

VERBATIM PROCEEDINGS  
DEPARTMENT OF PUBLIC HEALTH

CONNECTICUT HEALTH INFORMATION  
TECHNOLOGY AND EXCHANGE

DR. JEWEL MULLEN, CHAIRPERSON

MARCH 19, 2012

101 EAST RIVER DRIVE  
EAST HARTFORD, CONNECTICUT

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RE: CT HEALTH INFORMATION TECHNOLOGY & EXCHANGE  
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1 . . .Verbatim proceedings of a meeting in  
2 the matter of Connecticut Health Information Technology and  
3 Exchange, held at 101 East River Drive, East Hartford,  
4 Connecticut on March 19, 2012 at 4:39 P.M. . . . .

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8  
9 CHAIRPERSON JEWEL MULLEN: Good afternoon  
10 everyone. We're one person shy of a quorum but that does  
11 not preclude our discussing some of the items on the agenda  
12 that do not require one. So happy continuation of spring  
13 at the end of winter, and I'm happy to announce a few  
14 things one of which is that if you don't know Sarju Shaw  
15 had her baby, a son, on Thursday I think, last week. Mother  
16 and child are doing well and he's adorable and has a lot of  
17 hair.

18 MALE VOICE: That will change in time.

19 CHAIRPERSON MULLEN: What did you say?

20 MALE VOICE: That will change in time.

21 CHAIRPERSON MULLEN: That will change in  
22 time, yes. And Meg's been out on medical leave for a few  
23 weeks so she's not here but we hope to see her back at the  
24 next -- well, back at work well before the next meeting and

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1 certainly back with us at the next meeting. At the end of  
2 our marathon meeting from last month, which I intend not to  
3 repeat tonight, I told Marianne Horn that as her boss at  
4 DPH I was really appreciative of everything she had done to  
5 serve the Committee but that she did not need to come  
6 today.

7 So I thank her for being here and filling  
8 in, in Sarju's absence with a lot of help -- with a lot of  
9 help as well. And since we can't go on with the minutes, I  
10 think why don't we go down to Item No. 3 on the agenda, the  
11 ONC requirements for the PIN, and do you want to do that?

12 MS. MARIANNE HORN: I could do that, sure.

13 CHAIRPERSON MULLEN: Thanks.

14 MS. HORN: If you recall from last meeting  
15 this had just been sent out. This is a notice from ONC  
16 with requirements and recommendations for the State's  
17 Health Information Exchange Cooperative Agreement Program  
18 requiring an update to the State Plan. And the timing on  
19 our update given when we filed our first Plan is May 7th, I  
20 believe is the deadline for updating the Plan.

21 So it's really a HITE/CT responsibility, and  
22 we also have to demonstrate that we've made certain  
23 progress towards certain goals in order to progress into  
24 phase two of our Plan. I just bring this up as an FYI for

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1 the Board because there may be some requirements for input  
2 from the Board. But basically it will be a HITE/CT  
3 responsibility to fill in the charts that accompany the  
4 PIN. Some of the data will be provided by ONC in terms of  
5 updating, for example the number of pharmacies  
6 participating in e-prescribing. ONC is going to give us  
7 that number because they have the number through Sure  
8 Scripts.

9 Other -- the percentage of labs sending  
10 electronic lab results to providers in a structured  
11 format, that is something that we are going to have to  
12 continue to try to get our arms around and that's not easy  
13 -- an easy task. So they want the percentage of hospitals,  
14 ambulatory providers electronically sharing health care  
15 summaries with other providers, and then there are four  
16 areas where they want Public Health to provide an update in  
17 terms of what progress we've made on the Plan. So we'll be  
18 working away with that assisting HITE/CT to update the  
19 Strategic and Operational Plan and I'm sure that we'll be  
20 in touch with the Board as we need more information.

21 MR. JOHN LYNCH: The implication is we can't  
22 move to stage two funding. When did we plan for stage two  
23 funding and is it going to -- us not getting our percentage  
24 of whatever it is we have to get to, in other words trying

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1 to work backwards, what point do we plan to go to the next  
2 stage of funding where we will be to meet these numbers?

3 MS. HORN: I didn't have a chance to look at  
4 that in the Plan this morning. Did you have a chance to  
5 look at the implications of moving from phase one to phase  
6 two and whether that triggers release of additional  
7 funding?

8 MS. UMA KUTTY: I haven't done that --

9 COURT REPORTER: I'm sorry, you'll have to  
10 come up --

11 MS. HORN: You'll have to come up and use a  
12 microphone. I told her I would put her on the spot if  
13 there is anything that went below the surface because I  
14 wouldn't be able to answer it.

15 CHAIRPERSON MULLEN: And when I said that  
16 Marianne has been getting a lot of help, Uma is one of  
17 those examples. Thank you.

18 MS. KUTTY: Is this loud enough?

19 MS. HORN: No, you have to really speak  
20 loud.

21 COURT REPORTER: No, no, no, just put it  
22 down. It will be fine.

23 MS. KUTTY: Alright. And so I haven't found  
24 the specific dates on the Strategic and Operational Plan as

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1 yet, but we do have (indiscernible) with ONC very shortly  
2 so we will get in touch with them and get the exact dates  
3 that -- if they have set any dates for us with this stage  
4 one and stage two cutoffs.

5 MR. LYNCH: It's probably more -- and Dan, I  
6 don't know for the Finance Committee, you don't remember if  
7 we planned on when a stage two kind of funding would come  
8 in?

9 MR. DANIEL CARMODY: It wasn't so much a  
10 phase two funding. When we looked at that it came down to  
11 a timing of, we thought that we would have certain  
12 functionality up in the beginning part of the year and we  
13 would start to have people purchasing the services. That  
14 is not the way that it has eventually rolled out. So if we  
15 don't have the functionality that we were anticipating and  
16 we don't have people purchasing the services, so right now  
17 we're in the conundrum of -- again, we're surviving off the  
18 grant money.

19 So irrespective of whether we're meeting  
20 with meaningful use two, tell me when I go around this --  
21 my understanding is even under meaningful use two that  
22 folks, in order to get their incentive payments, have to  
23 exchange data but it doesn't have to be with an HIE. So  
24 the conversation that we started to have, especially with

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1 Axway was, again, building out that value proposition to  
2 get back to how are we demonstrating our -- the value of  
3 the services, when can we tell folks that we'll have stuff  
4 on line so that they will then start to subscribe. Did I  
5 misspeak --

6 DR. THOMAS AGRESTA: No, writing one is  
7 stage one -- it's really meaningful use stage one, that  
8 doesn't require that. Stage two is only proposed rules as  
9 of now and the final rules will be due out in the summer.  
10 And the proposed rules do say that you have to exchange  
11 with partners in a whole lot more sophisticated fashion.

12 I think at some point we need to actually  
13 create a summary document for this organization to  
14 understand the Health Information Exchange implications of  
15 even the proposed rule because they do require  
16 substantially more need for HIE. That's different though  
17 than reaching -- that's completely different than reaching  
18 this second phase for this particular ONC grant. So one of  
19 the challenges is, this PIN is actually sort of describing  
20 what it is for the first time, what the thresholds are that  
21 you have to receive. And we didn't know what they were  
22 beforehand.

23 So this is a new piece of data that  
24 describes what has to be accomplished before you get to

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1 phase two. And the way that I understood our Strategic and  
2 Operational Plan, it didn't have sort of a phase two, phase  
3 one aligned this way. It had phase two and phase one  
4 aligned according to what we decided we wanted to do in  
5 terms of our staging of the Health Information Exchange.  
6 And stage one had all of the things that are consistent  
7 under stage one. So transmitting data electronically,  
8 etc., they're aligned in a lot of ways but it's not clear  
9 to me what this means in terms of funding release, etc.

10 So I did need to clarify that. That's a  
11 part you need to clarify. On the other hand reading  
12 through this, you know, the primary stuff that it is  
13 actually tracking has a lot to do with what the REC is  
14 doing and not what the HIE is doing. And so in many ways  
15 we're going to really need to partner with and work with  
16 the REC to ensure that we're meeting the requirements for  
17 this and that's going to be one of the key issues. And  
18 some of the other things are going to be look at are the  
19 data that's being tracked by the evaluation of this grant.

20 So there's some other things that  
21 (indiscernible) is tracking for example. Actually we're  
22 going to have to take a look at that and see how do they  
23 actually match up with what is suggested in here. So it's  
24 not specifically aligned the way that it might seem so it's

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1 a little confusing.

