

VERBATIM PROCEEDINGS  
DEPARTMENT OF PUBLIC HEALTH

CT HEALTH INFORMATION TECHNOLOGY  
AND EXCHANGE STRATEGIC PLAN  
COMMISSIONER DR. JEWEL MULLEN, CHAIRPERSON

JANUARY 23, 2012

101 EAST RIVER DRIVE  
EAST HARTFORD, CONNECTICUT

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

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 . . .Verbatim proceedings of a meeting in  
2 the matter of the Connecticut Health Information  
3 Technology and Exchange, held at 101 East River Drive,  
4 East Hartford, Connecticut on January 23, 2012 at 4:38  
5 p.m. . . .

6  
7  
8  
9 CHAIRPERSON COMMISSIONER DR. JEWEL MULLEN:

10 So I think this is the time that I can say welcome to  
11 Health Information Technology Exchange 2012. Happy New  
12 Year. This is our first meeting for those who aren't  
13 members of the Executive Committee.

14 And I have to say that in a meeting  
15 earlier today I was, again, reflecting on the progress  
16 that we made and the accomplishments of last year. And I  
17 look over at Dave Gilberston and I don't want to call you  
18 an accomplishment, but that includes that we do have a  
19 CEO now and so I'm looking forward to the work that we  
20 also do this year. I know we have a lot to do, but I just  
21 have tremendous appreciation still for all of the hard  
22 work, time and effort that people have volunteered to the  
23 Committee.

24 And with that, I would ask for a review

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 and approval of the minutes from the December 19th  
2 meeting.

3 MR. STEVE CASEY: So moved.

4 A VOICE: Moved by Steve, is there a  
5 second?

6 DR. THOMAS AGRESTA: I'll second it.

7 CHAIRPERSON MULLEN: And I know that there  
8 is a -- okay.

9 DR. AGRESTA: The question that I have, we  
10 said that we would -- the website was being developed on  
11 the special populations and it would be translated to the  
12 top five or ten languages. I think that's probably would  
13 desired to be. My guess is that we wanted -- that was a  
14 desire that -- it takes quite a bit of work actually to  
15 translate that into a number of languages. You may want  
16 to reflect that as a goal.

17 CHAIRPERSON MULLEN: So are you suggesting  
18 that that sentence be modified to say that the website is  
19 being worked on with a goal of translating the  
20 information into the top five or ten languages spoken in  
21 Connecticut?

22 DR. AGRESTA: That's probably the goal,  
23 that's probably what I would suggest.

24 MR. DAVID GILBERTSON: The brochure.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 DR. AGRESTA: It says website.

2 MR. GILBERTSON: Yes, it was the brochure.

3 DR. AGRESTA: It was the brochure, okay.

4 MR. GILBERTSON: Yes. And I think we had  
5 agreed that we would start with Spanish and maybe  
6 Portuguese for the pilot.

7 MS. MEG HOOPER: Brenda, did you have --

8 MS. BRENDA KELLEY: -- well, I'm trying to  
9 recall, I mean clearly we talked about the brochure, but  
10 I think we did also talk about the website because there  
11 are tools out there that we should be able to look into  
12 relatively inexpensively that other groups in Connecticut  
13 are using, such as Info line. So, I would like to see  
14 it. I don't have a problem with you edit, Tom, that this  
15 is a goal because it isn't actually happening right now,  
16 and I don't we said that, but I do think it should be  
17 reflected as a goal. But -- and you're clearly right,  
18 David, that we did talk specifically about the brochure  
19 being translated.

20 MR. GILBERTSON: You can take it from the  
21 transcripts.

22 MS. KELLEY: And at the special pops  
23 meeting it was also discussed that, you know, we're doing  
24 a lot of things in house but that we wanted to be very

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 careful that we got a professional translation because it  
2 does matter, you know, in terms of the various dialects  
3 of Spanish that we get this professionally done.

4 CHAIRPERSON MULLEN: Would you like that  
5 added to the minutes?

6 MS. KELLEY: I don't think it needs to be  
7 in the minutes, but I do think the Committee met in  
8 December and is close to finalizing a brochure for the  
9 testing dates that will be translated into Spanish. And  
10 then I would say with a goal of also adding the top five  
11 or ten languages spoken in Connecticut. The website is  
12 also being worked on and has the same goal of being,  
13 having different languages reflected there.

14 MS. HOOPER: Is there a motion to amend  
15 the minutes with that amendment?

16 MS. KELLEY: I can make that motion, if  
17 you like.

18 CHAIRPERSON MULLEN: Thank you.

19 MS. HOOPER: And who was second? I'm  
20 sorry.

21 MR. CASEY: Second.

22 MS. HOOPER: Thank you, Steve. So you  
23 need a vote on the amendment or amended minutes, is that  
24 correct, Bruce?

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MR. BRUCE CHUDWICK: Right, for this  
2 particular amendment.

3 MS. HOOPER: So an amendment and the  
4 amended minutes?

5 MR. CHUDWICK: We had just a motion and a  
6 second to make that particular amendment.

7 MS. HOOPER: Correct.

8 MR. CHUDWICK: Let's vote on that now and  
9 then go back to the main motion. All in favor of that  
10 amendment, please, signify by saying aye.

11 ALL VOICES: Aye.

12 MR. CHUDWICK: Opposed say no. That motion  
13 is carried.

14 Now, we have one amendment to the minutes  
15 as presented. And I believe there is one other additional  
16 change under operating procedures on page two at the top,  
17 the second paragraph, that talks about Section 8 of the  
18 operating procedures. Towards the end there it says, "the  
19 Chief Executive Officer must obtain approval from the  
20 Board Chairperson and Vice Chairperson." I think that  
21 "and" should be "or", either one or the other, not both.

22 MS. HOOPER: For the over 100,000?

23 MR. CHUDWICK: No, between 50 and 100,  
24 between 50 and 100 contract requires the CEO and either

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 the Board Chair or the Board Vice Chair. So that "and"  
2 should be an "or". Is there a motion to approve that  
3 amendment?

4 DR. AGRESTA: So moved.

5 MR. CASEY: Second.

6 MR. CHUDWICK: Second by Steve. Any  
7 discussion? All in favor, please, signify by saying aye.

8 ALL VOICES: Aye.

9 MR. CHUDWICK: Opposed say no. Motion is  
10 carried.

11 And then now you have the final amendment  
12 minutes. There has been a motion and second to approve  
13 the amended minutes so we can go right to a vote on that.

14 MS. KELLEY: So moved.

15 MS. HOOPER: Thank you, Brenda. Is there a  
16 second?

17 CHAIRPERSON MULLEN: So all in favor?

18 ALL VOICES: Aye.

19 MS. BETTY JO PAKULIS: I'd like to  
20 abstain. I was not here at the meeting.

21 CHAIRPERSON MULLEN: We'll move onto the  
22 business of the Health Information Technology Exchange of  
23 Connecticut starting with the meeting schedule.

24 MS. HOOPER: We did share with you the

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 2012 meeting schedule. And we did account for some of  
2 the dates where there were holidays on the third Monday.  
3 We did submit that to the Secretary of the State's  
4 office, but we would like the adoption and recognition of  
5 this meeting schedule by the Board of Directors to be  
6 compliance with -- are you okay with this. So we have  
7 also brought a handout of those meeting dates for your  
8 information and they are posted on the DPH/HIE web page.  
9 So is there a motion to adopt?

10 MR. CASEY: So moved.

11 MS. HOOPER: Mr. Casey. Is there a second?

12 MS. PAKULIS: Second.

13 MS. HOOPER: Thank you very much. Ms.

14 Pakulis. Any questions or discussion? Those in favor?

15 ALL VOICES: Aye.

16 MS. HOOPER: Any opposed or abstaining?

17 Thank you very much.

18 CHAIRPERSON MULLEN: Treasurer's report.

19 DR. AGRESTA: The next item on the agenda  
20 is the treasurer's report and so for the period from July  
21 2011 to January of 2012 I have a sort of different report  
22 that now is coming officially from our CEO. It's a sort  
23 of full profit and loss statement that kind of goes  
24 through all of what has occurred during that timeframe.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 And I gather now all of our reports, etcetera, are  
2 generatable from Quicken, so from Quick Books, and we  
3 have a number of different kinds of reports. So this is  
4 structured in a slightly different fashion than our prior  
5 treasurer's reports. And we'll -- we're going to want to  
6 kind of experiment with what's the most effective means  
7 of communicating this with folks. So I'm going to tell  
8 you what we have and then I'll work with Dave over the  
9 course of the next month to try and come up with the most  
10 effective thing.

11 But we have a total income from the DPH  
12 contract or MOU of \$1,805,054.01. We have expenses that  
13 are total expenses of \$1,227,536.53 with a net operating  
14 income or a total net of \$577,517.48. I think that I  
15 want to kind of give folks a sense of where our dollars  
16 are going towards. We have a small amount of dollars  
17 going towards equipment, employee training and things  
18 that we need to pay for at the bank. The majority of our  
19 funds, \$947,145, have been spent on the HIE  
20 infrastructure and hosting implementation and  
21 configuration, licensing fees, technical support, and  
22 vendor travel back and forth to the state. And that's --  
23 we can share how that's broken out at a separate time.

24 There are two large components of that.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 There is a software licensing cost, which is \$400,000.  
2 And there is an HIE implementation and configuration  
3 cost, which is sort of a time and materials cost. So that  
4 is actually as it's incurred. And that is \$335,125 and  
5 Dave can give us a description or discussion later on in  
6 his report about, CEO report about what's been done to  
7 kind of meet that. One of the key things is that that  
8 time and materials cost is one thing that we may have a  
9 greater sense or ability to control over time.

10 And then the other major cost items are  
11 legal services, which are \$111,476.59 to date. And so  
12 we've kind of spent a lot on legal services and that's  
13 another time and materials cost. And then project  
14 management, technical and project management at a  
15 \$128,958.00, which is essentially our interim CEO over  
16 the course of a time frame from July to now and some  
17 other project management costs associated with that.

18 So, that is our treasurer's report. Any  
19 questions?

20 CHAIRPERSON MULLEN: Would you like  
21 feedback on the format?

22 DR. AGRESTA: I would love feedback on the  
23 format. Anything that is going to make it effective for  
24 the group would be helpful.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MS. HOOPER: We did not email that out to  
2 all, just to let you know.

3 DR. AGRESTA: Okay. And that is another  
4 thing that we can do prior to the meetings, we can kind  
5 of email it with the agenda.

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

7 CHAIRPERSON MULLEN: If people have  
8 feedback for you after today should they email you, send  
9 it to you?

10 DR. AGRESTA: Absolutely, email me. Send  
11 it to Dave as well, please, if you're going to email me  
12 feedback about the report, please, send it to Dave as  
13 well.

14 MS. HOOPER: And I will send it out to all  
15 of you tomorrow.

16 CHAIRPERSON MULLEN: Thank you. So we're  
17 at the update on the operating procedures comment period.

18 MS. HOOPER: Any that you're aware of --  
19 actually, Bruce, you would be the one. Have you received  
20 anything?

21 MR. CHUDWICK: No, I haven't received  
22 anything. The notice was published in the Connecticut Law  
23 Journal on January 10th, I believe, so there is a 30-day  
24 comment period. And so people can comment either today at

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 today's meeting or at the Board meeting on February 27th,  
2 which is when you will consider any comments to those  
3 operating procedures, which were reviewed at the last  
4 Board meeting in December. And based on those comments  
5 and your action you can approve those operating  
6 procedures at the February 27th meeting.

7 MS. HOOPER: And we will be asking in  
8 public comment if there are those specific to those  
9 operating procedures and other things.

10 MS. KELLEY: A comment that I made  
11 informally before the meeting is I was away, but I went  
12 looking for information about when this meeting was and  
13 notices were no longer on the DPH home page. And I had a  
14 hard time finding it when I tried to do the search engine  
15 at DPH. So, especially given the fact that we have a  
16 comment period going on, and I know people that read the  
17 Law Journal will see that, but I think it would be nice  
18 to be able to see it, to see it on some place that people  
19 are used to going to. So I'm not quite sure what  
20 happened. I know we're probably in transition to our own  
21 site, but I bring that to the attention of the Board  
22 because I think it is a short range problem if people are  
23 looking for information.

