2 ACTING CHAIRPERSON AGRESTA: Thank you,  
3 there's a lifetime of work for somebody. Next John, Legal  
4 and Policy.

5 MR. LYNCH: Yes, we met again this month.  
6 We're beginning to look at a series of documents. One is  
7 a draft testing participation agreement. A full-time  
8 DURSA notices the patients opt-in, opt-out, opt back in,  
9 BAA, all those types of documents. The first one in  
10 particular, testing participation agreement, we're ready  
11 to start trying to move forward on that and I guess  
12 question for legal counsel. I believe on all of these  
13 documents that we have to get 30-day notice process on  
14 them as well because they're procedures?

15 MR. CHUDWICK: No, I don't think so. The  
16 actual agreements do not have to go out for a 30 day  
17 comment period. The ability to contract and we're going  
18 to enter into agreements via to the CEO is all the  
19 authorization that is needed at this point in time.

20 MR. LYNCH: Alright, so various processes  
21 that we work out don't have to go through that 30-day  
22 process.

23 MR. CHUDWICK: I don't think so, no.

24 MR. LYNCH: Okay, because we were concerned

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1 that we -- you know, if we did then we would have to  
2 probably get you to recognize that we need to push them  
3 out to public comment today for the same purpose, to get  
4 them live by March. We would have to give the 30-day  
5 notice, we'd have to have the review and bring it back to  
6 the Board so we'd be able to get it in front of you in  
7 March -- we'd go live in March.

8 So with that, we're continuing to meet on  
9 those documents and we hope to have you some final  
10 documents in the near future.

11 ACTING CHAIRPERSON AGRESTA: So John,  
12 recognizing that there's a lot of learning that will go on  
13 by trying to implement one of these documents, you know, I  
14 think that that's probably true in any kind of setting.

15 This process then Bruce will permit sort of  
16 some rapid cycle improvement without having them opt back  
17 in because I suspect having just kind of looked at the  
18 testing agreement that it's going to need to be modified  
19 just to be understandable and accepted by an organization  
20 more quickly than the structure that it's in right now.  
21 And that feedback will probably come pretty quick when you  
22 start to actually sit down and meet with people to do  
23 that.

24 MR. LYNCH: Correct, that was part of the

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1 issue about putting it out because if we had to put it out  
2 we kind of would have to put it out in the version I'll  
3 call it, we have today, which needs cleanup. But we at  
4 least have to get it out so people can begin the formal  
5 process. If we don't have to we'll continue to wrap with  
6 cycle to try to improve those documents to get you a final  
7 document. Or I should say a first version of the final  
8 document even then because that comes back to even then --  
9 your comment comes back to comments we had on the policies  
10 we voted on last month where we voted on the 10 policies.

11 We had the meeting with CHA for example and  
12 the hospitals have a lot of comments about the 10 policies  
13 we've already adopted. We didn't get, I'm going to call  
14 it the dotting your I crossing your T kind of comments  
15 from them, they were more generic. But we did talk about  
16 that yes, we want to have that process to go forward so we  
17 would have a version two if we could get sufficient input.  
18 So CHA has agreed to try to pull together some of their  
19 technical people to try to give some of that more detailed  
20 comment so that we could actually figure out do we have to  
21 change, what would we potentially propose to change in the  
22 policies while we adopted, you know, version two.

23 So that process will continue to go on but  
24 at that point in time when we get the comments back from

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1 CHA and we determine that those are things that we want to  
2 incorporate, we'll have to again go through that 30-day  
3 cycle of putting them in the Law Journal and reviewing  
4 those because that will become version two of our policies  
5 as opposed to the procedures.

6 MR. CHUDWICK: If those changes are  
7 substantive, then I think that would be a proper way to  
8 go. If they're just crossing T's and dotting I's and  
9 doing minor changes to the existing policies, you probably  
10 wouldn't have to go through the public comment period.  
11 But it sounds like they're going to have some substantive  
12 changes and so you'd want to go through that process again  
13 in order to revise the existing policies, correct.

14 MR. LYNCH: That's my report.

15 ACTING CHAIRPERSON AGRESTA: Alright, very  
16 busy. Special populations, Brenda.

17 MS. KELLEY: We met last week and pretty  
18 much finalized a brochure that has been worked on by Lori  
19 calling a series of go-to meetings with basically a  
20 working group, people on the Special Pops Committee that  
21 have really lended their talents to meeting with Lori and  
22 kind of an ad hoc basis.

23 So this has really much been a real work in  
24 progress with a lot of people. And Mark Masselli also

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1       loaning someone from his staff to help with layout. I was  
2       really pleased that David has jumped onboard really  
3       quickly and I heard him on the phone I think -- Dave, two  
4       hours after he started working, and I wasn't sure that  
5       that was him. It was almost too amazing to think that he  
6       would be there. So I think it's shaping up nicely. Lori  
7       actually sent me the most recent rendition but I didn't  
8       get a chance to print it out before I left.

9                       I'll pass this around just so you can get  
10       an idea of what it looks like, but there are still some  
11       changes that came at last week's meeting. And some of the  
12       things that people are talking about is an attempt to make  
13       it it's literacy level and it's cultural sensitivity at a  
14       level that people can understand. So there is, you know,  
15       some level of controversy. For example, the word sharing.  
16       Matt Cooper who is from UConn, Infomatics at UConn, is on  
17       the Committee. And he had the benefit of doing a focus  
18       group with safety net providers. So he's done some  
19       research and he finds that privacy is a huge issue and  
20       sharing scares people to death. So -- the word sharing.