2 MR. CARMODY: Yeah, we need an alignment  
3 funding the way that it's going --

4 DR. AGRESTA: Yeah, this is not a funding  
5 alignment as far as I can tell.

6 MR. CARMODY: -- because when we went into  
7 it, the functionality that was going to be provided, we  
8 were going to deliver, that functionality was going to  
9 serve as the basis on what -- it would have satisfied the  
10 PIN and then some. And I think when we get into the  
11 conversation maybe later today, we're now talking about are  
12 there things on functionality that we would hold off on,  
13 how we would implement in order to be able to --

14 DR. AGRESTA: Yeah, in other words in order  
15 to meet the specific thresholds for this we might have to  
16 really specifically prioritize them more fully.

17 MR. LYNCH: I mean, it's kind of what I'm  
18 aiming at, that we may wake up and find out there's no more  
19 ONC funding until we achieve phase two and therefore, maybe  
20 all of a sudden maybe there's another cash flow issue or  
21 whatever.

22 DR. AGRESTA: Well, I think that this is one  
23 of those areas where as the Board and -- getting our CEO  
24 and the Board collectively together with the current

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1 grantee, which is DPH, and sitting down with ONC and saying  
2 exactly what does mean? Because I read through it and I  
3 can't tell exactly what it means.

4 CHAIRPERSON MULLEN: Right, but also -- and  
5 to address your point and to keep us moving forward without  
6 going -- having feeling as if I'm trying to stifle this  
7 conversation is, part of what you take us back to is the  
8 reality of what we've been discussing for months, which is  
9 that -- and then that this is supposed to get funded off of  
10 one little grant too at the Department of Public Health  
11 anyway. So that all just becomes part of the bigger  
12 conversations, which I would encourage us not to think are  
13 now complicated further because we have one or two  
14 thresholds to meet within phase one meaningful use.

15 We're still trying to address all of this  
16 that's in stage one meaningful use. And I'm very aware  
17 that every month some new language gets introduced that can  
18 confuse the picture even more about what it is that we're  
19 doing here. You know, so we have phase one and phase two  
20 along with stage one and stage two -- maybe I should stop  
21 there.

22 MS. HORN: We'll just continue to have it as  
23 an agenda item each month and work in between.

24 DR. STEVEN THORNQUIST: This is an ongoing

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1 thing. The due date for this is December correct, for this  
2 PIN?

3 MS. HORN: I think it is May.

4 DR. THORNQUIST: Oh it is May, okay, because  
5 the target -- the status dates are December 2012 in looking  
6 in the charts in the back.

7 MS. HORN: Right, those are I believe  
8 underlying targets.

9 MS. BARBARA PARKS-WOLF: Weren't they phased  
10 between the time you submitted your last one, it was very  
11 State-specific?

12 MS. HORN: Yes, they were State-specific but  
13 I think it is a Plan that we are submitting so we will  
14 continue to have --

15 DR. THORNQUIST: Yeah, since we don't have a  
16 whole lot of ongoing meetings to remind us until May.

17 MS. HORN: That's right.

18 DR. THORNQUIST: Okay. I just want to make  
19 it clear in my mind when the due date was on this.

20 MS. HORN: Yes, it's coming up.

21 CHAIRPERSON MULLEN: HIE coordination meet?

22 MS. HORN: I think the only thing there was  
23 that it did not meet this month but we'll be back on  
24 schedule next month when Meg returns.

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1 CHAIRPERSON MULLEN: We're still waiting for  
2 one person -- has anyone else joined Peter on the phone?

3 MS. ANGELA MATTIE: I don't know if you took  
4 a role call, this is Angela Mattie. I've been on since the  
5 beginning, how are you?

6 MS. HORN: Very good, you make a quorum for  
7 us Angela. Welcome.

8 CHAIRPERSON MULLEN: Hi Angela.

9 MS. MATTIE: Hello, I've been here since the  
10 beginning, I'm sorry. I don't know, are there others on  
11 the line? There were three when I started.

12 CHAIRPERSON MULLEN: We have Peter --

13 MS. HORN: And we count as one.

14 CHAIRPERSON MULLEN: That's it.

15 MS. MATTIE: Okay.

16 CHAIRPERSON MULLEN: Thanks.

17 MS. MATTIE: Thank you.

18 CHAIRPERSON MULLEN: So why don't we just  
19 bounce back up to the minutes from last month then.

20 MR. LYNCH: Move for approval of the  
21 February 27th meeting minutes.

22 MR. PETER COURTWAY: I'd like to make a  
23 motion to accept the minutes.

24 MS. PARKS-WOLF: Second.

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1 MR. LYNCH: I'll take that as a second.

2 CHAIRPERSON MULLEN: Yup, okay thank you.

3 Do you need to know who moved and seconded it or are you  
4 all set? All set, thank you. Any discussion?

5 MS. HORN: Okay, all in favor of approving  
6 the minutes?

7 VOICES: Aye.

8 MS. HORN: Opposed, abstained? Okay they  
9 pass, thank you.

10 CHAIRPERSON MULLEN: Great, thank you. And  
11 we're on to Board business.

12 DR. AGRESTA: Alright, so we are working on  
13 trying to get -- alright, so our current account has  
14 \$346,000 in it. We have \$876,000 and \$749 in accounts  
15 receivable that is in an approved MOA from DPH for their  
16 grant, and we expect that that transfer will occur shortly.  
17 So a total current assets of \$1,223,342.29.

18 We have accounts payable, which is  
19 essentially a bill from Axway, along with salaries and  
20 printer, committed \$932,677.48. So that leaves us a total  
21 in the account after -- an equity or net income of  
22 \$290,665.81. So that's actually done on an accrual basis  
23 and what I am working with -- we're working with Dan, with  
24 David, to actually create a format by which we can get this

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1 out as part of our meeting notices ahead of time and that's  
2 in an accounting format that's more readily understood.

3 So we're in the midst of doing that and plan  
4 by the next meeting to actually be able to have that occur.

5 CHAIRPERSON MULLEN: Thanks. The other  
6 aspect that we have --

7 DR. AGRESTA: Yes.

8 CHAIRPERSON MULLEN: -- is the, I think the  
9 finalization of INKIND report --

10 DR. AGRESTA: Yes.

11 CHAIRPERSON MULLEN: -- from the best unit  
12 to DPH for I think, it's 600 square feet?

13 MR. DAVID GILBERTSON: I haven't measured  
14 it.

15 CHAIRPERSON MULLEN: You haven't? That's  
16 what --

17 DR. AGRESTA: That's what the MOU says.

18 CHAIRPERSON MULLEN: -- was written yeah, it  
19 sounds like --

20 MR. GILBERTSON: Is that what it says?

21 CHAIRPERSON MULLEN: Yeah.

22 MR. GILBERTSON: Okay.

23 CHAIRPERSON MULLEN: So I can't tell you  
24 what the price per square foot is, but you have space.

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1 MR. GILBERTSON: We do have space, yes,  
2 right upstairs. That's good, thank you.

3 MS. PARKS-WOLF: Where is that?

4 MR. GILBERTSON: And it's good space.

5 CHAIRPERSON MULLEN: Barbara has a question.

6 MS. PARKS-WOLF: Where is the space exactly?

7 MR. GILBERTSON: Where is it at?

8 MS. PARKS-WOLF: Yeah.

9 MR. GILBERTSON: Oh, it's sixth floor of  
10 this building.

11 MS. PARKS-WOLF: Here, oh okay.

12 MR. GILBERTSON: It's two offices and three  
13 cubicles so we'll be able to -- and the cubicles, you could  
14 put two people in each one. So that gives us plenty of  
15 room to grow.

16 MS. PARKS-WOLF: That's great, excellent.

17 MR. CARMODY: And it's a place to call home  
18 and put your hat.

19 MR. GILBERTSON: What's that?

20 MR. CARMODY: It's a place to call home and  
21 put your hat and have people --

22 MR. GILBERTSON: Yeah, it's just kind of  
23 lonely right now.

24 DR. THORNQUIST: We'll come visit

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1 periodically.

2 MR. GILBERTSON: So yes, it is, it's good.

3 CHAIRPERSON MULLEN: Do you want to have the  
4 next meeting upstairs?

5 MR. GILBERTSON: Of this meeting? No.

6 CHAIRPERSON MULLEN: No, okay.

7 MR. GILBERTSON: We could do the Executive  
8 Committee, there's a conference room up there, but it's not  
9 big enough for this.