24 MS. HOOPER: Absolutely. That set are

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 still there and if you search HIE that welcome page will  
2 come up. I think it was a space issue on the DPH home  
3 page. You have the DPH Commissioner here to hear your  
4 points.

5 CHAIRPERSON MULLEN: In the spirit of  
6 making information as accessible as easily as possible I  
7 think that's a really important point that you've flagged  
8 for us for this time period and we can follow up with our  
9 information communication staff tomorrow about that.

10 MS. KELLEY: Okay, thank you.

11 CHAIRPERSON MULLEN: But you also make me  
12 wonder whether or not there are any other sites where we  
13 should post the link for right now because there are  
14 those who might not go to DPH first, but to some other --

15 MS. KELLEY: -- yes, I'm not sure how much  
16 traffic it was getting. I mean I was using it, obviously,  
17 and I think, obviously, people that are on committees and  
18 so forth were probably using it. But I'm not sure how  
19 accessible it is to the general public. And I think there  
20 is also going to be transition issues as we move to the  
21 new site. And then -- so I think maybe we might want to  
22 think of a publicity campaign at the point that our site  
23 is going to actually launch.

24 CHAIRPERSON MULLEN: For example would it

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 be the, and this is a question for the group, helpful to  
2 ask that there is a link on the health reform, the state  
3 health reform.

4 MS. KELLEY: I think that makes sense and  
5 maybe on your site, Vicky, if that's a possibility. I  
6 mean I'm trying to think where people would go and I  
7 think they would go to the health advocate. They would  
8 certainly go to the health reform and maybe OPM even.

9 MS. VICTORIA VELTRI: Yes, we can do that.

10 MR. GILBERTSON: Yes, I think we should  
11 look at that. We should also look at non state site like  
12 CHA and other places people might want to go and if they  
13 see a link for HIE they may actually click on it and  
14 learn something. So maybe we could work part of our  
15 marketing strategy is we work with some of the  
16 organizations in Connecticut, the associations, the  
17 provider associations, etcetera, and ask them to help us  
18 promote it by at least providing a link to our site once  
19 we get it up and running.

20 MS. KELLEY: I definitely think too Info  
21 line and that's been discussed at the special pops  
22 committee as that is the major source that the consumer  
23 is going to call and they need to be clearly current and  
24 up to date. And ideally we should be negotiating with

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 them to have like a dedicated person that knows this and  
2 can answer questions about it, which might cost some  
3 money.

4 MS. HOOPER: And, Mark, I believe that you  
5 are linked on the DSS web page, you are linked to our  
6 set, I believe.

7 MR. MARK HEUSCHKEL: I think so, but I'm  
8 not absolutely sure. But we also may want to put links  
9 on our -- we have HP, our MIS contractors, who runs our  
10 incentive program. That's another place where we might  
11 want to put links as well.

12 CHAIRPERSON MULLEN: CEO report.

13 MR. GILBERTSON: Okay. I will speak  
14 louder. I wanted to first introduce Chris Kraus, who is  
15 going to be supporting the ICT and she's on, as is Lori,  
16 is now on as the interim CTO. Chris is filling in as the  
17 interim administrative officer or what I'm really looking  
18 at is overall kind of project manager, chief operating  
19 officer type of role. And so welcome to the staff. So we  
20 now have a staff of three and we're growing, which is a  
21 good thing. And we all do everything so, you know, there  
22 is "no what's your role". Chris' role is the same as  
23 mine, it's whatever needs to be done, make copies, make  
24 phone calls, we do it all. But she's primarily, she comes

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 from UCONN. I'll let her introduce herself in a little  
2 bit, but she comes from UCONN where she worked with me.  
3 We worked very closely together. And we have a very good  
4 relationship in terms of complementing each other's skill  
5 set. So I thought she would be a really good addition to  
6 our team.

7 Chris, do you want to say a short  
8 introduction of your history.

9 MS. CHRIS KRAUS: First, thank you. I'm  
10 really excited to be here. In a week I've learned more  
11 acronyms than I thought possible. When I joined David in  
12 IT I thought that was overwhelming, but a lot more to add  
13 to my vocabulary. I actually have ten years of  
14 consulting background and I ran the survey research  
15 center at UCONN for three years and it's amazing how many  
16 people's names keep popping up. I tell David, oh, you  
17 know a blast from the past. I'm meeting with Bo Garish.  
18 I've done surveys, the NUR surveys. We did a lot of DPH  
19 surveys, the Asian flu survey. So, it's great to be back  
20 here and to be working with all of you.

21 CHAIRPERSON MULLEN: Welcome.

22 MR. KRAUS: Thanks.

23 MR. GILBERTSON: As I mentioned Lori is,  
24 luckily for us, is still with us as the chief technology

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 officer and her primary responsibility is to get the  
2 technology implemented and working. And so she's been  
3 working very closely with the vendor and with our test  
4 sites to bring that up and she will have a report after  
5 me where she'll give you the status of where we're at  
6 with bringing up the health information exchange itself.  
7 So I'm not going to spend much time on that. Okay.

8 I will -- so the budget, right now we've  
9 moved everything over to Quick Books and set up a chart  
10 of accounts. We have to start getting ready to set up  
11 accounts receivable and accounts payable because  
12 obviously once you have people that are part of the  
13 exchange and they're paying money you have to be able to  
14 track that, and have a way to process it, and then, of  
15 course, do the normal transactions of account receivable,  
16 accounts payable. So we're getting ready to be able to do  
17 that.

18 I'll probably look at potentially  
19 outsourcing that function at some point because it's just  
20 probably not a core function that we're going to really -  
21 - it's not going to require a full time accountant. So,  
22 it's probably better to outsource something like that.  
23 Much like we have payroll right now, payroll is  
24 outsourced, the paychecks. And I am the only person on

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 the payroll, but we had to -- I had to make that a  
2 priority to get paid. So --

3 CHAIRPERSON MULLEN: -- they forgot to  
4 tell you that you weren't getting paid.

5 MR. GILBERTSON: So we now do have a  
6 payroll. Now, they can do more than payroll. They can set  
7 up and function as our HR department for a fee and it's a  
8 very reasonable fee. And they can help set up the  
9 benefits' packages and administer the benefits' packages  
10 for us. And I've got the pricing on that. What I'm  
11 holding off on is some of the answers to the questions  
12 that we've asked of the AG's office on our benefits'  
13 packages and what has to be in it and out of it. Once we  
14 get the go on that I will set that up and I think we'll  
15 be in a position where we can recruit and hire, but until  
16 that time I think we're well served by the arrangements  
17 we have with Lori and Chris to bring us forward.

18 I did a lot of work with, and I talked to  
19 several of the folks on the finance committee this  
20 morning, about our cash flow. And looking at when our  
21 bills are coming due versus when we expect to have  
22 dollars in our account. Right now our only revenue is the  
23 grant, the only funding we have is the grant. So,  
24 looking at when the grant money is coming in versus when

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 our bills are due based on our contract with Axway and  
2 making sure that we're able to pay those bills. And so  
3 we've done some work with DPH to adjust some of the grant  
4 money timing and Axway is working hard to look at their  
5 timing of when they're asking us to pay for certain  
6 things so that we don't get in a situation where we're  
7 unable to pay, unable to pay our bills. And so both are  
8 working on that.

9 We know there is going to be a gap in  
10 funding. There is a lot of different options we're  
11 looking at, but there is -- the project overall is going  
12 to really count on us getting customers signed up early  
13 and paying early because there is just -- there is just a  
14 lot of bills that have to be paid in the first couple of  
15 years. And so that cash flow is going to be very  
16 important. So I think there will be a lot more to follow  
17 on that, but just be aware that there is definitely work  
18 to be done to make sure that we are sustainable in the  
19 next couple of years so that -- I think we've got a very  
20 good sustainability model in the out years. We've just  
21 got to get there. And so that's part of what we're  
22 working on.

23 A link to that is the adoption model and  
24 what we think we can do. How many people and what types

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 of organizations can we sign up? How fast and then how  
2 much are we going to charge them? And I think that's the  
3 -- that's the biggest issue and it really comes down to a  
4 couple of things. It's a perception issue and it's sort  
5 of discussion of who really should flip the bill and are  
6 we trying to push the bill off on a certain constituent,  
7 stakeholder group, more so than another stakeholder  
8 group. And, you know, how much can a stakeholder really  
9 pay? And some of this, some of the way this is designed  
10 is, puts a lot of cost on the licensing, the license fee,  
11 and the license maintenance. And if we try to just pass  
12 that off to a one provider office it's going to be -- I  
13 don't think -- it's going to be tough. I don't think  
14 we're going to get a lot of providers on board because  
15 it's high enough to where I think it's going to become a  
16 barrier. So we have to look at how we're going to do  
17 this.

18 We did look, meet with the Hospital  
19 Association. And, of course, you know I felt like that  
20 was a good meeting. Lori was there. Luckily Peter was  
21 there and Chris went with us. And we talked a lot about  
22 the funding and how it was allocated. I don't think the  
23 hospitals -- there are hospitals that are actually asking  
24 us to come back to them with a different approach and we

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 need to flesh that out. But they have -- each facility,  
2 hospital is going to have a different value proposition.  
3 I think it depends on where they are and what they've  
4 already invested in or not invested in. And they're very  
5 interested in how much of this are we asking the  
6 hospitals to bear versus others.

7           And I think what they're really looking  
8 for is that kind of discussion of where, who is actually  
9 going to be the -- how are we going to distribute the  
10 costs and how much are we going to ask of the hospitals,  
11 and are we going to ask the hospitals to take the brunt  
12 of the costs. And I think that's traditionally been the  
13 case in most states is the hospitals have taken the brunt  
14 of the costs. A lot of states don't charge the providers  
15 at all, but I think a lot of those states are also having  
16 issues with sustainability. So I think we need to really  
17 look at that closely. And I know the finance committee is  
18 on board with taking a look at that and coming back with  
19 an answer. There will be no answer that satisfies  
20 everybody, Nobody wants to pay ultimately, but everybody  
21 knows that somebody has got to pay and so how we allocate  
22 that.

23           What the hospitals did commit to, a couple of  
24 things. One is come to us and tell us what you think is

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 the hospital's share of this bill and let us sit down as  
2 a hospital association and figure out how we want to  
3 distribute that cost amongst the hospitals. We could  
4 certainly do that and I think that is an interesting  
5 model. And let them as an industry figure out who the  
6 payer is going to be instead of us trying to say large  
7 hospitals pay this much and small hospitals pay that  
8 much. They'd rather us just say how much do you want from  
9 hospitals and let us figure out how we want to allocate  
10 it.

11 The other thing is they are committed to  
12 being a part of this process. All the CIO's seem to be  
13 very interested in continuing to support our committees  
14 and provide membership to the Board and the committees as  
15 requested. So, I think we need to take advantage of that  
16 and really get them more involved. I know a lot of them  
17 have been involved, but they're opening the door and say,  
18 yes, we want to be involved. They're also -- the reality  
19 is we're dealing with a lot of different market factors  
20 that are happening right now. A lot of them have invested  
21 in their own HIE strategy and they're wanting to know why  
22 is the state -- is the state HIE going to add any value  
23 over what they've already achieved by, on their own.

24 And then there is also the question of,

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 you know, that we're going to have to work through is  
2 what is the value proposition for the hospitals  
3 themselves when you look at who the true beneficiary of  
4 this type of -- of an HIE it's oftentimes, it's better  
5 care. It's the patient, better care. It's the improved  
6 care, improved quality and how do you then translate that  
7 back to the hospital. So, there is a lot of work to be  
8 done.