21                      So there's some changes that are not on  
22       that document. For example we have a headline on that  
23       document, safe and efficient record sharing. And I think  
24       now we're saying safe and efficient records. So it's an

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1 interesting Committee because people are bringing their  
2 knowledge. Another one that probably could generate some  
3 controversy here is what do you call -- do you use the  
4 term provider or do you use the term doctor. The  
5 multicultural group prefers the term doctor, they say when  
6 people don't mean what provider means. But we had a  
7 healthy discussion from a doctor who said but there's  
8 nurse practitioners, there's all these things. But the  
9 consensus of the group was doctor because that seems to be  
10 what resonates with people. Now --

11 MR. CARMODY: The only thing I would --

12 MS. KELLEY: Aetna agreed with us by the  
13 way, they're on the Committee. I'm joking, but she is --  
14 we do have someone from Aetna on the Committee.

15 MR. CARMODY: Let me just -- the research  
16 that we've done what we found we ended up changing the --  
17 modifying out terms internally as well as externally to  
18 use the term health care professional so that it was more  
19 encompassing.

20 MS. KELLEY: Yeah.

21 MR. CARMODY: The provider didn't resonate  
22 with any of our customers and when we canvassed a lot of  
23 the folks in the medical community, health care  
24 professional seems to be the one that resonated. So -- I

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1 mean, take it for what it's worth. I mean, you're just --

2 MS. KELLEY: Yeah, we talked about that and  
3 the group still felt -- there was still pushback that  
4 doctor was what the consumer thinks about. Anyway, where  
5 we landed with is Lori has been pressing and I think  
6 appropriately so, that we reach good enough consensus so  
7 that we have something to go to testing.

8 And so I think we're close. Lori has the  
9 detail in her little computer there of what we modified  
10 last week, but the idea would be that we would try to get  
11 something that number one, I'm willing at AARP to take it  
12 out to a group of consumers that we have to get feedback  
13 but that we could go forward with the testing phase using  
14 the document knowing that we'll learn from the testing  
15 phase what's going to work and not totally get obsessed  
16 with having to have it totally perfect out of the gate.

17 But I think it's close. And we did say at  
18 the meeting that we would like to have it in Spanish and  
19 that it would be better to hire someone rather than to try  
20 to find someone like Lori, who said she speaks a little  
21 Spanish, to do a translation. We need to be very careful.

22 MS. HOOPER: Yeah, there are translation  
23 services that you can --

24 MS. KELLEY: Right, right, so I think we're

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1 going to need a little money to pay for a Spanish  
2 translation. And but the reality is, is that I think  
3 we're close to a brochure, which was our first goal. Lori  
4 is also working on a website that I think we're going to  
5 be able to look at very soon. And I don't think the  
6 Committee has weighed in on the website that much, but we  
7 will the minute that it's up in a form that we can start  
8 looking at it. One of the other things you'll notice  
9 there is playing around with the logo. I think David has  
10 done some thinking about that and there were some  
11 suggestions at the meeting.

12 And then the other issue is finding the  
13 appropriate pictures. The Committee really wanted  
14 diversity in the pictures. They wanted more consumers  
15 rather than providers. The other thing is there's a nice  
16 doctor/patient picture and we said oh wow, that's great,  
17 that looks good. And then our friend from Aetna said, but  
18 they have a paper record in their hand. So we're tending  
19 to not be happy with some of the pictures but we're  
20 working on that. That's another thing that will cost some  
21 money because some of these -- there is some charge to  
22 utilize some of the images that are out there.

23 MALE VOICE: Unless you want to make a  
24 watermark.

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1 MS. KELLEY: Yeah, unless we want a  
2 watermark on our brochure which I don't think we do. So I  
3 think we're making progress. I really am pleased with  
4 where we're going and I think it's a nice group of people  
5 that is a mixture of consumers and some providers and I  
6 think together it's really working. So that's what I have  
7 to report now. Yes?

8 MR. LYNCH: I just happened to run  
9 something recently where I think we found 40 different  
10 languages. We're starting to collect primary language  
11 spoken as part of the meaningful use kind of criteria.

12 MS. KELLEY: Right.

13 MR. LYNCH: I think it's 40 different  
14 language with some fairly high volume of Laotian and some  
15 of the other languages as well so -- and Portuguese, etc.  
16 So we're never going to be able to get all 40 into a paper  
17 or whatever pamphlet, but we might want to think about a  
18 process where at least on our website we get it translated  
19 into maybe the top five or 10 or something languages.

20 MS. KELLEY: Yeah, I would agree. And  
21 there are I think at -- I mean, there are some websites in  
22 Connecticut that do have that language capability. I  
23 don't know how good their translations are but I --

24 DR. THORNQUIST: You better be careful with

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1 that --

2 MS. KELLEY: Right, I know --

3 DR. THORNQUIST: -- especially when  
4 cultural transition is there. It's a whole difference  
5 between interpretation and translation that is becoming an  
6 issue in doctor's offices too. The idea that a translator  
7 is not enough you need an interpreter. Someone who can  
8 put it in the cultural language. So simply translating  
9 your document from English to Spanish is relatively easy  
10 to do, but translating it from English into street -- you  
11 know, intelligible Spanish to the average Spanish  
12 consumer, is a little bit more of an art.

13 MS. KELLEY: Yeah.

14 DR. THORNQUIST: And you need to -- so you  
15 need a little bit of a -- there's a cultural  
16 interpretation that goes into that too. So -- but there  
17 are services that are available that will do that for you  
18 it's just that you can't just simply go with a straight up  
19 translation necessarily.

20 MS. KELLEY: Right.

21 DR. THORNQUIST: Because of the way people  
22 refer to different things.

23 MS. KELLEY: And I think that in the  
24 consumer principles we said that we wanted to have

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1 everyone have equal access and we wanted all material to  
2 be culturally sensitive. The Department of Public Health  
3 leads the whole multicultural task force that's working on  
4 health disparities. So I think we have to do that and  
5 that is going to be a money cost.

6 And I think we begin by the Spanish  
7 translation but -- for the test base, but I think we need  
8 to quickly maybe narrow it down, what are the top  
9 languages that we want our priority to be initially and  
10 then how do we find the people.