10 CHAIRPERSON MULLEN: We'll keep that in  
11 mind, okay. Thanks.

12 MR. GILBERTSON: I'll give everybody a tour  
13 if they want one.

14 CHAIRPERSON MULLEN: Alright, we need an  
15 approval of the Treasurer's report?

16 DR. AGRESTA: Yes.

17 MS. HORN: Have a motion to approve the  
18 Treasurer's report?

19 MALE VOICE: So moved.

20 VOICES: Second.

21 MS. HORN: All in favor?

22 VOICES: Aye.

23 MS. HORN: Motion carries.

24 CHAIRPERSON MULLEN: Constituent Summary.

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1 MS. HORN: Angela is going to provide an  
2 update on the students I believe, Angela on the -- the  
3 students handling the Constituent Summaries update?

4 MS. MATTIE: Well, as we were meeting we  
5 chose four students all with varying backgrounds. Some  
6 have IT health care backgrounds, some have health care  
7 administration backgrounds. I had an overwhelming  
8 response. We sent out a little notice and I had to turn  
9 several very bright students away. So -- you know, it's an  
10 option as we move forward if we need more student groups  
11 I'd be happy to rally more.

12 And they currently are working with  
13 Christine on compiling the Summaries and I believe they  
14 should be ready by the 19th, by the next meeting if you  
15 want to give them an opportunity to have a short spot on  
16 the agenda.

17 DR. AGRESTA: That's excellent, thank you.  
18 That will be very helpful.

19 MS. MATTIE: And any groups that have yet to  
20 submit any updates are welcome to do so. I don't know that  
21 the students will be able to aggregate them or do their  
22 magic with them but --

23 MR. GILBERTSON: Yeah, Christine --

24 MS. MATTIE: And I know they're going to --

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1 they may be -- they're in the process of identifying gaps  
2 in the information. So if contacted, if you can all try to  
3 get them a few minutes on your agenda it would be much  
4 appreciated so they can follow up.

5 MR. GILBERTSON: Yeah, I'll just --  
6 Christine -- this is Dave Gilbertson, she put together a  
7 document which outlined what we were looking for and the  
8 deliverables and part of the deliverables go beyond to  
9 summarizing what's been provided.

10 But actually taking that and putting it in  
11 and trying to quantify it, the value, and if there is a way  
12 to quantify the value and to drill down. And it will  
13 require in many cases follow-up with the individual who  
14 submitted it because there may not be enough information in  
15 there for the students to really understand the true value  
16 proposition or how to -- whether it's even quantifiable if  
17 it is.

18 So I fully expect that there will be ongoing  
19 communication back and forth between the different members  
20 of the Board and others who have submitted input and the  
21 students. And I agree, please do try to provide them some  
22 time and help them with this.

23 DR. AGRESTA: And make sure you pass on to  
24 them our sincere thanks for the effort that they're taking

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1 on.

2 MR. GILBERTSON: Right. And I know they had  
3 a conference call today at 4:00, and so hopefully -- they  
4 had a laundry list. They had more questions than we had,  
5 so they had a laundry list of questions and I think we  
6 answered most of them. And the 4:00 meeting was to, again,  
7 allow them to be brought up to speed with what we're  
8 actually doing so that their analysis can be informed and  
9 helpful.

10 MS. MATTIE: Oh, thank you for the  
11 opportunity. They're enjoying this project.

12 CHAIRPERSON MULLEN: That's good, thank you.  
13 And if there's some -- I know that you're going to have  
14 some of us come to one of your classes, so I --

15 MS. MATTIE: On the 19th, yes.

16 CHAIRPERSON MULLEN: -- right, I don't know  
17 whether or not -- and these are some of the same students  
18 that we'll be thanking?

19 MS. MATTIE: Yes.

20 CHAIRPERSON MULLEN: Okay, I appreciate it.  
21 Well, maybe you can also share with them some of the other  
22 part of what this piece of the agenda was because I have  
23 also asked Dr. Minakshi Tikoo to present to us today  
24 because she has been for over a year -- two years, how long

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1 have you been doing this?

2 DR. MINAKSHI TIKOO: About a year and a  
3 half.

4 CHAIRPERSON MULLEN: A year and a half, been  
5 doing the evaluation of this effort. And as part of that  
6 conducted a number of stakeholder interviews and done, I  
7 think, a combination of qualitative and quantitative  
8 assessments that I thought would also be helpful for us all  
9 to hear about.

10 So I'm inviting you -- you can even have my  
11 seat if you like.

12 DR. TIKOO: No, I don't need your seat for  
13 that. I'll go over quickly -- I didn't prepare to do a  
14 talk but I can go over the fine points. Sit here?

15 MS. HORN: You'll need a microphone, yeah.

16 CHAIRPERSON MULLEN: And thank you again.

17 DR. TIKOO: So we did a mixed method  
18 evaluation and it has five components. At one point in  
19 time I had given a brief update. It has a physician's  
20 survey, a lab survey, a pharmacy survey, a consumer survey,  
21 and it has the qualitative aspects which we are gathering  
22 by interviewing both Board members -- but one of the things  
23 that we earlier identified, that it would also be better to  
24 identify other stakeholders that are non-Board members.

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1                   So we had sent out requests and interviewed  
2 the Board members early on in the beginning -- middle of  
3 last year and finished it by the end of last year. And  
4 this year earlier on we've been meeting with the non-Board  
5 members. So we have about 16 completed interviews in that.

6                   So going back I'll just go over each of the surveys and  
7 tell you where we are and where our challenges lie in the  
8 State. One obviously big challenge is that our HIE is not  
9 up and running. You know, so to ask people about what they  
10 think, they have to reflect back and talk from what they  
11 know about the potential of what HIEs can do and not  
12 exactly from experience.

13                   So in the physician's survey we started with  
14 a list of 18,642 physicians, and that was a rather large  
15 list. And everybody said that's not how many practicing  
16 physicians we have in Connecticut but that's the list we  
17 had from the Licensure Department. And we also got another  
18 list of Medicaid physicians from the Medicaid office so  
19 that we would -- so based on those two merging lists we had  
20 18,642. And that's when we said we'd mail out a postcard  
21 asking people about, you know, whether or not they were  
22 practicing in Connecticut and what they were using for a  
23 chart system and how they were storing medical records.

24                   We got a response right off of -- 20 percent

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1 of the postcards came back. It wasn't bad, it was better  
2 than we thought. And the second step of that process was  
3 that based on what they had said about not receiving our  
4 survey, we mailed out a survey to them. And so we mailed  
5 out 2,592 surveys and we so far have received 800 completed  
6 surveys. So the overall picture is that 37 percent of the  
7 physicians do have an EHR that they have implemented.  
8 About 15 percent are kind of in the process of either  
9 acquiring one or have acquired one or are in the process of  
10 implementing one.

11 Only about 20 percent of the physicians said  
12 that they did not plan on buying or adopting an EHR and  
13 they did have a whole bunch of questions about, you know,  
14 the utilizing of the EHRs and how are they using them and  
15 do they have them available, which functions do they use  
16 and what functions do they find are useful? And there's a  
17 whole report that is on the website, so all the details are  
18 there. And I'll be happy to send out links too. The other  
19 question I think that might be of interest to this group is  
20 that only 10 percent of the people are aware that there is  
21 a Health Information Exchange in Connecticut.

22 And about 10 percent or 11 percent I think  
23 total, when I looked -- we asked them both about the CCD  
24 and the CCR, whatever they were using, and it was about 10

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1 percent of the people who were ready to exchange  
2 information because if that was going to be one of the  
3 wrinkles that HIE was going to use that people are not  
4 paying. So those are the kind of the early findings and  
5 it's stage one. We have planned this study to be a  
6 repeated measure so again, everybody that answered is going  
7 to be followed up in a year and again in a year.

8                   So this is funded as a four year study. So  
9 we'll have three points and we're hoping that that will  
10 give us a good time series over time change and we can talk  
11 about how the landscape of Connecticut HIE and adoption of  
12 Health Information Technology is tinted. So that's the  
13 physician survey in a small detail. We had about I think  
14 38 questions, so the response rate on the survey after the  
15 first step is 44 percent so that we are happy with. People  
16 have been -- and my staff, I have to thank. They have been  
17 really diligent because, you know, a couple of states have  
18 called us, they say for that much money you couldn't be  
19 doing all this. People actually questioned if we were  
20 doing all the file parts and, you know, we are.