9           Likewise, I think we're going to have to  
10 be very focused on our marketing and our value statement  
11 to physicians, provider groups, and payers, all of which,  
12 I think, have value statements, but they're all  
13 different. They're not the same value statement. And I  
14 don't think we can make one blanket for any of them. I  
15 think it's going to be very important that we do a lot of  
16 leg work to sit down with the different organizations and  
17 say, well, what are the -- what's your business model,  
18 what are the things that you're looking to achieve. And  
19 then help them create a value statement themselves for  
20 how HIE's can help them do that. So I think that's going  
21 to be -- that's a lot of leg work, but I think it's  
22 important that we don't just say here is the technology,  
23 it's important because here is the global value  
24 statement. Now why is it valuable to St. Francis versus

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 Harford Hospital who are, have different things going on  
2 and have different drivers.

3 Pete, do you want to add to anything?

4 MR. PETER COURTWAY: No, I think that's  
5 it. I think everybody is searching for what the value is.  
6 It is different for each of them. Some of them have  
7 invested in their own master patient index. We provide a  
8 master patient index as part of the exchange. Some of  
9 them have invested in an interface to their physician  
10 practices. We offer that, but offer it on a much broader  
11 scale, you know, where a local HIE may be attaching their  
12 local physicians to the hospitals themselves, they don't  
13 interconnect to other physicians and other hospitals that  
14 are not connected to that particular system. So, it's a  
15 little bit different and it's a search for getting people  
16 to understand what we're doing, you know, how it can play  
17 inside of their environment and see the value of it. So  
18 I think that they are engaged, but people are just trying  
19 to get the heart of what does it really mean to me.

20 MR. GILBERTSON: Dan, do you have anything  
21 to add?

22 MR. DANIEL CARMODY: Sure. I mean I think  
23 it's maybe bringing forward some of the stuff I had  
24 reported to the finance committee, but I would say that I

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 think there is a couple of things. We started off when we  
2 started on the finance committee we went through and we  
3 worked with Gardner and we came up with sort of the  
4 hypothetical, how does the value get distributed. And we  
5 came with a -- you know, using certain models we looked  
6 at sort of how value accrued, and we looked at certain --  
7 you know, we came up with cohorts, I think, and  
8 distributed that. It's on the web -- it's on -- I think  
9 it should be on the website. If it isn't then it needs to  
10 get out there.

11 But the issue that we came back with is  
12 that it was a theoretical exercise. It was an exercise  
13 that was driven by the consultants that I didn't, you  
14 know, I think collectively as a finance committee we  
15 didn't disagree with it. I mean it seemed to have, you  
16 know, any way you want to get there that it had a  
17 methodology to it. But we get into the issue around then  
18 you have to prove it out around well, if you build it  
19 will this actually manifest itself. So, you know -- so  
20 the rationale is that payers, whether it be commercial  
21 and/or ASO customers, the administrative folks, you know,  
22 a lot of it accrued to them which would then get passed  
23 through, you know, the expectations and rates down to  
24 the customer, which is fine if you could actually

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 guarantee that the cost were going to actually manifest  
2 themselves, which drives us to, I think, something that  
3 I've raised for a period of time which is how does this,  
4 how does this tool, how is it being used to solve the  
5 overarching health care reform issue.

6           And so one of the things that becomes  
7 important is that when we put any costs on the table or  
8 benefit on the table we need to understand how the moving  
9 pieces come together. So, you know, one of the things  
10 that we need to look at that when you look at this as a  
11 tool what business problem are you solving and can we  
12 come back to and figure out, when you look at those  
13 accountable care organizations, and I know it's sort of  
14 the unicorn that's in the room because no one knows what  
15 an accountable care organization is, but the context of  
16 it is, you know, you will pay for cost and quality and  
17 that people have to sign up for achieving quality  
18 targets, being very cost effective. And at that  
19 particular point in time you would then get reimbursed  
20 for doing things that would maybe see, let's say, keep  
21 people healthy. That they normally wouldn't do because  
22 the widget machine of P for service says I need to hit  
23 the widget machine versus not doing something, or not  
24 doing a test, or whatever that came back to.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1                   But we don't have a statewide ACO. And we  
2 need to think about it in terms of how does this fit into  
3 this overarching health care reform component. Some of  
4 the technology that we talked about recently at the last  
5 Board meeting was, you know, the platform that we're  
6 developing, a master patient index, master provider index  
7 are all business functionality that's required by the  
8 health information exchange. Which means the health  
9 information exchange needs to say, look at it, we only --  
10 everybody gets some start up funds. If everybody pays for  
11 this multiple times we're not going to -- it's not going  
12 to be advantageous to us.

13                   Now, the Lieutenant Governor's office has  
14 been good around we started a meeting in December.  
15 Unfortunately, the meeting in January got cancelled and  
16 the next one I'm not sure if it's been rescheduled yet or  
17 not, but, you know -- and I apologize for being a little  
18 bit late and I'm not sure if we hit the issues around  
19 where we are in a cash flow position, but, you know,  
20 unless we're going to actually -- you know, some of these  
21 conversations have to be energized and fast tracked  
22 because we will run out and even though we're making and  
23 taking some steps to sort of resolve the cash flow issue  
24 we need to get to a point where we're putting certain

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 cards on the table around what we think is needed in  
2 order to get to that next level of determining a benefit.

3 Like when we came up with the conversation  
4 from last year it was if we were going to go through and  
5 ask the payers to sort of step up and ask, and do  
6 something, and/or the hospitals, and/or the physician  
7 groups and it was going to be if we build it they will  
8 come, then it would have to be legislated. You know, it  
9 was going to need to be legislated. We need to get it  
10 into the legislative process because you're not going --  
11 without having set targets that people agree to, and put  
12 it in the context of the business problem you're going to  
13 ask people to support a mechanism that was for the  
14 greater good of which maybe the benefit would  
15 materialize, but no one was signing up in order to insure  
16 that it was materializing.

17 And I don't think any business is going to  
18 sign up for something that may be materialize unless we  
19 have everybody at table, agreed upon metrics, and if  
20 we're not going to do that then going down the  
21 distributed benefit path is going to be difficult. Which  
22 is why we changed our thought process to looking at the  
23 folks that would be most likely to use it, which is why  
24 we came up with the adoption rate and the fee for service

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 -- not fee for service, but the subscription model, which  
2 said the folks that are going to use it would be the ones  
3 that would be willing to pay for it. I think the things  
4 that we heard out of the finance committee today, you  
5 know, based upon the conversation with the hospital  
6 association is that one of the -- I won't say it's a  
7 lynchpin, but one of the heavy weighting factors that  
8 went into that conversation when we went down that path  
9 was the fact that the hospitals would see value in the  
10 fact that they needed to connect to an HIE in order to  
11 achieve meaningful use.

12 Well, they all, in essence -- you know,  
13 and I wasn't at the meeting, but from what I gathered and  
14 from what we had today at the finance committee today was  
15 that was pretty much diminished. That that value of most  
16 -- you know most -- especially like let's say  
17 approximately, and I know that these are ballpark figures  
18 that John would attest to in the back, if he's not going  
19 to fall asleep, was approximately half of those -- of our  
20 hospitals or the acute care facilities may not see the  
21 value in thinking that this HIE is the gateway to achieve  
22 meaningful use dollars. Whether it's half or whether  
23 it's 40 percent, or 60 percent doesn't make a difference,  
24 there is a component, and it's not insignificant

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 component, that isn't seeing us as a key factor in  
2 achieving meaningful use. Well, that was a component to  
3 how we developed the subscription -- so if we can't get  
4 some of the hospital systems or a good portion of those  
5 hospital systems to step up and work with us to subscribe  
6 and act as a facilitator to the physicians that connect  
7 with them, I think then that subscription model is called  
8 into question.

9           So now we have two models that we're now  
10 looking at that says, one I need legislative push. One I  
11 need, you know, maybe to rethink that subscription model  
12 and how that would look. And/or lastly, you know, again  
13 these are some of the things that we have to come back to  
14 the table on is what is the business context that we  
15 could create or the environment that we could create that  
16 demonstrated that the HIE was an enabling factor.

17           So this comes back to is it a shared  
18 service model that the Department of Social Services, who  
19 is a key factor when you look at Medicaid, will they use  
20 us and do they see us as a lynchpin. Does -- will we  
21 create a statewide ACO? What ACO's are out there that  
22 see us a, as the tool that they need in order for them to  
23 be successful. And those are some of the conversations  
24 that need to be fast tracked.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1                   You know, one of the things that we may  
2 all consider, and I know I spoke with some folks on the  
3 Board, maybe we need to require that everybody that sits  
4 around this table represents a constituency. How have you  
5 engaged that constituency? One pager that says how are  
6 you going to enable this HIE or be supportive of this  
7 HIE. That would be incumbent upon me to go back to the  
8 health services company and the health insurers and say,  
9 as an association, just like CHA or the Connecticut  
10 Medical Association, or whoever else, the administration,  
11 how do they see the HIE, and how do they see us  
12 supporting it, and how does it factor into that overall  
13 approach.

14                   CHAIRPERSON MULLEN: Thank you. Thank you  
15 for the insights. I've been part of some of these  
16 conversations and some of the reflections that I've had  
17 as I've heard you all speak make me want to add something  
18 to the conversation because I think there are some other  
19 elements to this that had a lot of people interested in  
20 participating in the evolution of the health information  
21 technology exchange.

22                   I mean it's interesting to me in a way to  
23 have so much conversation about the value contribution,  
24 the value, or the proposition, or who needs to pay what

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 share of it when technically health information exchange  
2 is something that, from my perspective, everyone can  
3 benefit from. So in a certain way it sounds like the  
4 traditional conversation around a public good.

5           Maybe that's the Commissioner in me  
6 talking, but technically I hope that somewhere within or  
7 outside of the affordable care act there is going to be  
8 recognition that it's in everyone's interest to improve  
9 the quality of health care and lower costs. Now, maybe  
10 in addition to defining ACO's we need to be clear about  
11 what we mean when we talk about value because that's  
12 something that I have a lot of value for and that I think  
13 is a big piece of this. Not to at all minimize what  
14 you're saying about the business case, but that's another  
15 part of the business case as well as the issue of just  
16 advancing a better health care system, which is what a  
17 lot of this is part of. And I'm not sure that individual  
18 systems would ever get us there.

19           So, I'm curious how we go forward. And  
20 maybe this is an interesting way to start way to start  
21 the year because we are staring at some specific fiscal  
22 realities, but as the Public Health Commissioner I know  
23 that there is a lot that the health information exchange  
24 is intended to do, which doesn't happen at hospitals and

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 within small provider groups. There is a large share of  
2 stage one and stage two meaningful use, for example, that  
3 resides within state health departments across the  
4 country. And having had opportunities to talk to  
5 commissioners from other states I understand that there  
6 has been a lot of variation in the degrees to which  
7 states have recruited their partners. But there has also  
8 been, from what I hear from some of my counterparts,  
9 willingness and support of hospitals and health systems  
10 from the outset.

11 So, in addition to thinking about what we  
12 have to do to help people feel that they need to  
13 subscribe, maybe this is another piece of the  
14 conversation about what else we need to do in the health  
15 care climate in Connecticut for this to be a shared goal  
16 that everybody can see some value in beyond the cost and  
17 potential profit if what we're really talking about is  
18 improving people's health. So, I look we have a number  
19 of constituencies represented around this table and we  
20 have a lot of people who are very, working very hard on  
21 the business elements of it. But, once again, for what I  
22 see in many ways as a public good there are some other  
23 pieces of this that can't fall out of a conversation or  
24 we're sunk. Sunk not in terms of not sustainable, but in

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 terms of reaching what all of the intended purposes of  
2 the health information and technology exchange are by  
3 state and across the country.

4 So I'm just -- I hope -- I don't know  
5 whether or not the people on the phone can hear me, but  
6 I'm looking for some response and since we -- OPM was  
7 mentioned in the conversation, and DSS was mentioned in  
8 this conversation, and the Lieutenant Governor's office I  
9 think it might also be somewhat reassuring for people  
10 like David and Dan to hear some feedback. I don't want to  
11 speak for you, but all the feedback I can get.