11 MR. LYNCH: And as I said, it doesn't  
12 necessary -- I don't think we're actually -- a workflow  
13 where there's pieces of paper in every different language  
14 so it may be more that at least we have a website that --

15 MS. KELLEY: Well, I'm still thinking --  
16 you know, my recommendation because we don't have a huge  
17 budget until money starts flowing, is that we create a  
18 site where people that are participating in Hite/CT can go  
19 and download their materials, that we don't spend an awful  
20 lot of money running around the state with boxes of  
21 pamphlets that people are going to throw out.

22 I mean, that's how AARP has started to do  
23 business with its offices. You know, I don't like it  
24 sometimes because it comes out of my budget rather than

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1 the national budget, but I didn't like it when I had boxes  
2 of things that didn't meet my needs either. So I think  
3 that's probably the way to go and that way you can put  
4 everything up that you have and a health care professional  
5 can take what is going to work for their offices.

6 Now, Lori is also working on -- there's got  
7 to be a whole companion group of forms, the opt-out, the  
8 opt back in, I mean this is all part of the business  
9 procedures thing because obviously it's not good enough to  
10 tell consumers what they are entitled to. Doctors have to  
11 know what they have to do and they have to have the papers  
12 to be able to do that. So that's another thing that could  
13 rest in a central space. But we decided that we're not  
14 meeting in January because we're going to give the working  
15 group time to finish the brochure, work on the website,  
16 and then we'll meet again in February.

17 So that doesn't mean we're not going to be  
18 working because the group has been working pretty  
19 intensely. And not always me, so I'm real thrilled that  
20 the Committee has really stepped up to the plate and I  
21 think are real enthusiastic, which I think is positive.

22 ACTING CHAIRPERSON AGRESTA: Excellent. I  
23 think that you guys should be commended.

24 MS. KELLEY: And Lori has done a fabulous

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1 job and David, I think, has already offered some excellent  
2 suggestions that are consumer friendly, which is really  
3 great. So, we really appreciate it.

4 COMMISSIONER MULLEN: So we know that  
5 there's a huge piece of consumer education that goes along  
6 with the Health Insurance Exchange also. Just -- many  
7 people who haven't had to think about insurance before but  
8 perhaps in the spirit of efficiencies we can also  
9 determine ways in which part of the consumer education  
10 around the Health Information Exchange can be also  
11 integrated, delivered, paid for through some of their  
12 resources, especially since they're linked to the Office  
13 of Health Reform. And there are a lot of people who are  
14 interested in the health equity piece there.

15 MS. KELLEY: Excellent. Well that's good,  
16 and AARP is an organization. We'll lend some of our  
17 resources to help with education but I don't want to do  
18 that in a premature sort of fashion. I mean, it's --  
19 because we don't have unlimited resources so I don't want  
20 to be out there giving people -- oh, this is coming,  
21 coming, coming, and now six months from now possibly it's  
22 coming.

23 So we have to time this I think so that we  
24 get the biggest bang for our buck. But we have some

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1 resources that we can use to get the --

2 ACTING CHAIRPERSON AGRESTA: And this is  
3 exactly right, saying the same thing I'm thinking. This  
4 is also an area where the REC needs to spend some dollars  
5 and do some work. And so this is, again, one of those  
6 places where leveraging multiple, you know, hoops. And  
7 the REC has actually done some work I think in preparing  
8 already with agencies that will do marketing so we're  
9 already kind of engaged in starting that process.

10 I don't know Ron, if you know any more  
11 about where they stand with that.

12 DR. BUCKMAN: Not marketing to the  
13 consumers.

14 ACTING CHAIRPERSON AGRESTA: No, it's more  
15 to the providers but they've gone through the process of  
16 engaging marketing firms. The other thing to think about  
17 for funding this type of activity is this an activity that  
18 is done in the context of also looking at one alternative  
19 versus another alternative. It could actually be framed  
20 as a research question.

21 It could be put in front of groups like the  
22 Connecticut Health Foundation or other groups that are  
23 actually interested in seeing how to actually do this in  
24 the most effective way so that you could actually put this

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1 out as a potential research question that might allow you  
2 to get some of the materials developed, tested. And it  
3 may not be the way to get it all out there, but it is  
4 perhaps another funding mechanism that can be pursued.

5 MS. KELLEY: So are you seeing that as a  
6 role of the Special Pops Committee or are you just tossing  
7 that out as something that should be -- because I tend to  
8 think that that's a great idea but it probably goes beyond  
9 the role of that Committee, I think. It could be framed  
10 as a --

11 MR. COILBERTSON: I think communicating and  
12 marketing to the patients and the ultimate customers is  
13 probably within Special Populations. But I do think we  
14 need to also think about our enrollment, that would be in  
15 how we're going to come up with getting providers onboard  
16 and what does that strategy look like; a Membership or an  
17 Enrollment Committee of some type.

18 That's going to be a totally different body  
19 than the consumer who has -- really the decision right now  
20 for the consumer is opt-in, opt-out right?

21 MS. KELLEY: Ahum, right.

22 MR. COILBERTSON: The decision for the  
23 provider is just pay us --

24 MS. KELLEY: Right.

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1 MR. COILBERTSON: -- based on finances and  
2 value.

3 MS. KELLEY: But I also hear Dr. Agresta  
4 suggesting that perhaps there needs to be someone -- some  
5 part of the organization that approaches foundations,  
6 funders, Connecticut Health Foundation, there may be  
7 others that might be interested in jumping onboard with us  
8 and that would be a source of revenue for the consumer  
9 education piece.

10 ACTING CHAIRPERSON AGRESTA: It would be  
11 very reasonable to actually think about maybe even David  
12 having a meeting with several of the key funders in the  
13 state and inviting them specifically to participate even  
14 in some of the other groups. I think they should come,  
15 see what's going on, and they generally are very  
16 interested in participating in that fashion and then can  
17 see where there's overlap and where there's the  
18 opportunity that -- to fund in an appropriate fashion.