21                   On the pharmacy survey, that was also  
22 actually a pretty good response. We got a response rate of  
23 63 percent on the pharmacy survey and we again followed a  
24 step wise process for creating a master list of pharmacies

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1 in Connecticut. We got the list from the Consumer  
2 Protection Agency. We got the list from a website that  
3 actually lists all the pharmacies in the state and we  
4 downloaded that list and we had also received a short list  
5 from (indiscernible). So we merged all of them together  
6 and we came up with I think a unique count of unduplicated  
7 pharmacies at 672. And then we identified the independent  
8 pharmacies, the franchise and the chains, and any other  
9 kind of setting. And we have representation from all of  
10 the different categories of the pharmacies.

11 Independent as one would guess is the least  
12 likely to have adopted but overall adoption rate in  
13 Connecticut is high. From our data it is about between 80  
14 to 85 percent of the pharmacies actually have an e-  
15 prescribing system. So that data is -- again, we have it  
16 further analyzed and we're looking at differences by the  
17 status between the independent and the chain and the  
18 franchise together. And we're looking at any differences.  
19 We're not finding too many significant differences because  
20 overall adoption is high, so you're not really going to  
21 have the variability in the data.

22 The third is the lab survey and that is  
23 where we have come up stumped a lot more than we had hoped  
24 for or wanted to. We have a universal 370 unique labs in

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1 Connecticut and we started calling the labs similar to the  
2 pharmacies to ascertain the address and identify who we  
3 should be sending the survey to. In all of the surveys we  
4 also asked for which would they prefer the method of  
5 getting the survey, whether they wanted it over the phone,  
6 they wanted a web-base, they wanted a paper or they wanted  
7 us to fax it. Only what we found in the labs, 97 people  
8 said they wanted a fax and we only got two responses. So  
9 so far we have a completed response rate of seven percent  
10 of the lab and that is the biggest challenge.

11 As you will see, your PIN requirement, that  
12 is a gap in information that we will not be able to fill  
13 out based on that small sample that we have. But ONC has  
14 recently released what they're calling a crucial list of  
15 seven questions and we're trying to get those seven  
16 questions so one of the things that we can attempt to do is  
17 call the labs and say we're just going to ask you seven  
18 questions and can you answer it. The challenge though,  
19 because there's been all the national calls and this, is  
20 that the person that you call often doesn't know what  
21 standards they're using or if they have a system, what's  
22 the system version and is it released or not.

23 So my question to the Feds was that I wasn't  
24 sure that was going to give them the most reliable method

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1 for measuring and for the State's performance. So I don't  
2 know how well -- you know, but if that's all we have then  
3 we are going to make an attempt and try to see if we can  
4 get back to you so that you can meet the requirement of the  
5 PIN.

6 Then the most, I think, important and unique component of  
7 what Connecticut is doing is the consumer survey. We have  
8 -- it's a randomly generated telephone survey. It follows  
9 the random sample design so it has good faith -- that you  
10 can have good faith in the data.

11 So far we have completed 100 telephone  
12 interviews and we're getting a good representation of what  
13 you find actually in the literature. So you're seeing a  
14 lot of what you find about people's attitudes towards  
15 exchange of health information is true in Connecticut too.  
16 The one thing that I think the Board would like to know is  
17 that the opt in/opt out model, we did ask people about what  
18 they thought about the opt in/opt out model as we asked  
19 them also about their utilization of other health  
20 information technology tools and did they use them, did  
21 they want to use them. And we also have some variables on  
22 how the literacy that we asked them -- you know, do they  
23 understand the legal that is used in the health  
24 environment.

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1                   And actually it's a pretty high -- about 90  
2 percent of the people said they understood what they have  
3 in conversations with the doctor and if they don't they'd  
4 follow up, and mostly they did. So, that's a pretty high  
5 rate. And then on the use of internet, about 40 percent of  
6 the people said they do go to the internet to find answers  
7 about health issues. They also -- the opt in/opt out  
8 model, 44 percent of the people said they wanted to see an  
9 opt in model and that I think right around 35 -- you know,  
10 my percents could be a little off but that's generally in  
11 the ballpark, said that they wanted an opt out model.

12                   So you know, it's close and if you look at  
13 the literature it has interesting -- because Massachusetts  
14 is the one published study that has been put out, I think  
15 about a year and a half or two ago, and what they found was  
16 they actually spent a lot of -- they had a funding grant  
17 that supported this study. And what they did was they had  
18 the process of opt in and opt out. So they actually worked  
19 with people to see what would you like to do. And what  
20 they found was that 90 percent of the people opted in to  
21 the exchange or sharing of information.

22                   One of the things I think as we've been  
23 observing this, is that given that 90 percent of the people  
24 do opt in I think what is important for states, because

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1 given that money is limited -- you know, it takes a lot of  
2 money to do this kind of work. I think what is important  
3 for all states -- and I'm in Connecticut so I've got advice  
4 for making sure we do it a different way, is that we need  
5 to spend a lot of time educating that 10 percent so you  
6 make sure that the people that don't want to share that  
7 information get that chance not to share it. Because that's  
8 kind of more important that -- because it looks like from  
9 human behavior most people are fine sharing that  
10 information.

11 We have also collected some information  
12 about chronic diseases in our consumer survey, so we will  
13 see for differences. People that have, you know, a  
14 multitudes of conditions are they more likely to support  
15 then people that don't have. So then we can tease out some  
16 of the nuisances by the behavior. So that's our consumer  
17 survey, and then last is our stakeholders survey. And the  
18 findings are -- it's a small survey but it's qualitative in  
19 design. So what we've done, we've used some techniques  
20 that are used based on what is called free-listing and  
21 other team-driven identification. So I'm waiting to have  
22 up to 30 -- when we can use actually statistical tools that  
23 help you so it's not like me being bias and coming up with  
24 things but the tools based on a preconceived analysis

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1 structure.

2 One of the things that comes out is that the  
3 Board feels pretty strongly that it has accomplished a lot,  
4 which is obviously true because there is a Plan in place  
5 and an operation. But when you go outside to the  
6 stakeholders many people -- you know, we went to people  
7 especially who had heard about you. But when you call  
8 people generally people don't know about HITE/CT. And  
9 that's what we found true in pharmacy survey, that was true  
10 for the lab survey, that was true for the physician survey,  
11 that's true for the consumer survey. And so really at the  
12 end or in the middle of this hole is the consumer.

13 So if the consumer really isn't aware of  
14 what is going on it's very difficult to make such things  
15 happen because technically you can do anything or most  
16 anything I should say, but whether or not as a state you're  
17 successful for an HIE and health information is exchanged  
18 truly in a manner that benefits that person, you know, you  
19 really do have to take a different look at it. And I think  
20 that's where I think the consumer survey can be helpful.  
21 Not to say that it's the only thing, and I think some  
22 planning and access to information which I think is  
23 missing. Because many people when I interviewed that were  
24 non-Board members, they said what's the plan. Well, I

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1 don't know what's the plan, you know.

2                   So I would direct people -- I think what is  
3 needed, and we could identify this as a gap and something  
4 that the Board might want to consider, is a couple of  
5 public announcements so to say, you know, which are  
6 available on the HITE/CT's webpage. So if I was a person  
7 and I wanted to know what are the services that HITE/CT  
8 offers, I really don't know. I only know because I read  
9 the Operational Plan but how many people are going to want  
10 to read your Operational Plan? That's not really  
11 realistic. So I mean, so I think a one-pager that clearly  
12 lays out the phase where HITE/CT is and the service that's  
13 going to be available, and whether it's delayed or not  
14 doesn't matter, at least people know what to expect. Right  
15 now I think it hurts HITE/CT because it's not known to  
16 people.

17                   So even if we wanted to support you --  
18 people said they want to support exchange, they said their  
19 top concern was privacy but they still wanted to. So those  
20 are the kinds of things I think in the formative research  
21 we've made up, a brief report that kind of lays out our  
22 recommendations that in the short-term what is it that  
23 HITE/CT can do to improve what the outcome -- the long-term  
24 outcome is. But definitely in the short-term, having some

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1 clear messages that are not very verbose but very succinct  
2 and to the point that tie back to the Operational Plan and  
3 the Axway, you know, what they're going to deliver and when  
4 would be good.

5 Because lots of physicians actually -- when  
6 they send us our postcards we get what is it and what is it  
7 going to do? And we always call them back and tell them  
8 where to go look for it. But I think it would be better  
9 served if people knew what was out there.

10 CHAIRPERSON MULLEN: That's great, any  
11 questions?

12 DR. AGRESTA: It was very helpful. A lot of  
13 information wrapped into a short timeframe, that was very  
14 helpful.