12 Brenda.

13 MS. KELLEY: I like your public good  
14 statement and when I think of public good I do think of a  
15 role for government. And we are really involved right now  
16 in a lot of stuff in Connecticut and I think we're being  
17 very creative in many respects of how we're linking --  
18 you know, I heard the Commissioner of DSS talk at a  
19 meeting I was at about how some of the ways that some of  
20 the reforms at DSS are going to happen is taking  
21 advantage of some opportunities in the affordable care  
22 act.

23 But what worries me, because I've been a  
24 part of this either as a member of the Board, the health

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 board, or even before that watching from the side is, you  
2 know, we're getting -- we have a short legislative  
3 session and if we're going to do something that requires  
4 a legislative, budgetary action we have a short window in  
5 which to do that. Now maybe some of this doesn't need  
6 that, you know, there is ways we can do it without that.  
7 But I do personally believe, that doesn't mean I don't  
8 believe that stakeholders should ante up some resources,  
9 but I don't think it's going to happen without some  
10 strong government leadership coming in. And I've been  
11 very frustrated in the past that Connecticut seems to  
12 have not jumped on that in prior administrations, which  
13 is why we're sitting here right now with what I think is  
14 great possibilities, but not necessarily the resources to  
15 make this happen. And I would hate to see everything that  
16 all of us have worked so hard on go up in smoke because  
17 that leadership isn't here this year.

18 So I, too, would like to hear from the  
19 government part of this Board. Not to say that other  
20 people don't have responsibility because I think they do.

21 CHAIRPERSON MULLEN: Right. And I named  
22 agencies without wanting to have their people who are  
23 here, except for maybe those who run the agency, feel as  
24 if they can speak for their bosses, so to speak. But did

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 you want to say something?

2 MS. VELTRI: Yes, yes. Since you've  
3 basically asked me to, I will. Actually, I think I'll be  
4 quite honest, I think that a lot of people don't know  
5 that this Board exists.

6 CHAIRPERSON MULLEN: Um, hmm.

7 MS. VELTRI: And while this work may be  
8 going on, and it's really going on in a lot of detail, I  
9 think when you sit at the exchange, or at the health care  
10 cabinet, or at the Medicaid, or the medical assistance  
11 program, oversight council that it's now called, that  
12 there is not -- there is no discussion about this. So, I  
13 think part of the problem is a serious lack of knowledge.  
14 You know, I never get a call -- we don't get a call in  
15 our office about HIE, personal health records, or  
16 problems with emergency, or electronic medical records in  
17 a hospital, or something. Those are the kind of calls we  
18 get, obviously. We get calls about people's insurance and  
19 stuff, but this is, obviously, a huge part of where we're  
20 going, but it's not a major part, a big enough part of  
21 the discussion.

22 I mean there is a committee, there is a  
23 cabinet that's doing HIT stuff, but we were just talking  
24 today we have another -- Ellen and I were at another

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 subcommittee event, same cabinet, talking about the lack  
2 of integration between the committees and the work that's  
3 going on. And this is one example.

4 CHAIRPERSON MULLEN: Yes, we talked about  
5 that at the last health care cabinet meeting.

6 MS. VELTRI: One way to generate a lot of  
7 this support and financial support, but also just policy  
8 support and stuff is to get it better known. And I mean  
9 I don't know how you do that without resources and doing  
10 outreach and that kind of publicity campaign. Or get in  
11 front of the legislators and saying this is what it is.  
12 That's my two cents about it.

13 MS. KELLEY: But without being callous,  
14 and that's not what I want to be, we have the  
15 Commissioner of Public Health, we have the Lieutenant  
16 Governor's office, we have the Office of Policy and  
17 Management, we have the Department of Social Services,  
18 and we have the Office of Advocate all sitting here.

19 MS. VELTRI: Yes.

20 MS. KELLEY: And I basically think that  
21 what needs to happen is all of those groups need to get  
22 together quickly and say, we don't have much of a window  
23 of opportunity here if we're going to do something this  
24 legislative session. And figure out what that is. And I

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 think Dan had a model. I'm not saying it was a perfect  
2 model, no model is I mean. And probably anything that  
3 we're going to do will generate some opposition from  
4 somebody, but then that's the way you're going to get  
5 notice and somebody is going to find out you're here.

6 But if we don't do something I don't know  
7 that -- and I don't want this, as a consumer advocate,  
8 this totally driven by business interest. I really don't.

9 I want it driven by the public good. And I'm afraid  
10 that I don't know that it's going to succeed even if it  
11 was driven by business interest given what I'm hearing  
12 right now. But even if that was the case I'm not sure  
13 that's how I want to see something as important as my  
14 health information, you know, that it's only business  
15 interest. And if you want to talk about striking fear in  
16 consumers, and they have a lot of fear about this, it  
17 would be that it's only to save money, figure out a way  
18 to deny me something I think I need for a business  
19 interest.

20 MR. CARMODY: The only thing -- and I  
21 don't mean to interrupt, but most of the time when you're  
22 talking about the ACO you're not talking about just  
23 costs, you're talking about quality.

24 MS. KELLEY: I know.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MR. CARMODY: So it's quality in effect.  
2 So I think when you say business interest it's how do we  
3 operate -- and one of the things that health care reform  
4 didn't address, while it addressed access, it didn't  
5 address cost and quality at the same time. Now, it did  
6 through ACO's. Now, again, that's sort of how does that  
7 structure work. It's how do you make sure that you're  
8 talking about costs and quality and that's not denying  
9 claims it's how do you bring efficient health care in a  
10 way that allows us to have agreed upon targets and don't  
11 just put the -- don't put the technology in -- so the  
12 only reason I say that is that I don't want it to be --

13 MS. KELLEY: -- and I'm not saying that  
14 you're saying that, that I don't agree with what you  
15 said. I'm saying that if the only way we're paying for  
16 this is through a business interest, you know, then I  
17 don't know that people are going to trust it much. It may  
18 be totally trustworthy, don't get me wrong, but -- and I  
19 think that's what you're trying to say that there is a  
20 bigger deal here. You know, it's what drives me why I  
21 show up because I have a very serious situation going on  
22 in my family and something like this could have helped if  
23 it was in place.

24 MS. VELTRI: I think to add to that I feel

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 like, you know, as a head of an agency I don't go to -- I  
2 would not go to the legislature and say, pass this bill.  
3 What I do is driven by what my consumers are telling me  
4 that's the barriers they're facing and what they're  
5 seeing every day. Then we take that and we will shop it,  
6 so to speak, to the administration, to the legislators,  
7 to the chairs of the public health committee or whatever,  
8 but I think without that consumer component there it's  
9 kind of hard to just -- I mean I wouldn't sit in a room  
10 with the DSS Commissioner and hash out legislation unless  
11 I had some perspective from the impact of the community  
12 about they felt. So I really feel that that's the piece  
13 to me that's missing is a sort of let's get out here and  
14 tell consumers what this is going to be about. And get  
15 their, heh guys, this is coming, this is important, this  
16 is the new way it's going to go. It's going to benefit  
17 you in the long run that your records can be available at  
18 one provider and the other provider, like an educational  
19 piece. And that I'm willing to help with. That's the  
20 piece I think I can help with.

21 DR. ELLEN ANDREWS: I think that consumers  
22 have the same questions that hospitals and payers do is  
23 what is the value to us? Who is this really serving,  
24 whether you call it corporate interest or whose bottom

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 line, but why should we support this and why should we,  
2 as voters, ask our representatives to support this in any  
3 way. And I think that's an open question that's not been  
4 made.

5 CHAIRPERSON MULLEN: Thanks.

6 MS. PAKULIS: Now that we have David on  
7 board doesn't this begin the process really bringing the  
8 visibility of HIE up? I mean, David, you've talked about  
9 marketing. I think that all comes into play when making  
10 consumers more aware and not -- and understanding it. I  
11 wouldn't understand it --

12 MS. KELLEY: -- I don't want to be  
13 obstinate, but maybe I will be. I mean by the time --  
14 first of all, ARP is, as I've said many times, we will  
15 invest some of our resources to let consumers know what's  
16 going on, but I don't want to be educating consumers  
17 about something that isn't going to happen. That's not  
18 what we try to do. We try to say, this is going to  
19 happen, and this is what you need to know to protect  
20 yourself.

21 I don't think -- and by the time we get a  
22 consumer movement, if we even could do that, to demand  
23 this happen in Connecticut and put pressure on insurance  
24 companies, hospitals, doctors, and the government to pay

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 for it, you know, we'll be -- we won't have David anymore  
2 or Lori or anyone else. So I mean I think this is -- the  
3 time is now and it isn't going to be consumers that's  
4 going to be pushing it. It would be great if it would be,  
5 but it isn't going to happen. It's got to be the people  
6 that are leaders in Connecticut that are sitting around  
7 this table.

8 MS. PAKULIS: Which I think would be --  
9 Vicky made a good point.

10 MS. KELLEY: And I'm not one of them.

11 MS. PAKULIS: No, I think everybody around  
12 the table.

13 MS. KELLEY: Right, right.

14 MS. PAKULIS: Vicky made a good point  
15 though of not just going to the DSS Commissioner and say,  
16 hashing out legislation. So where is the small group? I  
17 mean are you suggesting that the government entity that  
18 sits around this table that gets together?

19 MS. KELLEY: Sure. Yes, absolutely, I  
20 think that would be the perfect place to start. And if  
21 you need other people to be part of that I think that  
22 that's appropriate. And I'm not saying that the solution  
23 should only be a government solution.

24 MS. PAKULIS: Right, I'm sure you're not.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MS. KELLEY: But it may very well be that  
2 part of one of the government solutions is to help work  
3 out how do we make, how can we make this fair for  
4 providers.

5 MR. GILBERTSON: And I think that's -- I  
6 think that's true for the whole health care reform in  
7 that we are nothing but a building block on a bigger  
8 vision of how we're going to transform health care.

9 Unfortunately, not everybody is on board  
10 with what transformation is going to occur or why it's  
11 important to them. And so I think it's kind of a chicken  
12 and egg type of thing, this is a necessary capability in  
13 order to change the way our health care system runs,  
14 which we all know at 19 percent of GDP is not the way it  
15 needs to run. But, again, getting people to change the  
16 way they practice, change what's important to them in  
17 terms of their value system, and look at -- and I think  
18 at a time when the whole health care market is changing  
19 you've got payers buying provider practices. You've got  
20 hospitals buying up provider practices and connecting  
21 them. You're got -- it talks about different models like  
22 ACO's, but there has always been these changes in the way  
23 health care is organized.

24 So I think the value is going to shift

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 over time. It's going to change depending on the  
2 landscape. But this has to be seen as a critical  
3 building block to no matter what that landscape looks  
4 like, the bottom line is that we have electronic health  
5 records that are available to our providers at the time  
6 of care so that they can make the best care possible. And  
7 we have data that's coming out of our health care system  
8 that allows us to invest in the right things because we  
9 invest a lot of money in the wrong things all the time  
10 because we don't have the right data.

11 So, I mean I think this whole thing has  
12 got to be seen as this is not a standalone product. This  
13 is not an end game. This is a building block and it has  
14 to be seen as a strategic piece of a bigger vision that  
15 somebody in the state has to be able to articulate to  
16 consumers to convince a consumer that health information  
17 exchange is important. It's different than talking about  
18 how we're going to make sure that your health information  
19 is available, and the information that your providers  
20 need and that you need in order to manage your own health  
21 care is going to be made available to you and here is how  
22 we're going to do it.

23 CHAIRPERSON MULLEN: Well, let me just  
24 say, thank you. Wait, did you finish your sentence?

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MR. GILBERTSON: I'm done.

2 CHAIRPERSON MULLEN: Okay, sorry. Just  
3 being aware of the time, and I want -- I actually did  
4 want to get this conversation started or continued based  
5 on everything that everyone said, and I have a sense we  
6 could spend the next hour continuing it, but I think it's  
7 the kind of conversation we need to have every month.  
8 We've dealt with a lot of very technical issues and  
9 action items, some of which we'll probably end up coming  
10 back to, but this is a really important piece of our  
11 conversation for this year as well. But I know we have  
12 other things on the agenda.