19 MS. KELLEY: We need the resources, we  
20 clearly do.

21 ACTING CHAIRPERSON AGRESTA: Yeah, and they  
22 need us to do this the right way. I mean you know, so  
23 there's a lot of overlap in terms of value. They want to  
24 see the same things happen, they just want to see it

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1 happen well, so.

2 MS. KELLEY: Well, I would certainly -- I  
3 don't think I could lead it but I certainly would join in  
4 any meetings that we organize with the -- I would start  
5 with the Connecticut Health Foundation. We also can look  
6 at approaching the Council --

7 ACTING CHAIRPERSON AGRESTA: Foundations --

8 MS. KELLEY: -- yeah, Council on  
9 Philanthropy and see what other foundations in Connecticut  
10 tend to want to do this kind of thing so we can zero in on  
11 where we might have the best impact.

12 ACTING CHAIRPERSON AGRESTA: Alright.

13 MR. COILBERTSON: I have a life event. I  
14 got invited to join AARP.

15 ACTING CHAIRPERSON AGRESTA: This is a good  
16 thing, I hope you do.

17 MR. COILBERTSON: That was a life event, I  
18 mean that's when it hits you.

19 MS. KELLEY: Oh boy. Oh, it can get a lot  
20 worse than that, believe me. I'm moving well beyond the  
21 AARP joining phase. Anyway, thank you. I mean, if you  
22 have other suggestions but seriously, I don't have a lot  
23 of time but I am willing to work on both talking to  
24 funders if we need to and also trying to make certain that

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1 what we're doing with consumer education matches what the  
2 doctors are going to do -- the doctors are going to be  
3 told they need to do and we resolve any difficulties that  
4 might come up because I think that we have some good stuff  
5 here and I'm getting very excited about the possibilities.

6 ACTING CHAIRPERSON AGRESTA: I'm really  
7 happy with what you have and I think it's great.

8 COMMISSIONER MULLEN: Thank you for all  
9 you've done to keep this at the fore and our  
10 conversations. It's been easy for me to reflect at the  
11 variety of tables that this Board has heard your charge  
12 and even in the conversation that we had with hospitals  
13 recently and that that's not going to change, so thank  
14 you.

15 MS. KELLEY: Thank you.

16 MS. REED-FOURQUET: And just to add on sort  
17 of as a defacto or artifact of having to put this  
18 together, we've had to also look at what our presence in  
19 logo or at least interim logo is. And so David is going  
20 to be getting a lot of feedback and input as to what this  
21 might look at. This is a prior version sort of displaying  
22 the latest release based on input. And this is going to  
23 end up on our test portal, it's going to end up on our  
24 website, so we have to put a stake in the ground on this

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1 and David will finalize that --

2 MR. COILBERTSON: We'll go live with a  
3 version and it doesn't mean it's the only version, but.

4 DR. THORNQUIST: Right now it looks like C  
5 plus.

6 MS. KELLEY: Well, that was somebody on the  
7 Committee.

8 MS. REED-FOURQUET: This one looks like a  
9 T.

10 DR. THORNQUIST: I just think you'd make  
11 the left handbar blue. You'll still get the Red Cross  
12 effect but at least it looks like a T instead of a C plus,  
13 which is not --

14 ACTING CHAIRPERSON AGRESTA: Well, you  
15 could put a little stethoscope at the bottom.

16 MS. KELLEY: Hey, that's a thought I hadn't  
17 even thought of. I think David actually pointed out in  
18 the call that I think I wasn't sure it was David, that our  
19 name isn't very consumer friendly and that -- so we're not  
20 using it an awful lot in the brochure because it doesn't  
21 really mean much to the average person, what is a Health  
22 Information Technology Exchange.

23 You know, what is that to the average  
24 person. So you won't see an awful lot of use of that name

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1 throughout the brochure because it really doesn't mean  
2 anything. So maybe that will be the first -- when we get  
3 money we can have a consultant come in and help us change  
4 our name. I'm sorry, I have to go. I have an appointment  
5 so I'm going to have to leave early, so thank you.

6 ACTING CHAIRPERSON AGRESTA: Thank you.  
7 The Technical.

8 MR. PETER COURTWAY: Well, the Technical  
9 Committee has been meeting I think weekly. I thought it  
10 would be even less after we had David but we seem to be  
11 meeting more, so he must be driving us along. The  
12 Technical Committee has been looking at the infrastructure  
13 component and I think I reported last time they were  
14 talking, they confirmed about this should be in the  
15 management of the enterprise masterpation index to larger  
16 providers and confirmed that that was certainly possible  
17 to do. So that is in the cue to evaluate as far as the  
18 design.

19 And for the past couple of weeks we've been  
20 focusing on authentication and identity management. And  
21 we're looking at different ways to, you know, authenticate  
22 to the network whether or not it is through RSA tokens,  
23 certificates, trusted networks, trusted electronic health  
24 records, bank-type cookies, you know, where you answer a

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1 series of questions the first time you use a machine and  
2 it drops a cookie out of the machine so it's something you  
3 have, something you have already loaded on your machine.  
4 So we are evaluating the different components to hear  
5 which of the technology or technologies are really in the  
6 mix that are actually supported by the computer  
7 associates.

8                   And it will also tie to the GE portal and  
9 whatnot. And then looking at what are we going to do to  
10 trust other networks in terms of perhaps identity  
11 management. You know, do we trust an AD log-on, some  
12 other networks, how do we pass credentials from EMRs  
13 directly but EMR can only create a tab for the portal but  
14 it's not context sensitive or how do you get access to the  
15 portal and authenticate if you have no EMR at all. You  
16 know, what other combination of the other security  
17 components are actually there. And I don't think that we  
18 have exhausted the possibilities yet. We're still working  
19 on some of the design and use cases for it so we can take  
20 a use case and then tag a particular set of rules to it in  
21 terms of what you need to be able to connect to it.