15 MR. LYNCH: Yeah, on the lab it sounded like  
16 an awful lot of labs. I would think that maybe five to 10  
17 labs in the State is probably 95 percent of the volume.  
18 Are there other labs like small like individual doctor  
19 offices or something that say they're a lab on the side or?

20 DR. TIKOO: So one of the interesting  
21 findings is that out of the 370, 95 -- when we called 95 of  
22 the locations they said that they were not a lab but  
23 they're on your list. So that's why -- you know, this is  
24 one of the challenges that we've identified and it's

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1 difficult for me to know, you know, what does that mean?  
2 Is it that just that person doesn't know but they may have  
3 some kind of a lab because you have a licensure number?

4           So I think we do have a challenge and we  
5 need to identify it and like you were saying John, is  
6 there, you know, 10 to seven or seven to 10 labs that do 95  
7 percent of the business and just talking to them actually  
8 tells you that 95 percent of Connecticut can or cannot  
9 exchange information depending on what they're using as a  
10 system. So that would be helpful. But the ONC guidance  
11 actually has been to use the -- very recently, about three  
12 weeks ago, they issued the guidance that you go to the CDC  
13 website and they want you to actually only look at  
14 pharmacies that are independent -- for labs that are  
15 independent and are hospital-based. That's all they want  
16 you to look at and nothing else.

17           And there is -- so we've downloaded that  
18 list and we're trying to see how we might go about --

19           MR. LYNCH: Should be a very short list.

20           DR. TIKOO: -- yeah.

21           DR. THORNQUIST: That should be a fairly  
22 short list though.

23           DR. TIKOO: It's 150 but like I said, you  
24 know, my numbers might be just like off by plus/minus five

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1 or 10, but that's what they are. So it was only about  
2 three weeks ago so we are kind of taking a look at it and  
3 seeing what we might be able to do. And we had initially  
4 started even with the CHA and 16 of the 17 -- you know, of  
5 the 24 hospitals responded but we didn't get all of the  
6 information we were still looking for at that time.

7 So still -- so that's like the question  
8 marks so to say. You know, that's the gap for us, is that  
9 lab information.

10 DR. THORNQUIST: Are we at a point now where  
11 we can really do outreach about what our timeframe is for  
12 rolling this out? I mean, do we have -- first up, do we  
13 have a one page summary we could put up somewhere? And  
14 second up, once we have some of these short blurbs aimed at  
15 specific populations, you know, there are ways at which --  
16 there's a lot net traffic looking for health information.

17 There are sites that doctors tend to go to  
18 if we put a little tab there, link here, you know, HITE is  
19 coming. And a site for patients, you know, DSS looking at  
20 Medicaid, put a little window out there that says HITE is  
21 coming, check here to find out. Things like that would be  
22 useful because those are fairly cheap and you'll get a fair  
23 amount of traffic and a fair amount of outreach that way.  
24 I mean, I suppose you could put a sign on the back of a bus

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1 too. But, I mean, I think we do need to start thinking  
2 about outreach because it sounds like it's a real issue.

3 DR. AGRESTA: I agree with you Steve and I  
4 think that the Special Populations group has actually done  
5 a fair amount of work in setting that up particularly for  
6 consumers. I don't think that they've set it up -- that  
7 process to think about outreach to clinicians and other  
8 health care providers but part of -- I mean, David can talk  
9 a little bit more about this but part of what he's been  
10 doing is going out and meeting with CIOs and the others in  
11 the Hospital Association and also starting to now meet with  
12 some of the leaders in the medical community.

13 And I think that we do need to have those  
14 sort of one to two pagers, but I think we're close to being  
15 able to do that.

16 CHAIRPERSON MULLEN: Right.

17 DR. AGRESTA: I mean, we can talk a little  
18 bit about that later right, as part --

19 CHAIRPERSON MULLEN: Right, and I think the  
20 other piece that will inform that is back to those  
21 constituent summaries, because part of the outreach -- it's  
22 almost like the market and the brand, and I think there  
23 will be a lot of information in those to help us know the  
24 appropriate messages for each of those groups.

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1 DR. THORNQUIST: Well, one way to reach out  
2 as well to two groups at once is to reach out to physicians  
3 to put information in their offices and explaining what the  
4 information we're putting out is. You educate the  
5 physician and hospital or clinic or whatever, and then you  
6 use that to educate the consumers.

7 CHAIRPERSON MULLEN: Right.

8 DR. THORNQUIST: Pharmacies, the same way.  
9 They're happy to put little brochures out, so.

10 CHAIRPERSON MULLEN: That's good, thanks.  
11 Thank you very much.

12 MS. HORN: Did we have somebody join us on  
13 the phone? Did somebody else join us during that last  
14 conversation on the phone?

15 MR. MARK MASSELLI: Yeah, Mark Masselli.

16 MS. HORN: Hi Mark, thanks.

17 CHAIRPERSON MULLEN: Hi Mark, welcome.

18 MR. MASSELLI: How are you Commissioner?

19 CHAIRPERSON MULLEN: Just fine thanks.

20 MR. MASSELLI: I'm sorry for running late.

21 CHAIRPERSON MULLEN: Thank you for getting  
22 here. So we're at Item No. 4C on the agenda, legislation,  
23 Senate Bill 368, An Act Concerning the HITE/CT. Who wants  
24 to start? Want to start?

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1 DR. AGRESTA: Sure.

2 CHAIRPERSON MULLEN: Okay.

3 DR. AGRESTA: So as all of you are aware,  
4 the Public Health Committee -- the Legislature is in  
5 session. The Public Health Committee had raised before it  
6 a bill that pertains to HITE/CT. The actual language of  
7 the Bill was sent around to individuals late last week sort  
8 of describing the Raised Bill No. 368, which is called An  
9 Act Concerning The Health Information Technology Exchange  
10 of Connecticut.

11 And it's new legislation that is basically  
12 as an overview stating that patients or parents as an  
13 authorized person for a minor individual can elect to  
14 authorize their information to be shared or to be made  
15 available through Health Information Technology as  
16 described in Section 19a-25d of the General Statutes. And  
17 the General Statutes that that refers to is a definitional  
18 section of the legislation that describes basically all of  
19 health information technology. So it describes the use of  
20 electronic health records, personal health records and  
21 other types of technology, so it was a definitional section  
22 of the General Statutes.

23 This got raised in the Public Health  
24 Committee after our last full Board meeting and just prior

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1 to our last Executive Committee meeting. And we discussed  
2 at the Executive Committee and decided that it was  
3 appropriate that we respond on behalf of the Board to sort  
4 of say that this was not what we had voted on in the Board.

5 But also to point out the fact that actually required  
6 HITE/CT to be the group that created the forum and a  
7 process by which authorization was utilized or developed  
8 and disseminated for this process. And because it applies  
9 to all health information technology, part of the response  
10 that we submitted was stating that really was outside the  
11 scope of what HITE/CT was authorized and created to  
12 perform. And that this really actually -- the way it was  
13 described and written also was very confusing because it  
14 didn't use consent language it used language of  
15 authorization, which is more in line with the type of  
16 language that's utilized for HIPAA, etc.

17 So both John and I submitted testimony  
18 stating that HITE/CT was in opposition to this -- or  
19 opposed to this Bill as written. And I wanted to open it  
20 up because there was others there and different opinions,  
21 so I just want to open it up for conversation.  
22 Conversation?

23 MR. LYNCH: Tom, a couple of things. In  
24 addition to the language you're talking about that

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1 referenced electronic health records, etc., it's important  
2 to note that the exceptions were kind of tied to emergency  
3 language that was in another section. And that was the  
4 only kind of availability from that perspective, which  
5 meant that it also impacted other State Agencies like  
6 Consumer Protection, etc., that really didn't fall under  
7 that emergency component.

8 My concern going forward would be we don't  
9 know what the status of when that will get voted on up or  
10 down or not. If it does get voted on, I suspect we would  
11 need to continue to pursue educating others in the  
12 Legislature. So I guess if we need to we should seek that  
13 approval now to continue to educate others.

14 DR. AGRESTA: Right, so there are a couple  
15 possible paths just so everyone is reminded of the  
16 legislative process. And this is something I've been  
17 learning, but there are a couple possible paths. One path  
18 is that it does not get voted on, it just stays as a Raised  
19 Bill but doesn't get passed forward.