13 What I wanted to say was that, one, I'm  
14 pretty confident that that meeting is going to happen  
15 that people are saying because I'm working on it. I  
16 don't want to sound over confident. The -- but the other  
17 piece of it is my recognition that this Board and the  
18 Executive Committee need to really support you in your  
19 role because there is the reality that everyone needs to  
20 really see what the state government is doing to support  
21 this. And on the other hand, what the state government is  
22 supporting is a quasi public agency, the work of a quasi  
23 public agency, which you're the CEO of. So -- and that's  
24 something that Betty Jo said about you're being here

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 reminds me of that. You've been here for a couple of  
2 months now and you've been doing a lot.

3 In the meantime I know that we still need  
4 to go forward with the hire of an HIT coordinator that  
5 works statewide, which will hopefully help that. But  
6 let's think about that and I think that we as a Board and  
7 the Executive Committee really need to in these coming  
8 days make sure that we are supporting all of your work in  
9 the right ways now that you have two other people working  
10 with you, sort of. I don't want you to feel like we just  
11 dropped everything in your lap, but part of the work  
12 going forward also is having people understand that this  
13 isn't just the work of state government because the  
14 legislature did not ask the Department of Public Health  
15 or any other agency to run the exchange. So, now that  
16 we're here I think it's the information we impart should  
17 also help all that be clear for people.

18 DR. AGRESTA: So one thing that I'm  
19 hearing that may help is maybe that we can each commit  
20 representing our stakeholder group to come back with sort  
21 of the one pager. The one pager being what's the value to  
22 our stakeholder group that we represent so that we're  
23 helping to define that much more effectively, which makes  
24 us go do some work as Dan mentioned. But the other part

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 of that one pager is what is our stakeholder group going  
2 to do to support this, which also makes us talk to the  
3 leadership in that stakeholder group and start to get  
4 them to think carefully about what they're going to do to  
5 support this and make it a high priority and value. And  
6 if each of us committed to do that and we could actually  
7 make that maybe part of our -- we can rotate what we do  
8 across time as part of our Board meetings, but that would  
9 enable us to have a conversation that was an on-going one  
10 and would make it a two-way conversation between each of  
11 us as Board members and the groups that we represent.

12 MR. CARMODY: I think that that's a great  
13 idea and I think that if we committed to doing that and  
14 we developed that sort of one pager by the next Board  
15 meeting or at least some type of draft then maybe we can  
16 incorporate it so that everybody has a chance to see what  
17 that looks like, come to the next Board meeting, and  
18 maybe we can get through some of those around how does  
19 this fit together. I mean is that something we need a  
20 motion on or want to make a motion on? Or if you just  
21 made the motion I'll second it.

22 DR. AGRESTA: I'll make it a motion.

23 MR. CARMODY: And I second it.

24 MS. HOOPER: And can you restate it?

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 DR. AGRESTA: You want me to make it nice  
2 and --

3 MS. HOOPER: -- you want a one pager from  
4 the Board members on their stakeholder's needs and --

5 DR. AGRESTA: -- their proposition as they  
6 -- their proposition as seen from their stakeholder group  
7 and how they will contribute to insuring the success of  
8 the HIT mission.

9 DR. RONALD BUCKMAN: They meaning the  
10 individual or the group?

11 DR. AGRESTA: The group. So the group  
12 that you represent in whatever way you can, obviously.  
13 You may have to --

14 MR. CARMODY: I'll second the motion so  
15 then it becomes open to discussion and then eventual vote  
16 on is this a good idea, a bad idea, do other people feel  
17 differently.

18 MS. HOOPER: And a draft do you want that  
19 in the motion or simply an agreement that a draft to  
20 begin discussion on February 27<sup>th</sup>? All those in favor?

21 ALL VOICES: Aye.

22 MS. HOOPER: All those opposed? Any  
23 abstentions? Dr. Buckman, thank you. Motion passes.  
24 Thank you.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1                   Next on the agenda is the --

2                   MS. LORI REED-FOURQUET: So, since January  
3                   12<sup>th</sup> I've been involved, as I had mentioned during the  
4                   last meeting, in what we call the configuration marathon.  
5                   And this was done in association with the organization  
6                   from which we're adopting the interoperability  
7                   specifications, IT, interconnecting -- they gave us the  
8                   last two days of their annual Connectathon where all the  
9                   vendors go to test their conformance to their  
10                  interoperability profiles. And they took Connecticut and  
11                  Pennsylvania Keigh as two example implementations of  
12                  those specifications as an HIE and offered to vendors to  
13                  test their EMR systems within those structure. And I was  
14                  making fun of the name Configuration Marathon, but I no  
15                  longer do. It was quite a very active event that carried  
16                  on even past those two days of the Connectathon.

17                  We had EHR's testing with us and with  
18                  Pennsylvania Keigh and in some cases they did not get a  
19                  chance to fully test their system and they asked if they  
20                  could continue testing with us after the fact, which I  
21                  think is fully in our benefit. Alscripts, both My Way  
22                  product and the enterprise product, we have worked with  
23                  Alscripts to get their system on a local HITE CT machine  
24                  so that we can not only test with it, but we're looking

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 forward to being able to use that for demonstration in  
2 association with Capital Community College. So they  
3 finally did turn around and support and deliver on that,  
4 which we have been actively working with over the last  
5 week.

6 The My Way system is not yet tested with  
7 us. Once we get the enterprise completely tested then we  
8 will take that knowledge. We're told by the vendor that  
9 the same configuration process is done, across all of  
10 their products, so we'll find that out. E-Clinical  
11 Works, we've actually been working with them over the  
12 last six months. And we had some verbal success with the  
13 sales infrastructure last week. They pointed to our HITE  
14 CT infrastructure and we're progressing there. The GE  
15 EMR system, and actually the E-Clinical Works system both  
16 of those were being tested from the actual test systems  
17 at the provider sites as opposed to just the vendor  
18 system, which was very helpful.

19 Greenway Technologies, they tested with  
20 us. They were partially successful and they're looking  
21 forward to continuing with us. NextGen was primarily  
22 testing with Pennsylvania Keigh, but they said that they  
23 very much would like to test with us although it may not  
24 be until after the big HIM's conference, which is coming

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 up in February. Lawson, which is an interface engine,  
2 successfully tested with us. And Orion Systems, which is  
3 the interface engine for the Department of Public Health,  
4 successfully tested with us.

5 We literally just got off a call right  
6 before this session to debrief from that. We took large  
7 amounts of logs and issues that were identified during  
8 the process with the goal IT USA as an organization is  
9 trying to help us to streamline the process from when the  
10 vendor says my system and successfully implement these to  
11 a real HIE thing or ready to connect with that vendor,  
12 what information do we need to give you to streamline the  
13 process. And we identified some tremendous opportunities  
14 for facilitating that.

15 So that's the testing event. We also have  
16 received a number of pilot applications and so we have  
17 been reaching out to 21 organizations that range, I made  
18 a brief note, that range -- we have roughly five  
19 organizations that fall into the one to nine physician  
20 office. Nine that fall roughly in ten to fifty, three  
21 mid-size organizations and four hospitals that have asked  
22 to participate as a pilot that we expect to be working  
23 with.

24 There are four key areas or three key

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 areas, I guess, central Connecticut up in the Hartford  
2 and Middlesex area, the Norwalk area, and the New London  
3 area. There is also some interesting opportunities with  
4 some of the providers that submitted for possible  
5 inoperability with the Department of Children and  
6 Families. We had some that are focused in those areas and  
7 focused on mental health. It will be an excellent way  
8 of, you know, validating our security and privacy as  
9 well.

10 CHAIRPERSON MULLEN: And did you have as  
11 much fun as you thought you were going to have at the  
12 Configuration Marathon?

13 MR. GILBERTSON: She was in her element.  
14 She was glowing.

15 MS. REED-FOURQUET: It was a very --

16 CHAIRPERSON MULLEN: -- it sounds  
17 fantastic. It sounds fantastic.

18 MR. GILBERTSON: One of the things I was  
19 supposed to give back to the Committee today is high  
20 level idea of where we're at and some schedule. So Lori  
21 has been working a lot with Axway and, of course, our  
22 implementation schedule will always depend, it takes two  
23 to tango, so Axway has to do their thing, but then we  
24 also need to make sure that our testing partners have put

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 enough resources and priority on getting the testing done  
2 in a timely manner. So from our perspective we should be  
3 ready to have the production environment up by the end of  
4 March and bringing our initial providers on in the  
5 beginning of April.

6 CHAIRPERSON MULLEN: Okay. Committee  
7 reports.

8 DR. AGRESTA: So the Executive Committee  
9 met two weeks ago. There were two primary issues on the  
10 Executive Committee agenda. One was sort of talking  
11 about the pilot phase testing, which we sort of approved  
12 the folks who had requested to be pilot testers given the  
13 scope and the range of types of organizations that  
14 presented themselves. We said if they can meet the need  
15 then they can successfully be pilot testers for us. And  
16 the second was sort of an Executive Session to just sort  
17 of discuss the finances and try to understand  
18 implications and options as was presented tonight for  
19 folks.

20 And the business and operations committee,  
21 Kevin, are you on the line?

22 MS. HOOPER: Dr. Carr were you able to  
23 hear Tom asking if you're still on the line? I'm getting  
24 the phone over to them now.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 DR. KEVIN CARR: I did not hear, but I am  
2 on the line.

3 DR. AGRESTA: Kevin, you're on the spot.  
4 You may not have been hearing all of that's been going  
5 on, but we just wanted to get an update on the business  
6 and operations subcommittee.

7 DR. CARR: So I think the last time that  
8 we were together the thing was that we needed to have  
9 more clarity around it and did some homework prior to  
10 getting the operations committee together. And so we had  
11 our meeting with Tom and David and -- Tom could give a  
12 little bit of background around what happened in that  
13 meeting as well, but essentially what we did is agree on  
14 a more limited set of power point slides that we needed  
15 to create. One of them is around this imperative that  
16 we're trying to address as health information exchange  
17 instead of focusing only on the technology making sure  
18 that we have our clear business objectives outlined. And  
19 then behind that have the technology matched up to a set  
20 of -- that are launched as business imperatives. -- pro  
21 bono for the organization so I sent those out to Tom and  
22 David today. They're probably in transit --

23 DR. AGRESTA: -- I haven't had a chance to  
24 look at it.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 DR. CARR: Tom suggested we try to do a  
2 little bit more homework prior to brining the group  
3 together and make sure that we're adequately  
4 communicating the stakeholder value and the technology  
5 implementation as it relates to that, achieving that  
6 value.

7 So, Tom and David, I'm not going to ramble  
8 on since I'm on the phone, but I'll let you fill in any  
9 gaps.

10 DR. AGRESTA: I think we had a -- we had a  
11 very good session and we really talked about setting the  
12 stage effectively for starting a new subcommittee and  
13 trying to give them guidance, direction, etcetera and  
14 utilizing a lot of the work that's gone on in other  
15 states and a lot of visual information because this is a  
16 complex task that we're going to ask a new group to take  
17 on. And I think one of the key issues was, as we've  
18 talked to potential members, they've said, well, what's  
19 the specific -- what am I specifically going to work on.

20 And so what we were able to kind of really do is  
21 leverage what other states have been doing around HIE and  
22 I think we have a pretty -- well, in the next week or so  
23 have a pretty good sort of outline of the type of tasks  
24 that need to get taken on, that the processes that need

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 to get taken on, and how to help this group prioritize  
2 for the entire Board what are the use cases and how they  
3 get rolled out, and what are the operational pieces that  
4 need to occur in regards to that, etcetera.

5 So, David, I don't know if you have any  
6 additional -- and I will share, as soon as we get these  
7 tools that are set up we'll share them with the rest of  
8 the Board as well because they are going to be helpful  
9 for us.

10 MR. GILBERTSON: Yes, I think we're --  
11 what we started was really with the strategic kind of  
12 vision for HIE and then fleshing that out. So I think  
13 what benefit that we had of Kevin's expertise is to  
14 understand how a business who really is trying to -- has  
15 a vested interest in quality cost and patient outcomes is  
16 approaching their HIE strategy as just a component of a  
17 bigger, their bigger strategy. So, that was helpful and I  
18 thought that the way we're going to approach this is to  
19 try to put a framework around our value statement and our  
20 business statement and then flesh it out with the actual  
21 committee. So, we'll work on that. I think it's a good  
22 start.