22                   It is likely and -- not likely, it's a  
23 certainty that there will not be just one way to do this  
24 because of the variety of the size of the providers. You

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1 know, a hospital may have a certain security paradigm that  
2 they would use in their more sophisticated secure network.  
3 Larger physician groups certainly in that same category.  
4 But as you range down to the providers that have a smaller  
5 network and smaller technology capabilities you almost  
6 need to dummy down to a lower level to provide the same  
7 level of security that you would take for granted in some  
8 of the larger providers. So that's what we've been  
9 working on and I think we also have a meeting scheduled  
10 right now for next Thursday to hear more about how some of  
11 these technologies would integrate or to make sure that  
12 the possibilities are there and know which ones the  
13 possibilities are not there for.

14 So Lori, you've been driving a lot of the  
15 sessions. Did I miss anything from what we've been  
16 covering in the past month?

17 MS. REED-FOURQUET: Yes, some of it has  
18 been covered during the session but I would round this out  
19 by some of the other discussions that we've had with  
20 Axeway for instance. We had a two day face-to-face  
21 session with them, I think it was last week and maybe the  
22 week before to cover what our operational processes are  
23 going to be for managing the masterpation index, how we  
24 would resolve identities across organizations and other

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1 details about some of the implementations in accordance  
2 with our policies but with some technical decisions that  
3 had to be made.

4           Also been sitting with those that are  
5 helping us test our configuration to identify more  
6 specifically what the use cases will be. So for instance  
7 -- and Peter just referenced the authentication use case  
8 suite for getting to the portal, laboratory results is  
9 another type of use case. So if you're delivering results  
10 to an EMR that hasn't integrated access versus if they can  
11 only receive an HL-7 message versus -- you know, we can do  
12 a lot of things but we want to constrain each of these  
13 solutions to a few selections and make those offerings  
14 work for the variety of implementations we're going to  
15 come across.

16           The other thing I wanted to point out is we  
17 have an offer from IHE/USA that is fresh off the press --

18           ACTING CHAIRPERSON AGRESTA: Explain IHE  
19 because nobody is going to know but a few people --

20           MS. REED-FOURQUET: --IHE is the  
21 interoperability standards that we are using for our  
22 solution. It is --

23           MS. HOOPER: You haven't offered --

24           MS. REED-FOURQUET: -- but we haven't

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1 offered to participate at the end of what they call --  
2 they call this a connect-a-thon, which is hundreds and  
3 hundreds of systems in the basement of a hotel that are  
4 connected to one another and they test each of these  
5 interoperability specifications that we have with them  
6 with one another. So they stay in a room, they lock out  
7 the marketing people and the engineers are in the room for  
8 a week.

9                   And at the end of this week what they're  
10 offering us is to be one of two or three HIEs that is able  
11 to go to these venders and say okay, now you're done  
12 testing with your partner here can you please test against  
13 our HIE infrastructure. And one of the challenges we've  
14 been finding in working with the handful of providers that  
15 we have is getting systems that are clean, that have no  
16 patient data in there, that they're just purely test  
17 systems so that we can hook them up to our infrastructure,  
18 document what the configuration is, what it needs to look  
19 like and know that we can connect to Alsteps or a Greenway  
20 or Sage or whoever the EMR vender is. They're all going  
21 to be there in that room with all the right resources.

22                   So they're offering the last two days of  
23 connect-a-thon, that we could be one of the two or three  
24 HIEs that can do that testing -- the week of January 10th,

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1 so it's right around the corner.

2 MS. HOOPER: How did we get invited?

3 MS. REED-FOURQUET: Knowing the right  
4 people in the right places. I actually saw an invite  
5 because of the distribution list go out to a group of  
6 organizations, and I'm going to forget the name of the  
7 group without looking, the EHR/HIE Interop Workgroup is a  
8 group of seven states and vendors that we have not yet  
9 joined but it's something that we've expressed interest  
10 potentially to do so, they have a set of specifications  
11 that they're going to test at the end of the connect-a-  
12 thon as well.

13 And so I asked whether or not Connecticut  
14 could test along side them as part of that and they said  
15 well, you would be better served by testing your own  
16 implementation and configuration and let this group in  
17 parallel test their configuration. And they're also -- so  
18 the other two HIEs are likely to be a group in Tennessee  
19 and Pennsylvania.

20 MS. HOOPER: That definitely adds value to  
21 the product to be able to come back and say it tested  
22 amongst all these.

23 MS. REED-FOURQUET: Oh yeah.

24 ACTING CHAIRPERSON AGRESTA: Well, it also

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1 adds motivation to the venders. There's a whole --  
2 there's two sides to this. It permits us to kind of --

3 DR. THORNQUIST: And kind of for the  
4 doctors that if they know that the EMR they bought or are  
5 thinking of buying already is compatible then they're  
6 going to feel a lot more comfortable buying it also and  
7 joining it.

8 ACTING CHAIRPERSON AGRESTA: Right.

9 COMMISSIONER MULLEN: It also sounds like a  
10 lot of fun to be --

11 ACTING CHAIRPERSON AGRESTA: So there is  
12 some cost associated with that that we're going to have to  
13 shoulder?

14 MS. REED-FOURQUET: They are -- yes, they  
15 are looking for us to make sure that we have our own HIE  
16 resources doing the testing and would need to be more than  
17 just me be there anyway but we need to bring somebody else  
18 to help make sure that we go to each of the venders, go  
19 through the test plan and document that. And they're also  
20 looking -- this is a pilot for IHE as well. They're  
21 trying to see whether or not how they can use their EHR  
22 testing tool kits to the benefit of HIE, so they would be  
23 looking for us to give feedback as to the experiences and  
24 what they could do better if they were to make that an

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1 offering.