20 Another possible path is that substitute  
21 language is submitted, okay. Substitute language can be  
22 anything from revising it substantially to modifying it in  
23 a small way. And the third possible -- and it could be  
24 substitute language could get submitted and voted on or

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1 substitute language which could either be up or down. Or  
2 substitute language could get submitted and not voted on  
3 from what I understand, so it would not proceed if it's not  
4 voted on. Or it could get voted on in an up or down vote  
5 in the Public Health Committee and then it would pass out.

6 If it passes out in any fashion it will pass  
7 out to the full Senate first since it's a Senate raised  
8 Bill and therefore, it would go to the Senate and then same  
9 things can happen in the Senate. You know, same whole  
10 process. And then it would go to the House if it was  
11 passed on to the House. So that's the process as I  
12 understand it and I think -- please correct me if I'm  
13 misrepresenting that process in any way.

14 MS. PARKS-WOLF: If it had a fiscal note on  
15 it, it would have to go to the Appropriations Committee as  
16 well.

17 DR. AGRESTA: Correct

18 DR. THORNQUIST: And if the President Pro  
19 Tem of the Senate or -- I mean, the problem is if it's felt  
20 that it would also impinge on any other Department or  
21 Committee it would go to another -- it could be referred to  
22 another Committee other than Appropriations. DSS perhaps  
23 because of the Medicaid connection, DCP, that's another  
24 possibility.

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1                   And that's just on -- those are joint  
2 Committees, it would still be housed in the Senate in those  
3 regards, but yeah.

4                   DR. AGRESTA: And my understanding is that  
5 the Public Health Committee will probably take action on it  
6 sometime this week, Friday.

7                   CHAIRPERSON MULLEN: Maybe Friday.

8                   DR. THORNQUIST: When is the deadline for  
9 them to report those out?

10                  MS. PARKS-WOLF: The 30th I think.

11                  DR. THORNQUIST: It's soon isn't it?

12                  MS. PARKS-WOLF: Two weeks.

13                  DR. AGRESTA: So -- I mean, we should  
14 continue to track and understand this. And one of the key  
15 issues is that we need to understand the impact not just to  
16 us but to others that may not be aware of the potential  
17 impact, both positive and negative. I think we just need  
18 to be studious of that.

19                  CHAIRPERSON MULLEN: So do people know -- a  
20 lot of people know a lot about how the process works. Do  
21 you know how to go into the website and see -- track the  
22 Bill, see the testimony that was submitted from last week?

23                  DR. THORNQUIST: Yeah, it's on ct.gov.

24                  CHAIRPERSON MULLEN: Right, Legislative and

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1 -- I mean, I could just put the Bill No. 368 in.

2 DR. THORNQUIST: Ahum. Yeah, the Bill is  
3 368. That's all you'd need and it would search for the  
4 Bill and then you get all your little active --

5 CHAIRPERSON MULLEN: Right, and there was a  
6 variety of testimony submitted last week. So if there's no  
7 comments, we'll move on. Okay, I think we're to agency  
8 business then. Thank you, and thank you for doing that. I  
9 wasn't at the Executive Committee meeting but was fully  
10 aligned with the decisions, and particularly given all the  
11 work that we invested last year and understanding what we  
12 decided.

13 I think it was wise to take the appropriate  
14 steps and I think you did a really good job, so thanks.  
15 Okay, you would be the CEO.

16 MR. GILBERTSON: Okay. Just from an update  
17 perspective, we continue to make progress on configuring  
18 and testing the HIE. The organizations that we're testing  
19 with, we're having to work with them on timing. Obviously  
20 this is not the only thing on their plate and there are a  
21 lot of other things that they're working on. So fitting  
22 their schedule with the Axway schedule and trying to get  
23 those tests through have been challenging, but we're  
24 working through it.

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1                   Now, during the process we're documenting  
2                   our lessons learned and I think we're finding out that a  
3                   lot of the systems that are supposedly 100 percent  
4                   compliant still need some work. And so we're having to go  
5                   back to some of the venders and make sure that some of  
6                   those changes get made. There remains one anticipated  
7                   issue that needs to be resolved with our -- one of the  
8                   components of software which was supposed to be in place  
9                   and now won't be delivered until June. However, we do  
10                  think that there's going to be a workaround for that piece  
11                  of software, and so we're waiting for the vender to come  
12                  back to us with what their proposals are and how they plan  
13                  to deliver the functionality as we described without that  
14                  software until that is available.

15                  So that is an ongoing issue. It's one more  
16                  -- you know, we really -- it's out of our hands at this  
17                  point. It's just not been delivered by the vender so it's  
18                  not available for us to use. We did -- you know, we felt  
19                  like -- I felt like there was a lot of things that had gone  
20                  on over the last year and a half and certainly during the  
21                  negotiations with the vender and the RFP process and the  
22                  Committees that we really needed to take a step back and  
23                  just take a look at where we're really at and what are we  
24                  really going to do to go forward. And I call that a

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1 program review. It was an all day meeting, good  
2 participation from a couple of the Board members that had  
3 been involved in a lot of the negotiation and setup of this  
4 contract. And also in sort of the visioning of what we  
5 were trying to do, what the intent was, and sort of where  
6 we're at today and how do we move this thing forward.

7           There's no doubt that this is a complex  
8 endeavor, this is not simple. There's not only technology  
9 involved there's politics -- yes, there are politics  
10 involved. Not just at the political level but certainly  
11 within the health care arena in the State of Connecticut  
12 and competing interests. So the landscape has shifted a  
13 little bit over time and so just trying to reset that and  
14 really look at where we really are, what's the landscape,  
15 what are we trying to achieve. We had a facilitator who is  
16 someone that has worked with companies that are trying --  
17 you know, as a business consultant and companies that are  
18 in, he calls them distressed situations, but that's not a  
19 bad thing. These are companies that have really had to  
20 turn some things around and to figure out how they're going  
21 to survive.

22           And I think that -- not that we're in that  
23 situation but I think it helped sort of rethink some of the  
24 things that we were doing with our partner in Axway. I

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1 think the biggest thing that we accomplished is I think we  
2 reaffirmed our partnership. We've laid all the cards on  
3 the table. They know where we're at financially. We know  
4 where they're at from an IT implementation perspective. I  
5 think we sort of leveled that out to start and said okay,  
6 now here we are. How do we go forward from here? What  
7 we're -- there's no doubt that we have financial challenges  
8 that are going to be really driven by how fast we can get  
9 adoption and people signed. And then a lot of that has to  
10 do with a lot of what you just heard in terms of who is our  
11 target audience, who are we going to focus on first, who do  
12 we need to get signed up.

13                   And more importantly that sticky issue of  
14 who should be paying and how does value relate to the fee  
15 structure and who's getting value and how much of that  
16 should they be paying towards an HIE and what's their  
17 incentive to do that. It's kind of related to sort of the  
18 value propositions you put together. I don't think we have  
19 agreement on that in the state and -- I know we don't. And  
20 everybody is -- that's going to be something that we -- I  
21 can't figure that out myself. That's something we have to  
22 figure out, who's going to pay for this thing and how are  
23 they going to pay it. And more importantly, we don't have  
24 a lot of time to figure it out.

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1                   So we did a baseline review. I think we  
2 came around with a couple of things that we definitely came  
3 out of that meeting with. One is, we needed a call to  
4 action. One of the biggest things we need is to make sure  
5 that we have ongoing involvement from Axway senior  
6 leadership. This is not being run as -- I think the  
7 technical implementation was not necessarily the focus  
8 point for the meeting but I think it became over time sort  
9 of, the status reports were on the technical  
10 implementation. But we realized that technology is not the  
11 driving force here.

12                   So getting that relationship with Axway  
13 because they have more than technologists, they have some  
14 people that can talk to us about how to make this thing  
15 work within the landscape and the environment. And so  
16 these are not technologists, these are people that  
17 understand health information from a policy program and  
18 procedural issues. So talking at that level with them and  
19 making sure that they're involved. The other thing is  
20 making sure we have a good decision-making process that we  
21 understand sort of what the decisions are and who'd making  
22 them. And so we're going to be documenting that and making  
23 sure that we manage this project to within scope so that we  
24 don't -- every time you talk to somebody else it's oh, if

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1 it can do one more thing.

2                   And Steve knows that. I mean, that's just a  
3 common thing with IT. You have to somehow manage that  
4 scope and manage that expectation. The other thing is that  
5 we do need to have some focus groups. We have to be very  
6 focused in our attempt to roll this out. And one of the  
7 key areas that we all agree, and whether they should be the  
8 funder or not, is not really the issue. The point I think  
9 we all agreed on was that if we don't have the hospitals,  
10 this won't work. I mean, the hospitals are the key to  
11 this. They have to be onboard. They have the networks.  
12 They have the physicians. I cannot possibly talk to every  
13 physician in this country -- or in the state, nor should I  
14 try.