23 CHAIRPERSON MULLEN: Anything else, Kevin?

24 DR. CARR: That's it. I think we're going

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 to get very close to being ready for the first meeting  
2 and I hope that given the pre-work that we've done we'll  
3 have a very effective first meeting and kick-off. So I'm  
4 looking forward to it.

5 CHAIRPERSON MULLEN: Thank you.

6 MR. CARMODY: So finance committee met  
7 today and so we made progress on a couple of different  
8 things. One, we talked about there were -- at the last  
9 Board meeting there was some administrative procedures  
10 that we had voted upon in order to put a framework so  
11 that David, as a CEO, could sort of function. Those  
12 operational policies or that authorization that we gave  
13 really should be supported by financial policies and so  
14 we started down the path of locking what O&C had  
15 submitted as draft policies by other HIE's. And what  
16 we're going to be doing as a finance committee is  
17 reviewing those, making modifications to them so that we  
18 can make them Connecticut specific, looking at the other  
19 quasi's, just much like we did when we created that. And  
20 then what we would plan to do is review them, there is  
21 about 17 of them, review them in chunks at a time over  
22 the course of the next few months and then make  
23 modifications to them, and then bring them back to the  
24 Board. Or go through the process that we had outlined

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 before of getting public comment around what they should  
2 look at and so we're going to start to sink those up.

3 We spent a lot of time on the conversation  
4 that we had just articulated that David gave us so I  
5 won't go into that again around what -- the conversation  
6 went with CHA and what we need to do. And I think we  
7 already voted upon that as the far as the one pagers. I  
8 think will help start to frame that conversation on how  
9 everybody is going to be supportive of that so that we  
10 can get to the value conversation sooner rather than  
11 later.

12 The one thing that we didn't talk about is  
13 -- and while we're going through and out of the Executive  
14 Committee, there is a review process on validating our  
15 cash flow and making sure that Axway is bringing  
16 resources potentially to the table with some sort of  
17 adoption. And I think we'll have to look at that in light  
18 of the conversation that went forward with hospital  
19 association. But whatever model we come up with we're  
20 going to validate are they in agreement based upon that  
21 contractual structure and what we can do to modify that I  
22 think will be helpful. And I think there is a meeting  
23 Friday.

24 DR. AGRESTA: Friday.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MR. CARMODY: Where they're going to bring  
2 resources to the table to either agree and understand how  
3 that contract is put together and David is going to be  
4 talking with them to make sure that we get some  
5 validation.

6 What I think that we also could make  
7 progress on, again it goes back to expenses and that's  
8 going to be a two-fold. So, one, again, I think  
9 challenging, you know, any time that there is a position  
10 that's laid out and hired from HIE coordinator on down  
11 that we challenge ourselves of how does that all fit  
12 together. So, you know, because we are -- and we are  
13 burning through a certain amount of cash we need to  
14 figure out how we can capitalize and leverage on what our  
15 expenses is. So, I think that there is room for -- and I  
16 know we started off with the health of meeting at one  
17 point in time around how we can maybe better collaborate,  
18 and maybe what we need to do is not only talk about  
19 expenses, but also the governance process around how this  
20 Board interrelates to E-Health.

21 So, I would make a motion that the Board  
22 either direct the CEO and/or maybe the Executive  
23 Committee or put together another committee to engage  
24 with the E-Health board to figure out how we can more

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 collaboratively govern ourselves in this HIE space as  
2 well as explore how to capitalize and maximize and  
3 optimize our expenses.

4 MS. HOOPER: Is that a motion, Mr.  
5 Carmody?

6 MR. CARMODY: It's a motion.

7 MS. HOOPER: Is there a second? I'm  
8 sorry, I didn't hear.

9 DR. AGRESTA: I'll second that.

10 MS. HOOPER: Thank you, Dr. Agresta. So  
11 that you're making a motion to engage with the E-Health  
12 board of directors on some --

13 MR. CARMODY: -- optimizing the governance  
14 structure and understanding expenses around how we can  
15 most maximize making sure, again, they have a pool of  
16 money, we have a pool of money are we operationally  
17 effective as possible and that would include whatever  
18 we're doing on the state side too.

19 MS. HOOPER: Any discussion?

20 CHAIRPERSON MULLEN: I'm still trying to  
21 get what optimizing on the government structure means and  
22 I'm also trying to read the room with even the lack of a  
23 second, to make sure people understand what you're  
24 talking about.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1                   MR. CARMODY: So a good portion of the  
2 Board sits on E-Health, a good portion of the Board is  
3 redundant with this Board should we collapse the Boards  
4 together, explore around how do we better govern. Again,  
5 this goes back to how does the HIE, how does the state  
6 actually intertwine themselves so that we're most  
7 effective and start a dialogue around how do we optimize  
8 how we're governing the small amount of resources that we  
9 have. So, I know we want to push this forward on the  
10 state level around what the Commissioners are doing and  
11 how that's taking place, and while that's working its way  
12 through the state system, you know, is there a way in  
13 which, you know, either from our quasi public perspective  
14 and/or from how the regional extension center is working  
15 how can we better optimize so that we can streamline the  
16 decision making and not have so many meetings where there  
17 is redundancy from a Board member's perspective as well  
18 as from, you know, making sure that we're looking at all  
19 of this collectively. And I would just go from expenses  
20 on either side of the -- where we're looking how to  
21 maximize the small amount of dollars that we have.

22                   It's an exploratory conversation. I  
23 didn't say that we would I think that it just has to be  
24 explored to see if there is interest on how to do that.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MS. HOOPER: And you said maximizing  
2 operating costs or --

3 MR. CARMODY: -- operating costs and  
4 operating efficiencies as well as the governance  
5 structure.

6 MS. HOOPER: Thank you.

7 MR. CARMODY: I mean, again, I'd be  
8 interested to hear what other people think maybe is this  
9 a good idea or is it a bad idea. I just think that we  
10 have the state government, we have this HIE, we have --  
11 we're all talking about a very small universe, how do we  
12 operate effectively and this is something that we maybe  
13 should start off and then as we get into conversations we  
14 can talk about what we're going outside of state  
15 government on those -- and how we all got money to  
16 maximize ourselves and optimize ourselves.

17 MR. CASEY: Wouldn't leveraging resources  
18 and looking for efficiencies be the responsibility of a  
19 CEO?

20 MR. CARMODY: We could, but that's one  
21 thing to -- I think that we can do that, but that's why I  
22 think it needs to be both. I think it has to be at the  
23 governance structure. I think if you set it at a  
24 governance structure piece as well as at the CEO piece I

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 think you can do them both simultaneously. I don't think  
2 it's one or the other, but sending them down the aisle at  
3 the same time.

4 DR. BUCKMAN: I question though, since  
5 this Board is legislated, the governance is legislated I  
6 don't see how that conversation can even take place  
7 because you're not going to change the legislation.

8 MR. CARMODY: No, but maybe there could be  
9 something as you have the conversation of where is there  
10 redundancy. Maybe it's a recommendation to the  
11 legislature, maybe the E-Health board decides that they  
12 dissolve themselves into this Board because it is  
13 legislated. I think those are the conversations that  
14 have to be put on the table to figure out what makes  
15 sense or doesn't make sense. I mean at the end of the  
16 day everybody is sitting around this table and we're all  
17 having the same conversation on the same topic. And  
18 while we all have -- and we can continue to keep it  
19 bifurcated or we could figure out what's the best way  
20 that we should maximize it. If we don't have any power  
21 to do it that's great, but at least if maybe what comes  
22 out of this is a recommendation maybe that's the best  
23 that we can do.

24 The worst thing that happens is nothing

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 happens and we continue down the path that we're already  
2 on. I mean does it make -- are we any worse for it?

3 MS. HOOPER: Further discussion? Motion  
4 being to engage.

5 MR. CARMODY: In a dialogue and then  
6 report back.

7 MR. COURTWAY: I guess I would like to  
8 hear from the CEO's what they think the opportunity is  
9 because I'm not sure that they're -- where the  
10 opportunity is for this and I'm not sure that it's  
11 governance. I hear the call for wise use of resources,  
12 but I get to hear where the overlap is between resources  
13 to engage at the Board level.

14 MR. GILBERTSON: I will say that there is  
15 -- at the states that are being most successful these  
16 activities are more centralized and combined. And the  
17 things are overseen by an entity that has a common  
18 structure, not all of them, but it's different in every  
19 state, but a lot of them are -- they're all governed  
20 through the same group.

21 MS. HOOPER: Discussion? There is a motion  
22 on the floor. Do we call the question?

23 MS. KELLEY: I just have a question, who  
24 is doing the meeting?

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MS. HOOPER: It was for the Board to  
2 engage with the E-Health board.

3 MS. KELLEY: But the Board being?

4 MS. HOOPER: Well, that wasn't part of the  
5 original motion.

6 MR. CARMODY: We can make it -- do we want  
7 it to be the Executive Committee? Do you want it to be -  
8 -

9 MS. KELLEY: -- I couldn't vote to support  
10 it if I didn't know who was doing the meeting because how  
11 are we going to evaluate what actually happens. So we  
12 have to be clear as to who is it.

13 MR. CARMODY: Do you think the Executive  
14 Committee would be the right place to have the  
15 conversation? It's more of a conversation -- I mean this  
16 is a dialogue. I mean I put the motion on the table to  
17 try to drive -- I mean if we're going to -- like I said,  
18 I think we're running out of runway. If we don't put the  
19 elephant on the table and have some of these  
20 conversations we're going to find ourselves short on  
21 cash, short on a structure, and quickly out of business.  
22 And I think --

23 DR. AGRESTA: -- the risk is, I think, the  
24 same there for E-Health. I think the risks are similar.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 There may be some solutions that come out that are unique  
2 and opportunistic and there may not be. I don't know the  
3 answer to that.

4 DR. ANDREWS: I just -- I'm not on the E-  
5 Health board now, but --

6 MS. KELLEY: -- either am I, by the way. I  
7 think people think that there is more overlap than maybe  
8 there is.

9 DR. ANDREWS: But I was and I really  
10 enjoyed that time. It was actually -- I learned a lot and  
11 people came to a place of understanding together. It was  
12 a place this Board hasn't gotten to yet. And it would be  
13 too bad to lose that in Connecticut, to have that, to  
14 lose that kind of collaborative more informal, very  
15 positive place in Connecticut and have that come into --  
16 the two boards operate as differently as two boards I've  
17 ever been on in very different ways, very formalized, who  
18 make decisions, where they get made, microphones and  
19 cameras, the LOB here. It's just very different cultures  
20 and this one is not to the same place that that was. And  
21 it would be too bad if we lost that. I left that Board  
22 with a lot of reluctance. I liked it. It was fun.

23 MS. HOOPER: May I ask for a  
24 clarification? The E-Health board or the REC

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 responsibilities from that board because they are two  
2 different -- there is a regional extension center  
3 responsibility and then E-Health as its own operating  
4 entity.

5 MR. CARMODY: I would say that, again, the  
6 purpose of this is the discussion so maybe it's let the  
7 acting CEO's have a conversation or ask for the Chair and  
8 the Vice Chair of E-Health to see where there is  
9 commonality. I mean usually that's the way some of those  
10 conversations go to try to figure out where there is  
11 commonality, how can we leverage it, how could we, and is  
12 there a possibility. I'm not saying it would happen. I'm  
13 just putting the conversation on the table that we've  
14 never talked about it. We've sort of -- it is the taboo  
15 conversation?

16 I mean if it is then I'm going to put it  
17 on the table because, again, this is a small state. We  
18 are not that big. You know, going back to what David  
19 said, it doesn't make a lot. I mean to be able to say,  
20 what's the role of these boards in relationship to the  
21 state government. I mean, you know, we talked about the  
22 one pagers, but, you know, at some point what is the  
23 vision from the administration on how health insurance  
24 exchange, E-Health Connecticut, or the REC, if you want

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 to -- you know, are they one in the same or not? I don't  
2 know. Put it on the table as well as the HIE, what's the  
3 way to maximize the way that this is working? You know,  
4 going back to what Victoria had to say, if this is the  
5 best kept secret, you know, we have cameras at the table  
6 then lets it make it not the best kept secret and let's  
7 force the hand that says, drive our governance structure,  
8 drive our operating mode.