2 DR. THORNQUIST: Who would that other  
3 person be in your estimation?

4 MS. REED-FOURQUET: That is something David  
5 and I have been talking about.

6 DR. THORNQUIST: But I mean there is a  
7 potential person identified, persons identified?

8 MS. REED-FOURQUET: Well --

9 MR. COILBERTSON: Oh, we love volunteers.

10 MS. REED-FOURQUET: -- yeah, we would love  
11 volunteers. We'll try to see what we can do about the  
12 resources not internally but if you have a system that you  
13 would really like to make sure is going to connect -- you  
14 know, just if you could offer one of your resources to  
15 come and test, you know, whether it's an E-clinical or an  
16 Allscripts or whatever, we can make sure that that product  
17 is tested --

18 MS. HOOPER: It's not a system but there's  
19 also the REC -- again, the familiarity and their awareness  
20 of what we're doing because that will help with their  
21 campaign also.

22 MS. REED-FOURQUET: Yeah.

23 MR. COILBERTSON: This is something I think  
24 we should do, and I can respond to this and I'll figure

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1 out what could cost us and look at our budget. And I  
2 guess within my authority now I can figure out how much  
3 we're going to spend on this or not spend on this. And I  
4 can certainly report back to the Board and I'll keep the  
5 Commissioner and the Vice-Chair updated on what we're  
6 doing unless there's someone that feels that this is not  
7 the way to do it.

8 ACTING CHAIRPERSON AGRESTA: This seems  
9 like money well spent.

10 DR. THORNQUIST: Yeah, it sounds like a  
11 very good idea.

12 COMMISSIONER MULLEN: Is it in Aruba or any  
13 place where people are going to spend --

14 MS. REED-FOURQUET: In Chicago in January  
15 where everybody stays in the room --

16 MALE VOICE: So where this year --

17 MS. REED-FOURQUET: -- in Las Vegas.

18 ACTING CHAIRPERSON AGRESTA: In Las Vegas,  
19 yeah. At least you may be able to go and come back with  
20 more money than you went with, right.

21 DR. BUCKMAN: Is there the possibility that  
22 our vender would share in the cost?

23 MR. COILBERTSON: I'm sorry, what --

24 DR. BUCKMAN: Is there the possibility that

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1 our vender would share in the cost?

2 MR. COILBERTSON: A way of sharing the  
3 cost?

4 ACTING CHAIRPERSON AGRESTA: Would a vender  
5 share in the cost.

6 MR. COILBERTSON: Well, I think the vender  
7 is going to have to pay ---

8 ACTING CHAIRPERSON AGRESTA: Their way.

9 MR. COILBERTSON: -- their way.

10 ACTING CHAIRPERSON AGRESTA: Yeah, I don't  
11 know that we can do that as a quasi-public, allow a vender  
12 to pay a way for us individually, I'm not sure.

13 DR. THORNQUIST: The contract is already  
14 set. It's not going to influence the contract.

15 ACTING CHAIRPERSON AGRESTA: Our vender or  
16 a vender -- the other reason, it's not just simply our  
17 vender --

18 MR. COILBERTSON: You'd probably have to  
19 donate -- you'd probably have a way for organizations to  
20 donate to us and move around how we use those dollars.  
21 We're not a State agency. If we were a State agency, it's  
22 very strict.

23 MS. HORN: Yeah, but we're pretty much by  
24 the same ethics.

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1 MR. CASEY: I can check with the Ethics  
2 Commission --

3 MR. COILBERTSON: Individual ethics, yeah,  
4 but I mean there's a gifting policy --

5 MR. CASEY: It would be best to contact --  
6 you know, find out what is being offered and we can check  
7 with the Ethics Commission compliance officer.

8 MR. COILBERTSON: Okay.

9 ACTING CHAIRPERSON AGRESTA: Right, so we  
10 would want to make sure that everything is appropriate --

11 MS. HOOPER: Yeah, Mr. Casey --

12 ACTING CHAIRPERSON AGRESTA: -- otherwise I  
13 think even if we have to pay for it out of the budget,  
14 it's still --

15 MS. REED-FOURQUET: Yeah, the event itself  
16 will not have a base because we'll be helping them test  
17 it. The cost is going to be to the travel resource and  
18 contracted resource -- the vendors themselves will  
19 actually potentially incur more because they're  
20 encouraging not to have just their development engineers  
21 there but the people who are really supporting the  
22 deployment, which are different. So their engineers will  
23 also -- or their deployment people will also learn from  
24 that configuration exercise.

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1 MR. COILBERTSON: Well, we'll check on it.  
2 I just want to make sure that we don't make it too  
3 difficult for people to give us money. And you laugh but  
4 in the federal government, it's too difficult for people  
5 to give you money so they don't even if they want to.  
6 It's just too hard, so.

7 MR. CASEY: We can take donations, we just  
8 have to go through the --

9 ACTING CHAIRPERSON AGRESTA: Alright, so  
10 I'm going to -- I think we've got a solution to this and  
11 we'll look forward to hearing how this turns out. Last  
12 item before we go on to public comment is an update from  
13 the Patient Privacy Advisory Committee to Hite/CT, which I  
14 gather did meet.

15 MS. HORN: Well no, they're meeting --

16 ACTING CHAIRPERSON AGRESTA: Or is going to  
17 meet.

18 MS. HORN: -- they have a Chair appointed  
19 by the Lieutenant Governor, and that's Michele Wilcox-  
20 DeBarge. And they are going to meet January 11th from  
21 12:30 to 2:00 at the Legislative Office Building. We  
22 haven't got a room yet, so that will be their inaugural  
23 meeting.

24 ACTING CHAIRPERSON AGRESTA: And can we get

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1 -- do we know who's officially on that Advisory Committee?