15                   I mean, I think what we have to do is get  
16 them as our advocates. If they're on board, the Docs will  
17 get onboard, it will work. If they're not on board, it  
18 doesn't matter. So I think that that's one focus group, so  
19 I've met with CHA and several of the CIOs. I've been to  
20 see several of them one-on-one, but I've also met with them  
21 as a group. They did provide us -- you know, after they  
22 kept saying all the things that we were doing wrong I asked  
23 them to just give me a letter, tell me what it is you want  
24 from us and let us work from there. So they've done that.

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1 They've responded, we do have a letter from them, so we  
2 will respond back to them and tell them how we can help  
3 them, how we can meet those issues or needs of theirs.

4 The other focus group, I think we need to  
5 pick an area that we think we can use as a -- I won't say a  
6 demonstration but as proof that this thing will work in the  
7 community. And so there are pockets of areas where I've  
8 been around through the state that I think are ready to  
9 come together as a group. So not just the hospital, not  
10 just the provider groups, not just the labs, not just the  
11 insurance companies, but let's get all those people  
12 involved in that community together and say let's focus  
13 some effort here and figure this out for this community. I  
14 won't name those but I think there is some -- there are a  
15 couple of them that I think that I've identified and will  
16 certainly want to work with with different members of the  
17 Board to make sure that that's right, and then approach  
18 those groups before we necessarily volunteer them to be  
19 that.

20 But I think if we can get this connected  
21 community identified and get them up and get the Docs up  
22 and the insurance guys involved and the hospitals involved  
23 and everybody, long-term care, everybody that's part of  
24 that care team, I think that's a way forward for us. That

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1 also sort of helps us with this whole marketing thing  
2 because it's three million people, that's a lot of people  
3 to educate and we just may not have the budget to do that.  
4 So again, we need to really leverage the community  
5 infrastructure that's already in place to do that. They do  
6 patient education all the time, we don't. So I think  
7 that's going to be a key.

8 We need a sales plan and Axway took that on  
9 as being the lead of developing that. So the first draft  
10 of that will be out the end of this week. And I have taken  
11 the lead of an overall program plan. There's a lot of  
12 activities that have to happen from -- and you know, John  
13 was mentioning today that we've got to get a participation  
14 agreement through, which means we've got to get a draft to  
15 the Committee. But that's just one of maybe 100 things  
16 that have to get done in sequence. So I'm going to try and  
17 sequence those. And these are not -- this is not the  
18 technology implementation plan, this is a level above that  
19 that is sort of the program implementation plan.

20 But then we also need to have an onboarding  
21 process so when we approach organizations and say we want  
22 you to be part of the Exchange, they need to know what is  
23 it they need to do. So there's the technical piece of  
24 Connecticut to the Exchange, but then they also have to

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1 teach everybody about the consent process. They have to  
2 teach physicians that they know that there's information  
3 there. And if the physicians are the people that are going  
4 to educate the patients, then we got to educate the  
5 physicians so that they can educate the patients right? So  
6 there's a process that has to -- onboarding is more than  
7 just making that technical connection to your system. So  
8 that means we've got to get the Business Operations  
9 Committee going. A lot of these things just need to  
10 happen.

11                   The other thing that we identified is we  
12 definitely need to communicate to DPH and make sure we  
13 understand the Public Health timelines and what's going to  
14 be available. I think we're telling people they're going  
15 to be able to report certain things through the HIE, but I  
16 don't know that that's necessarily true or if it is true,  
17 when. But I think we need to make sure that back piece  
18 coordination is done. And the same with DSS and making  
19 sure that we understand what their plans are for Medicaid  
20 and making sure that not only in what are your plans, but  
21 also a letter that says here what we can provide for you.  
22 Here's some ideas for your consideration and how the HIE  
23 can help.

24                   Insurance companies, again, Dan's been

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1 helping me with that. I don't know how best to get into  
2 that market. I think that's going to be a challenge for us  
3 but it's one we have to hit head on because there is -- we  
4 are working close with Medicaid and there are  
5 opportunities. I met with CMS, I met with our Medicaid  
6 folks here. They're very anxious to be part of the  
7 solution. They have certain requirements that we have to  
8 meet as a state and we have to show that they're only  
9 paying for their fair share of the solution. That means  
10 other payers are also engaged and part of the solution so  
11 that's going to be -- we have to demonstrate that and --

12 CHAIRPERSON MULLEN: Write you a check?  
13 Sorry, I just want to know.

14 MR. GILBERTSON: Can they write -- can who  
15 write a check?

16 CHAIRPERSON MULLEN: Medicaid.

17 MR. GILBERTSON: Nobody's written any checks  
18 yet, I mean, so --

19 CHAIRPERSON MULLEN: Okay, let me -- I don't  
20 mean to let you digress, I just -- that's one of my little  
21 items, go on.

22 MR. GILBERTSON: So to write the check,  
23 again, they've got to put in a grant proposal and get the  
24 funding from the Federal Government and then they can write

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1 the check. One of the requirements of course is that we  
2 can show them that there's commitment from other payers to  
3 do their parts. Is that right Tom?

4 DR. AGRESTA: Yes, they have to give them  
5 something called -- and Mark knows this very well, a health  
6 -- they have to do an IAPD, an Implementation Advance  
7 Planning Document, which CMS has made very clear that  
8 they're very willing and want to support HIE efforts in the  
9 state. And they're now actually providing 90 percent match  
10 dollars for certain elements of it and 75 percent match  
11 dollars for others.

12 And now there's a process by which we can go  
13 through to seek those dollars, so we have to go through  
14 that process as a state. We have to do it and that's  
15 something that's on the docket and the plans for Medicaid  
16 to participate in.

17 MR. CARMODY: When are you -- when do you  
18 plan on doing that? Is there a timeframe, is there like a  
19 window that you have to just look --

20 MR. MARK HEUSCHKEL: Well, the first thing  
21 we have to do is, when we are ready is submit an IAPD  
22 update to fund our underlying -- or continue our operation  
23 of our EHR incentive program. So we're almost ready to do  
24 that. And then as a supplement of that or a second order

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1 activity is a separate IAPD to propose how we would fund  
2 the -- or help fund the HIE.

3 MR. CARMODY: And how long does that  
4 typically take, like once you write it to go after it again  
5 and when you would -- like if you had -- ideally like when  
6 would you want to do that?

7 CHAIRPERSON MULLEN: Hi, can you hear?

8 MALE VOICE: Oh, we got disconnected sorry.

9 CHAIRPERSON MULLEN: Okay.

10 MS. HORN: But people do need to speak up so  
11 the people on the phone can hear.

12 MR. HEUSCHKEL: Okay, I'll try to do that.  
13 So I'm sorry, what were you asking?

14 MR. CARMODY: Just generally like when would  
15 you -- ideally like when would you want to be able to  
16 submit that and say okay--

17 MR. HEUSCHKEL: The answer is as quickly as  
18 we can. I mean, we have to get -- we're almost finished  
19 with this stuff so we have to submit this stuff and then as  
20 quickly as -- you know, we're partnering with UConn Health  
21 Center to help us put this together and working with David  
22 and others in putting it together as quickly as we can. I  
23 think that's the answer.

24 It's -- I mean, the problem I have is I have

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1 to get the basic funding of the program extended out just  
2 to keep operating and then we have to continue after that.

3 So there's --

4 DR. AGRESTA: This is a bridge on top of  
5 that?

6 MR. HEUSCHKEL: Yeah.

7 DR. AGRESTA: So this is almost like a  
8 supplement to the EHR incentive program or is it the --

9 MR. HEUSCHKEL: Yeah, under our template  
10 it's literally a -- I guess it's like an appendix, but  
11 there's a huge potential for funding there and there's  
12 really a precedence set with Massachusetts and what they've  
13 done.

14 MR. CARMODY: So if you had a certain level  
15 of funding that was committed to by the other payers, what  
16 type of dollars would that release or what would that  
17 generate as far as their ability to match the 90?

18 I believe I said today that they could --  
19 you know, the industry was going to commit to using the HIE  
20 or pay a certain dollar amount, whatever the case may be.  
21 What would that then translate into as to oh, that means  
22 Medicaid, the Feds would free up a certain dollar amount?