9 I heard that there was an E-Health CEO  
10 position that's opened up. Why do I have an E-Health CEO  
11 position when I have a CEO here? Why do I have a state  
12 coordinator when I have a CEO there? Are they playing  
13 different roles? Those are the things that we have to put  
14 on the table. I'm not saying that those are fun  
15 conversations, I'm saying that those are conversations  
16 that need to be asked.

17 CHAIRPERSON MULLEN: I appreciate a few  
18 things one of which is you pointed out how many of us go  
19 to so many different meetings to do the same thing. I  
20 mean that's just one piece of it. And I'm one of those  
21 people who has many times wanted it all to make perfect  
22 sense. So I hear you. And I also understand that a lot  
23 of your recommendations are geared to be thought of as  
24 solutions to a series of different issues or

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 inefficiencies not all of which are within our control to  
2 fix, or even at our control as Board co-chairs. But I  
3 think there are within all the conversations we've had  
4 today there are some immediate issues for the Board to  
5 tackle.

6 I'm still processing your recommendation.  
7 It makes me want to think maybe the Executive Committee  
8 also needs to talk about this some and come back to the  
9 group with some other thinking about what we see as  
10 possible. At the same time that we -- since I said I was  
11 working on that government meeting as well, have some  
12 other feedback to bring to people.

13 In my year here one of the things that  
14 I've come to appreciate is that many people have really  
15 found reassurance in knowing that very complicated  
16 initiatives that have all different kinds of  
17 ramifications are being overseen and informed by a  
18 variety of perspectives and constituents, different kinds  
19 of boards and groups. And for that to happen sometimes  
20 there are inherent inefficiencies which technically  
21 aren't inefficiencies because they're necessary to make  
22 sure we have all the bases covered. So, we wouldn't want  
23 to lose some of that along the way.

24 But while we deal with what's been

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 identified as the financial piece there are lots of other  
2 elements where about health reform in this state that we  
3 can make suggestions about and help lead. But I also  
4 understand that it's not within our scope to bring  
5 ultimate efficiency to all of those efforts and that  
6 there are different reasons, maybe some of which are out  
7 of our control, that some of the positions that people  
8 are even going to be filling have to fill, but we should  
9 look at that. But, I don't know, I'm trying to glean  
10 what's going on around the table and we can take  
11 something to a vote, but I'm not quite sure where people  
12 are to even be able to vote on something as opposed to  
13 say, you started another conversation that we need to  
14 continue. And maybe we need to continue as a Board before  
15 we even know the series of action steps that would come  
16 out of it. So, I look to you all for some feedback on  
17 this.

18 MR. HEUSCHKEL: I would say that if you  
19 listen to this conversation and you listened to the  
20 earlier conversation about governance within state  
21 government and these different -- I think some of it is  
22 even before you get to questions of efficiency or  
23 inefficiency it's just understanding. You can't even get  
24 there without the basic understanding. I think there is a

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 lot of confusion and just, again, lack of understanding  
2 amongst the different constituencies in part in terms of  
3 the governance. And there is, as you say Commissioner,  
4 some of this is by design in a sense because that way you  
5 make sure all of those voices get heard.

6 But from my perspective, I don't think it  
7 hurts to have a conversation in the interest of  
8 furthering the understanding because you can't get  
9 anything further -- and maybe that's part of our problem  
10 is there hasn't been enough conversations within and with  
11 outside of government.

12 MR. CARMODY: And that was the intent of  
13 the motion. The motion wasn't that we had any ability to  
14 do anything, it was to start conversations that maybe  
15 haven't been started and maybe need to be stimulated. I'm  
16 not sure that I think people approach this the way they  
17 did because of some overarching plan around that we  
18 wanted various boards together, I think they grew out of  
19 various granting and funding approaches that were across  
20 various agencies at the federal level that started off  
21 with grant funding and they didn't do it. I think it's  
22 incumbent upon us to be able to at a state level say  
23 where were the inefficiencies in that and drive a  
24 conversation that we think that we can be at a better

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 spot. And, again, all it is is a conversation.

2 DR. BUCKMAN: Excuse me, have you asked if  
3 that conversation has already started?

4 MR. CARMODY: I have and the last time I  
5 was told that it wasn't started at the board level and  
6 that it needed to be done and that's why I'm putting it -  
7 - that's why I'm putting it together now that said, this  
8 is the way we want to maybe start off to see where that  
9 goes. My understanding is that there was interest on the  
10 other side --

11 DR. BUCKMAN: -- my understanding there  
12 has been conversation.

13 MR. CARMODY: Well, there was. My  
14 understanding there was interest at one point in time and  
15 that this Board didn't take any action on it.

16 DR. BUCKMAN: No, that there has been  
17 recent conversation.

18 MR. CARMODY: My understanding when -- I  
19 mean you're asking me a direct conversation and I'm  
20 telling you within the last two months my understanding  
21 is that this Board has, other than sending me as an  
22 embassy to talk with Scott around interests, we have  
23 not furthered the conversation any further and if there  
24 was then maybe other people can share what that is.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 DR. BUCKMAN: So then there has been  
2 conversation.

3 MR. CARMODY: It was a conversation around  
4 expenses that moved to interest in how we can better work  
5 together and I'm saying that I think there needs to be a  
6 more formal vote by this Board of do we want to further  
7 that or not. And if we don't that's okay. I mean if you  
8 decide this is a really bad idea, fine. I don't take it  
9 personally. I'm just putting the moose on the table.

10 CHAIRPERSON MULLEN: We can call the  
11 question or I can ask a question, make a request that if  
12 that conversation has occurred maybe that's something we  
13 can get updated on at the next meeting and figure out  
14 where we want to go next. And that would answer part of  
15 what you raised. 0020

16 MR. CARMODY: I'm not sure I understand  
17 that.

18 CHAIRPERSON MULLEN: So the point would be  
19 to have people understand the substance of the  
20 conversations that have gone on up until now so that they  
21 would be able to vote on whether or not they would like  
22 to continue. So, everybody would be up to speed on  
23 what's gone on thus far and I think basically that was  
24 the basis of your question, what's happened this far.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MR. COURTWAY: So I'm not sure if this is  
2 the Robert's Rules way to do it, but is it that to make a  
3 motion to table the motion pending clarification of the  
4 conversations that have already taken place.

5 MR. CHUDWICK: Or the motion could be  
6 withdrawn and the second could be withdrawn on the  
7 understanding that this discussion would take place at  
8 the next Board meeting and there would be more -- what  
9 has actually occurred was discussions --

10 MR. CARMODY: -- I have no problem  
11 withdrawing the motion so long as I know who is going to  
12 come back and give up the update and what, to the extent,  
13 did I understand what the framework is. So I have no  
14 problem withdrawing it if I know that there is -- does  
15 somebody have a takeaway. My takeaway was or what I put  
16 on the table was having the Chair or Vice Chair and/or  
17 CEO's start up the process. If -- I will have no problem  
18 withdrawing the motion if I know either, I guess  
19 Commissioner Mullen if you're going to act to give us the  
20 update then that's the update or David is going to do it,  
21 I'll withdraw.

22 DR. BUCKMAN: If I may, correct me if I'm  
23 wrong, but there is nothing in our bylaws that prevents  
24 our CEO from having conversation with the CEO of E-

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 Health. And if any conversations have occurred already,  
2 as you say you've had a conversation, there is nothing to  
3 prevent those conversations from continuing to occur.  
4 What we're saying is is that those conversations should  
5 come back to the Board and there should be a report to  
6 the Board on what those conversations have been so that  
7 we can know what's been talked about and whether or not,  
8 at that point, we want to move forward. Now, that  
9 doesn't stop you from having more conversations between  
10 now and the next meeting. Right?

11 MR. CARMODY: I'm fine with that. I guess  
12 my only concern with the vagueness and how obtuse this  
13 conversation is turning into is that a Board of  
14 Directors, which is what we are, should set guidelines  
15 around a framework on how they want to start to go out.  
16 And the framework that I said was optimizing governance  
17 structure and expenses. So I think, you know, if the  
18 Board doesn't want to set a direction on how you engage  
19 another organization that's fine. I just think that  
20 typically when boards have a conversation there is a  
21 framework and the board members agree to that framework  
22 otherwise exploring it, you know, is a question.

23 CHAIRPERSON MULLEN: And I think people  
24 will be better prepared to do that after we get the

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 update on the conversations up until now. So, the  
2 February 27<sup>th</sup> conversation --

3 MR. CARMODY: -- so that means you have  
4 the -- you're going to give us the update?

5 CHAIRPERSON MULLEN: I haven't been  
6 meeting with the --

7 MR. GILBERTSON: -- is the question has  
8 anybody talked to their board? I had a talk --

9 MS. HOOPER: -- board to board and then  
10 staff to staff is a separate issue. Dan's motion was for  
11 the board to approach so that's what's on the table right  
12 now.

13 MR. GILBERTSON: I don't know if anybody  
14 has approached their Board. I mean I've talked to Scott  
15 in general about like office space and how we can  
16 collaborate and what was his take. Now remember he's also  
17 in sort of a funny position because he's the interim CEO,  
18 but he's also the prime contractor. So, he's kind of in  
19 an awkward position. So he was certainly open to any kind  
20 of discussion I had with him. I'll tell you though he --  
21 he bills for time and materials so basically he bills  
22 against his contract with the board. So if he was to give  
23 me space or any resources to do anything he'd have to  
24 bill for it. I mean it's just kind of -- he's kind of in

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 that --

2 MR. CARMODY: -- which is fine, which is  
3 the reason why I said I wanted to see it as a board  
4 dialogue that enabled somebody from this board to reach  
5 out to that board and have a more structured conversation  
6 as well as, you know, when you eventually get into it  
7 well, it may be time and materials there is still issues  
8 around why do we need multiple CEO's. Why do we need a  
9 state HIE coordinator? I mean those are things that have  
10 to be put on the table to say how is that coming  
11 together. So, we can send David off and wait for a  
12 report back or if somebody is not going to do it, I think  
13 there should be a formal motion by this Board to decide  
14 do we want to engage that board in a dialogue so that we  
15 know what everybody is thinking as opposed to doing it  
16 under the covers. It's done with transparency that says  
17 this is what we want to get an update on.

18 DR. ANDREWS: I guess I'm concerned about  
19 taking it -- for the same reason that you want some  
20 definition from this Board and some go ahead, I'm really  
21 concerned about that. And a decision by this Board to  
22 start looking at that I see as a movement toward doing  
23 that and not just the discussion that you're talking  
24 about because a lot of -- I mean a lot of here what

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 happens in Executive Committee, not everybody comes to  
2 every meeting. I feel like I could show up in two months  
3 and, oh my gosh, we're merged. And that worries me. So  
4 for the same reason that you want that definition I'm  
5 worried about it.

6 MR. CARMODY: What would you do to frame  
7 it out? I mean you're putting a barrier, but my push to  
8 you, it's just a friendly push, is then put a -- help  
9 frame it out. Like what do you want to see happen? I  
10 don't think anything -- I'm not trying to rush your  
11 conversation. I think what I'd like to see is a  
12 conversation to figure out is there anything there or is  
13 there not. And if there is no interest by that other  
14 board by saying is there a way to optimize this  
15 governance structure and we're not interested in you  
16 having the dialogue then fine. Then we've gone down that  
17 path, we've decided that we weren't going to do it,  
18 that's okay.