2 MS. HORN: Yes, it's Dr. McClain, Bob  
3 McClain, Lud Johnson, Ellen Andrews, Vicky Belcher and  
4 we're still needing an insurance representative.

5 FEMALE VOICE: I'm not an insurance  
6 representative but I'd certainly like to be on that  
7 Committee --

8 MS. HORN: Okay, that's it.

9 MR. CASEY: Marianne, can you add me to  
10 that list. I'd like to volunteer even if it's just to  
11 watch because I'm the assigned privacy and security  
12 officer --

13 MS. HORN: Oh excellent, yes, so we'll put  
14 you on that list. So January 11th, 12:30 to 2:00.

15 ACTING CHAIRPERSON AGRESTA: Alright,  
16 public comment?

17 MS. HOOPER: And if you could come up to  
18 near -- close enough to one of the microphones that would  
19 be great.

20 MS. SUSAN ISRAEL: Okay, I'm Susan Israel.  
21 My first question is -- I understand that I have a right  
22 to make public comment. Is there any obligation for  
23 anyone to actually answer my questions specifically?

24 MR. CHUDWICK: I don't believe so, no.

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1 MS. ISRAEL: Okay, then maybe I  
2 (indiscernible) because I have asked questions and I  
3 haven't gotten answers and I feel like it's -- I mean, I  
4 could talk for 20 minutes but I guess I'd like to clarify  
5 the opt-out policy. As I understand it it's opting out of  
6 having your records shown to other providers it's not  
7 actually opting out --

8 MS. HOOPER: You need to speak up a little  
9 bit louder Ms. Israel.

10 MS. ISRAEL: -- is that correct?

11 MS. HOOPER: There are different  
12 interpretations on opt-in/opt-out and then the variations  
13 in those definitions. There's not one clean in or out.

14 ACTING CHAIRPERSON AGRESTA: But we do have  
15 a policy though. I think what you're asking is what the  
16 specifics of our policy are. That we can -- that is out  
17 there and available online and it describes it.

18 MS. ISRAEL: So is it -- it's online,  
19 where? The actual policy?

20 MS. HORN: Did we put our revised policies  
21 up yet?

22 MS. HOOPER: But it is in the Strategic and  
23 Operational Plan.

24 MS. ISRAEL: Oh, I've read all of that and

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1 it's not clear. Again, it's a very specific question.  
2 People here are talking about opt-out, do they know what  
3 opt-out means because you're not having a policy as I'm  
4 understanding where patients are choosing to opt-in. And  
5 as I understand it records will be going to the Exchange  
6 even if a patient opts out. It's just opt-out for other  
7 providers seeing their records.

8 COMMISSIONER MULLEN: Well you guys know me  
9 already, hi, I'm Dr. Mullen --

10 MS. ISRAEL: Hi.

11 COMMISSIONER MULLEN: -- the Commissioner.  
12 I'm such a stickler for that. I have a hard time even  
13 having the conversation go forward every time I hear you  
14 say records because Health Information Exchange  
15 technically is not taking people's scanned or whatever  
16 else health record and just sending it places.

17 So it might be a nuisance that some people  
18 would say why bother to make the distinction but we are  
19 not planning to a system in which health records are just  
20 getting sent from one place to the next. And you might  
21 not mean it that way, but in the event that you do I just  
22 wanted to clarify that point, okay.

23 MS. ISRAEL: I have a question for you.

24 COMMISSIONER MULLEN: Okay.

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1 MS. ISRAEL: Would you be willing to spend  
2 any time talking to me personally or anyone else about all  
3 of the specifics because I'm really getting the feeling  
4 that you'd rather not have the public know exactly what's  
5 going to be done with whatever you want to call it. And  
6 I'll give you an example of where that was very  
7 distressing.

8 You said that you're not going to -- that  
9 mental health information and HIV information is going to  
10 be held but you're going to have a list of someone's  
11 medication. Are you going to leave off someone's  
12 antidepressants, are you going to leave off their drugs to  
13 be treated for HIV? I mean, these are very important  
14 questions and I really have the feeling that you really  
15 don't want the public to know. Even in your brochure  
16 about explaining to the public, they might really want to  
17 know who exactly is going to see their records and who is  
18 not going to see their records and exactly how the records  
19 will be used and by whom and who will see them and what  
20 the law is that allows the Public Health Department to see  
21 what part of the record or whatever you want to call it.

22 But I really get the feeling, because I  
23 have asked questions, I've sent in questions, and they  
24 haven't exactly been answered. So -- you know, here I am

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1 but if the rest of the public knew what I knew, they would  
2 also be here. And I realize it's public but you can't  
3 have your questions answered and I don't have access to  
4 the minutes. I have access to an agenda list that's very  
5 --

6 MS. HOOPER: The minutes are also posted to  
7 the Committees --

8 MS. ISRAEL: Well, but they don't go in --  
9 I don't think -- do they go into details or do they just  
10 hit the main topics?

11 MS. HOOPER: The transcripts are also  
12 listed there for the Board, but I very much hear what  
13 you're saying. I just don't want you to be misled about  
14 where information is going.

15 MS. ISRAEL: Well, I've looked. And maybe  
16 I don't know where online, but when I've looked under the  
17 meetings and they have the minutes, it's very sketchy.  
18 And I can't even get the answer to my question about what  
19 exactly your policy is about opt-in or opt-out, and that's  
20 -- and yet you're writing brochures to give to people and  
21 you're not even clear on what the actual policy is.

22 ACTING CHAIRPERSON AGRESTA: The policy is  
23 adopted, it hasn't been posted, it's just simply a matter  
24 of getting posted fully.

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1 MS. ISRAEL: I think I know what the policy  
2 is and it's really very upsetting and very scary. And you  
3 talked about that people don't like the word share, you  
4 know.