19 MS. KELLEY: Who is the current president  
20 of the E-Health board?

21 DR. BUCKMAN: Angela --

22 MS. KELLEY: Angela? And who is the  
23 current president of this Board?

24 DR. BUCKMAN: The Chair.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 MS. KELLEY: Then I don't know that this  
2 needs to be a motion, but it would seem like -- I mean  
3 I'm not saying that you're not raising very legitimate  
4 questions and they have a long history that precedes this  
5 Board. But I would think that the logical people that  
6 should have that reach out would be the Commissioner and  
7 Tom. And I don't know that that would be my top priority  
8 given all the things that we're facing. In fact my top  
9 priority would be -- because you can't do everything  
10 simultaneously, my top priority would be the government  
11 meeting because time is fleeting here. I mean we're  
12 getting into a legislative session. We will miss an  
13 opportunity. I don't know that you're going to change  
14 this structure between E-Health and HITE/CT. You might  
15 be able to do that over time especially if there is a  
16 need in both organizations to get together.

17 MR. CARMODY: We have 200,000 dollar CEO's  
18 that may get hired in the interim. What I'm trying to  
19 avoid --

20 MS. KELLEY: -- I'm not saying -- all  
21 right, but what I'm suggesting is I tend to -- if I'm  
22 overworked, which I generally always am, I tend to  
23 prioritize where do I think I'm going to have my best  
24 success. And I personally believe the timing of what's

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 going on right now is the Commissioner needs support to  
2 have that government discussion with her colleagues on  
3 the state level. And I also personally believe that if  
4 that can't happen I think the state has a lot of risk  
5 down the road because they've, face it, we've created an  
6 agency, we have hired people, we have hired a vendor.  
7 We've taken federal money. And so if I -- I have worked  
8 for state government. I would want to say we need to get  
9 our act together to make certain that this succeeds. Part  
10 of that conversation, by the way, could incur what do we  
11 do about looking at this resource called E-Health  
12 Connecticut. But I personally think we should trust our  
13 Commissioner, because she is the Chair of the Board,  
14 because I think -- and Tom to hear what's been said and  
15 figure out what needs to come first. And I think you've  
16 articulated. I'm not disagreeing with you at all really.

17 MR. CARMODY: If we don't need a motion  
18 then, fine. I withdraw the motion.

19 MS. HOOPER: Tom, do you withdraw your  
20 second?

21 DR. AGRESTA: Sure.

22 MR. CARMODY: I only ask that a  
23 conversation happen and somebody needs to have it as a  
24 takeaway. So my motion was intended to put that on the

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 table. The withdrawal of that motion doesn't require  
2 anybody to come back if they're not going to engage in a  
3 conversation.

4 MS. KELLEY: Well, I think clearly it  
5 sounds like we have to come back and talk about the  
6 financial health of what we're doing here and that is  
7 part of the solution, one of the solutions.

8 MR. CARMODY: My only push on that is  
9 going to be having a staff to staff conversation is not  
10 going to change if you're going to hire a CEO because  
11 that board is going to go off and hire a CEO. And,  
12 again, we're talking about a small pool of money with  
13 high level executives and unless it's top down you're not  
14 going to get our CEO to convince another board not to  
15 hire a CEO because of something, or a HIE coordinator, or  
16 whatever the case may be. You can make recommendations,  
17 but if it's not top down you're not going to get that  
18 type of support. Having been in a large organization  
19 where you have to try to influence up you can spend a lot  
20 of time and sometimes you have to work it from both  
21 angles.

22 CHAIRPERSON MULLEN: Thank you.

23 MS. HOOPER: Is John Lynch still on the  
24 phone? I heard somebody hang up. I know that they met

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 once to talk about the legal implications for  
2 implementing the operating procedures based on comments  
3 that come back. I don't know if there was more that John  
4 was going to add.

5 MS. REED-FOURQUET: I can fill in. We've  
6 been meeting to discuss the actual supporting agreements  
7 and documents for moving toward our pilot operations that  
8 include -- I just had it in front of me, our draft  
9 testing. No, we've already completed the draft testing  
10 for the patient agreement. The HITE CT participation  
11 agreement, that larger document that's going to frame the  
12 agreements with the participants, we've been reviewing  
13 although we've already collected comments on notice to  
14 patients, on draft op out and draft op back in, and draft  
15 business associated agreements. So we've been revising  
16 those documents as they come through.

17 CHAIRPERSON MULLEN: Thank you.

18 MS. KELLEY: Special populations met in  
19 December but did not have a scheduled meeting in January.  
20 They have been having working meetings with Lori on a  
21 regular basis. Unfortunately I was on a lot of travel at  
22 this time and my husband -- I'm involved in a major  
23 medical issue with my husband, so I have not been able to  
24 be part of that. But I know that they're happening and I

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 know that they've moved pretty much from the brochure  
2 stage because we pretty much have consensus on a  
3 brochure, which is great, to the website and what the  
4 website is going to look like. And, Lori, I think you had  
5 a meeting on Friday. I was going to call in from  
6 Cleveland, but unfortunately couldn't. So you might want  
7 to fill people in on the nature of those conversations.

8 MS. REED-FOURQUET: So we have met a few  
9 times because of the holidays and people getting back  
10 from the holidays and then my testing engagement it has  
11 been fairly light participation, but we did take the  
12 opportunity to re-review, originally when the group got  
13 together we looked at all the HIE websites that were out  
14 there, what we liked, what we didn't like, so we took  
15 those notes and tried to come up with some high level  
16 points that we would like to see as our major bullets and  
17 style on web pages that would be targeted towards the  
18 consumer.

19 We looked a little bit deeper. There is a  
20 very interesting video that was identified from  
21 Colorado's HIE and in looking into that further and when  
22 we played it it sounded extremely familiar to me. It was  
23 actually part of an ONC project that Connecticut was  
24 involved in a few years ago, the security and privacy

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 collaborative. And one of the groups that was multi-state  
2 had prepared some very nice videos that the core material  
3 was reused across multiple states and then they tailored  
4 it for the -- so that struck up some interest. And in  
5 going back to that website there are a lot of other  
6 consumer focus materials that were created. And so the  
7 homework assignment for the group now is to go back and  
8 review all of those materials to see if there is anything  
9 that we can adapt here.

10 CHAIRPERSON MULLEN: Great.

11 MS. KELLEY: I will also add that I was in  
12 Cleveland because my husband is a patient at the  
13 Cleveland Clinic and I did bring back with me their  
14 brochure for their patient portal, which was a very --  
15 and they also have a doc portal that they gave us  
16 brochures at the earlier meeting to give to all of Tom's  
17 doctors in Connecticut.

18 And so it's not perfect by any stretch of  
19 the imagination because immediately when I had the chance  
20 -- when Tom and I had the chance to see the patient  
21 portal we immediately signed up to get on his patient  
22 portal. And one of the things we discovered was that  
23 certain things were there, all of his appointments, a  
24 record of what he had done, his medications. But then we

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 get to all the tests and even though there is space for  
2 that none of them were there. And so we raised the issue  
3 with the doctors and with the translink coordinator and  
4 they said, well, the doctors are kind of reluctant to  
5 make certain that that information is there. And we're  
6 having more trouble with this part of the Cleveland  
7 Clinic then we are with other parts.

8 So, I think some of the -- what am I going  
9 to say, I think a different perspective that I've learned  
10 from being on this Board really surfaced in this. But  
11 it's a wonderful thing, and I brought the brochure back  
12 to show Lori and the committee.

13 It's not an HIE. It's one big giant  
14 hospital and what they've created. But we loved it. I  
15 mean we got on and we said this is great, now we just  
16 wish they'd fill in the information that they're not  
17 putting on there. But this is exactly what we need as a  
18 patient. And Tom's doctor at Yale was thrilled with the  
19 doctor portal and I don't think there is any problem with  
20 that. I think he can get anything he wants by just going  
21 into the system.

22 So even though I wasn't at the meetings,  
23 Lori, I was doing my homework at the Cleveland Clinic and  
24 getting another model that we could take a look at.

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 CHAIRPERSON MULLEN: You're always doing  
2 your homework. I mean I think so many instances in which  
3 whenever you're doing in your personal life there is a  
4 part of you that still refers back to these other bits,  
5 whether or not it's an AARP or here, and I really  
6 appreciate it.

7 MS. KELLEY: Thank you.

8 CHAIRPERSON MULLEN: I really do. I thank  
9 your husband too.

10 MS. KELLEY: My husband is going through a  
11 lot. I'll tell you about it after the meeting.

12 CHAIRPERSON MULLEN: Okay.

13 MR. COURTWAY: The technical committee has  
14 met. We're trying to finalize a number of use cases which  
15 are very important to get executing and from a technical  
16 committee perspective I think the most important thing we  
17 can do is to execute well and execute quickly. I think  
18 that's the most important thing to carry forward.

19 So in terms of getting to that, we are  
20 working to finish up with Axway and its partners on the  
21 access control use case and sort of the securities in  
22 there, and how do people get access to the information so  
23 that there is transparency to what the security is,  
24 following up on the policies and procedures that have

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 already been written and approved by the Board.

2           The second piece is really around identity  
3 management. You know, being able to know who somebody is  
4 who is coming in. And there is two other pieces that are  
5 important to the efforts and that is although they're  
6 configuration items, they really are sales items as much  
7 as anything else. One of them is branding of the portal,  
8 being able to show large hospitals and small hospitals  
9 and large practices how they can use this work that we're  
10 doing to extend their brand as a halo effect of the good  
11 work we're doing. And the other is on the master patient  
12 index management where we have very sophisticated  
13 technology at the state level that only one or two other  
14 hospitals in the state have which have great value to  
15 them and having them invest separately in them.

16           So we're finishing these four different  
17 configurations. We should come out at the next committee  
18 meeting with the finalization of those four. They can  
19 then get actually put into a configuration document that  
20 we can use to execute against those participation  
21 agreements.

22           I find it interesting that even though  
23 there is a lot of discussion on the hospital CIO group in  
24 regard to the value and how much is too much, we have

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 four of the hospitals who are committed in a  
2 participation agreement to sign the papers and want to go  
3 forward. And I think that's an important step. I think  
4 that the gauntlet is down. I think it's up to us to  
5 execute with the stuff we do and to execute well and I  
6 think that really is the focus of moving forward because  
7 as those four come up and see the value others will see  
8 the value and this thing will move forward.

9 And towards that end we are taking a look  
10 at the geographic distribution of the EMR's that have  
11 come forward for people who want to participate to see  
12 whether or not we can identify healthy communities. And  
13 say, okay, is there a prevalence of particular EMR's or  
14 particular focuses of events around these hospitals who  
15 want to do and can we create a healthy community that can  
16 help us with our marketing efforts as well as having  
17 people really understand it.

18 So, I think there is more to come on that,  
19 but from my perspective the most important thing we can  
20 do is really focus on execution. It will be exciting.

21 CHAIRPERSON MULLEN: So technically the  
22 patient privacy group is not one of the Board committees  
23 so we don't have a committee report from patient privacy.  
24 I can add that I know that the committee, advisory

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 committee that was created through legislation did have  
2 its first meeting on January -- earlier this month,  
3 chaired by Michelle Wilcox. Ellen is a member of the  
4 committee. Anybody else here? Anything you want to say.

5 MR. CASEY: It was around op'd in, op'd in  
6 discussion. There were many proponents for changing the  
7 policy that we have adopted here. And it was an  
8 interesting conversation.

9 CHAIRPERSON MULLEN: Anything you want to  
10 add?

11 DR. ANDREWS: We're getting lots of  
12 information and boxes full.

13 CHAIRPERSON MULLEN: Great.

14 DR. ANDREWS: Things that -- emails that  
15 have to be chopped up because they're too many  
16 attachments. So we have a lot of homework for our next  
17 meeting, which is coming up real soon.

18 MR. CASEY: The 25th.

19 DR. ANDREWS: Yes.

20 CHAIRPERSON MULLEN: Great, thank you. So  
21 we're at the public comment portion of the meeting.

22 Motion to adjourn?

23 DR. AGRESTA: So moved.

24 CHAIRPERSON MULLEN: Does everyone want to

RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
JANUARY 23, 2012

1 second it together? Thank you. All in favor?

2 ALL VOICES: Aye.

3 CHAIRPERSON MULLEN: Okay.

4 (Whereupon, the meeting was adjourned at

5 6:35 p.m.)