5 MR. COILBERTSON: So I think I understand  
6 what you're saying and I don't have any problem meeting  
7 with anybody --

8 MS. ISRAEL: Would you talk with me?

9 MR. COILBERTSON: -- I'll talk to anybody,  
10 I mean I'd be glad to talk to you. But I think you're  
11 asking the questions that are kind of in a loaded way and  
12 I think we need to kind of break that down and say --

13 MS. ISRAEL: Well, I'm sorry to ask them in  
14 a loaded way but it's really upsetting --

15 MR. COILBERTSON: -- well, we're trying to  
16 --

17 MS. ISRAEL: -- when you get the feeling  
18 that people would really not answer your questions.

19 MR. COILBERTSON: -- yeah, and I understand  
20 and that's why I think there's a little bit of a --

21 MS. ISRAEL: Yeah, I understand but I've  
22 talked before --

23 MR. COILBERTSON: So I'll be happy to talk  
24 to you --

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1 MS. ISRAEL: -- and I've been ignored.

2 MR. COILBERTSON: I will tell you this,  
3 that today when you go into a hospital you don't opt-in or  
4 opt-out of their EMR. It's not something you do, yet that  
5 data may be shared with multiple hospitals that are part  
6 of that hospital system.

7 MS. ISRAEL: Yes, I know.

8 MR. COILBERTSON: So we're really not  
9 talking a lot different than that, just a little bigger  
10 scale. So I'll be more than happy to talk to you about  
11 any questions you have. You know, we can meet one-on-one  
12 or a couple of us but I don't want you to feel we're  
13 hiding anything because I don't think we are.

14 I mean, I think everything the Policy  
15 Committee has done has been very open and has been --  
16 everything that Brenda and her Committee is doing is  
17 trying to be very clear about what it is and what it's  
18 not.

19 MR. CARMODY: I also think that that the --  
20 there's two things. Some of the questions as you're  
21 asking, I don't think that we've got to that level of  
22 operation, that level of granularity on how you take the  
23 policy, not that that's part of the operations. The other  
24 piece -- part that is that is true, I don't think that

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1 you've to the level of operations that is the devil is in  
2 the detail to your point.

3 MS. ISRAEL: Well --

4 MR. CARMODY: So it's not -- I used an  
5 example. So I know that when I exchange data between my  
6 organization and other people I know very specifically and  
7 have documented what we mean by diagnosis, which ones are  
8 contained and which ones aren't. That's not going to be  
9 in the policy. I mean, it's going to be -- we're going to  
10 restrict mental health, substance abuse, Aids, genetic  
11 testing.

12 All that has to be codified, that  
13 codification needs to be articulated as to what exactly  
14 would be restricted, what would not be sent and we haven't  
15 gotten to that level of detail. So you're asking a  
16 question at this particular point in time that we can't go  
17 into more detail.

18 MS. ISRAEL: You're also asking the patient  
19 to trust that you will have operations and systems --

20 MR. CARMODY: We will.

21 MS. ISRAEL: -- but you're asking the  
22 patient to trust. You're not giving the patient --

23 MR. CARMODY: We haven't gotten to that  
24 level --

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1 MS. ISRAEL: -- yes --

2 MR. CARMODY: -- we haven't gotten to that  
3 level of that piece yet. So you have to take the piece --

4 MS. ISRAEL: -- but you have done the  
5 piece. You said you're going to have an opt-out model --  
6 well, okay.

7 MR. CARMODY: Well, there's two pieces  
8 here. I think you've asked questions that we don't have  
9 answers to that will come further to light because we  
10 haven't gotten to that level yet too. Just to frame where  
11 people make public comments --

12 MS. ISRAEL: Yes.

13 MR. CARMODY: -- there's a Board that meets  
14 in public, so going back to Bruce's responsibility --

15 MS. ISRAEL: Yes.

16 MR. CARMODY: -- it's a Board that meets in  
17 public and lets you have the ability to participate, to  
18 have your voice heard.

19 MS. ISRAEL: Yes.

20 MR. CARMODY: The expectation by any public  
21 Board, whether it be this Board, a State Board or even at  
22 the municipal level, is to listen and make sure that you  
23 have a forum in which to express your opinion.

24 MS. ISRAEL: Yes.

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1 MR. CARMODY: It's not a dialogue back and  
2 forth. I think we're pretty open and want to share that.  
3 I mean, it's not like we have people bantering down the  
4 house.

5 MS. ISRAEL: Yes.

6 MR. CARMODY: But don't take the fact that  
7 when you've come to the Board and it's not a dialogue --

8 MS. ISRAEL: Yes.

9 MR. CARMODY: -- it's not intended to be a  
10 dialogue.

11 MS. ISRAEL: Yes, I see, okay.

12 MR. CARMODY: So just level setting on what  
13 it means, the public participation.

14 MS. ISRAEL: I understand, I appreciate it  
15 thank you.

16 MR. CARMODY: But I think that the goal  
17 would be that as we operationalize some of the questions  
18 that you've asked, I don't think we've gotten there and  
19 when we do get there you're right, it's going to be fully  
20 transparent about exactly what that means. So your intent  
21 in policy, policies that are applied by administrative  
22 procedure, administrative procedure is then laid out in a  
23 forum that allows people to get to that level of  
24 specificity.

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1 MS. ISRAEL: Okay, well thank you.  
2 ACTING CHAIRPERSON AGRESTA: Thank you.  
3 MS. HOOPER: Any other public comment?  
4 ACTING CHAIRPERSON AGRESTA: Any other  
5 public comment? No, can I have a motion to adjourn?  
6 MALE VOICE: Motion to adjourn.  
7 MALE VOICE: Second.  
8 ACTING CHAIRPERSON AGRESTA: All in favor  
9 say Aye.  
10 VOICES: Aye.  
11 (Whereupon, the meeting was adjourned at  
12 6:21 p.m.)