23 MR. HEUSCHKEL: Well that's --

24 MR. CARMODY: It's kind of like what's being

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1 held up as far as like --

2 CHAIRPERSON MULLEN: And since I asked that  
3 burning question because it's the elephant that's been in  
4 the middle of the room for about a year now, not that you  
5 can answer it all yourself, I know I did that in the middle  
6 of the CEO report which only has 10 minutes left to it. So  
7 I don't know whether or not we should continue down that  
8 line now but it really is a big elephant in the room, which  
9 is why you also mention it every time.

10 MR. GILBERTSON: Yup, I mean funding is an  
11 issue.

12 CHAIRPERSON MULLEN: So -- but I don't know  
13 whether or not we should continue down that path instead of  
14 finishing your report. We definitely need to get those  
15 answers and I don't want to pin you to have to answer  
16 things that you don't have all the response for.

17 MR. HEUSCHKEL: Yeah, I don't have it all.

18 CHAIRPERSON MULLEN: But --

19 MR. HEUSCHKEL: That's part of what we have  
20 to figure out, is the bottom line.

21 CHAIRPERSON MULLEN: -- but you're hearing  
22 my urgency in his voice.

23 MR. HEUSCHKEL: Yes, absolutely.

24 CHAIRPERSON MULLEN: In Dan's voice.

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1 MR. HEUSCHKEL: And seeing e-mails and so  
2 forth, so yes.

3 CHAIRPERSON MULLEN: Are they coming to you?  
4 People are being sent to you after they come from --

5 MR. HEUSCHKEL: Yes -- well now they are,  
6 yes.

7 CHAIRPERSON MULLEN: Okay, so that's -- it  
8 sounds like progress.

9 MR. GILBERTSON: It is, it is.

10 CHAIRPERSON MULLEN: Okay.

11 MR. GILBERTSON: And I am meeting with the  
12 DSS folks fairly recently but also regularly. I did brief  
13 one of the major Committees that was talking about the  
14 Duals program and how that's going to work. And I'll be  
15 meeting tomorrow with them to talk about how we can support  
16 their ACOs and their ASOs that they're planning. So it's  
17 coming. Of course the timeline for that may not be  
18 necessarily the timeline that is going to help us with some  
19 of our immediate financial concerns.

20 So we're really going to have to look at  
21 that. That means -- like I said, we've got a real partner  
22 I think in Axway. I think we've asked them to look at  
23 options for how they can adjust our payment schedule and  
24 come back to us with what they can do. Again, this would

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1 be in the spirit of partnership understanding that we are  
2 not able to necessarily maintain the current payment  
3 schedule that we have contractually. So we're waiting back  
4 on -- to hear back on them, but it just highlights the fact  
5 that we really have to get somebody writing a check. So  
6 we've got a lot of people saying yes, right, but who's  
7 going to write the checks and how do we close the deal.  
8 And that's the sales plan and that's the -- ultimately this  
9 comes down to closing a deal where someone writes a check.

10 I've talked to a lot of the other HIEs, met  
11 with several of them last week, all the New England ones.  
12 They all have the same problem in terms of everybody says  
13 yes, yes, yes, until it comes time to write the check and  
14 then it's always this pregnant pause. So there's --  
15 closing the deal is going to be challenging for us and it's  
16 one we have to really drive home and that's where the value  
17 has to come in. The other thing that I think we've -- I've  
18 certainly gleaned from the other states is that we are  
19 really doing more with less than -- and I mean that  
20 literally. I mean, these states have multi-year plans that  
21 are really much better funded than what our plan is in  
22 terms of they can take their time.

23 So they're starting out with Direct and  
24 they're foreseeing how that goes. And they're starting out

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1 introducing something else and then maybe introduce  
2 Provider Directory then maybe introduce EMPI and then  
3 Clinical Document Exchange. I mean, these are sort of --  
4 they phase theirs very much in baby steps. I think because  
5 we have such a good vision and the fact that this all has  
6 to work together, but also we have to get to cash positive  
7 revenue in a very short period of time. I think our  
8 schedule is very aggressive in terms of rolling out as much  
9 functionality as anybody could ever want to meet -- not  
10 only meaningful phase one but also phase two in that short  
11 of a period of time.

12 So where they plan months and weeks and  
13 years to roll something out, we're planning weeks and  
14 months to roll something out. So we are very much on the  
15 forefront. I think that's a good thing, we just have to  
16 make it work and I think we can. I have met with several  
17 CIOs and gotten an earful and we are starting to set up our  
18 back office function. I met with Direct today and they  
19 were describing some of their accounting nightmares and  
20 their hundreds of providers that they have to track. We're  
21 going to have the same thing. I mean, if we have hundreds  
22 of providers that are part of the HIE we're going to have  
23 to have contracts with them, we're going to have the  
24 payments that we have to track, billing that we have to

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1 track. So a lot of back office things.

2 We have a lot of grant management that has  
3 to happen, a lot of reporting and HR, we are meeting with  
4 our HR specialist. We do have one now that is part of our  
5 Paychecks ASO model. And they'll provide our HR manuals,  
6 procedures training, onboarding, interviewing, all the  
7 things we have to do legally. There is a lot of work with  
8 the Special Populations on branding and patient education.  
9 Obviously they're going to need money because they're going  
10 to need to produce something, videos, brochures, so there's  
11 money issues there that we have to address. But they are  
12 working and it's a very good group.

13 I am conducting a search for a CTO. We went  
14 through and did the interview -- I did some initial  
15 screening of 26 candidates. There are between four to six  
16 that I think we want to bring to an interview. I will be  
17 looking for people to participate in that. It's critical  
18 that we have a full-time CTO onboard. We don't -- we just  
19 -- that's one of the holes that Axway pointed out that we  
20 need to fill. We just have to have a full-time contact for  
21 them to be working these issues on the ground here. Value  
22 statement, you heard about that, the updates. We also have  
23 interviewed 15 students from the HIT program at Capital  
24 Community College.

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1                   One of the things that we want to do is for  
2 each Committee, see if there is a student volunteer that  
3 can help the Chair with scheduling and agenda and minutes  
4 and that type of thing because I just cannot take minutes  
5 for six Committees and make sure that they're all up to  
6 date, so hopefully these students will work out. We've  
7 given you a couple resumes, look at them, interview them if  
8 you want. If you don't want a student to help, fine. I  
9 will also be looking at a couple students to help me now  
10 that we have offices to put them in. We just have to work  
11 through the legal folks to make sure that we have correct  
12 agreements and that we're not opening up any labor laws or  
13 issues with liability for HITE/CT. So these will be  
14 official volunteers done correctly.

15                   I am looking at insurance. You know, one of  
16 the things for the volunteers you brought up is do we have  
17 general liability for HITE/CT? The answer is no, we don't  
18 but I'm looking into it. I did create an escrow account  
19 for retirement. I used the 42.41 percent, which Bruce  
20 reported as what SERS would cost if we had to go into it.  
21 So that's in a separate account but it's visible in the  
22 report. And we do have offices here on the 6th floor  
23 thanks to Steve and for DPH for making that happen. Now  
24 again, I think from my perspective we are really at a

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1 critical point and I think it's time that -- if we don't  
2 move quickly I don't think that -- I don't know how long  
3 our partner will be able to stay with us. So we need to  
4 make this happen.

5 DR. AGRESTA: And as an update, they are  
6 taking a very active role in trying to help develop a  
7 marketing and outreach program.

8 MR. GILBERTSON: Right.

9 DR. AGRESTA: In fact they're going to run a  
10 national Webinar and they pay for it and demonstrate and be  
11 available for everybody in the next few weeks, sometime in  
12 mid-April they're going to do that. We'll actually be able  
13 to see the technology run end to end and actually be then  
14 able to download it. It will be available on the web and  
15 much, much easier for us to actually show to folks  
16 precisely what it is we're trying to accomplish and it will  
17 be use case-based.

18 So it will say if you want to try to  
19 accomplish this function that has value to you as a  
20 provider, here's how it would happen, here's what it looks  
21 like, here's what it feels like, etc.

22 MR. GILBERTSON: Yeah, they are helping with  
23 that and I have done a few interviews. I've presented at  
24 four or five conferences throughout the state so we're

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1 getting the word out. But again, it's like a needle prick.

2 It's a big state, a lot of people, a lot of things  
3 happening. We really need that network to get the word out  
4 and we have to find our network. We have to find our sweet  
5 spot. And I think they're out there, we just need to plug  
6 into them and get the word out.

7 DR. THORNQUIST: Well, I think having  
8 something physical to show people and demonstrate, it's  
9 going to be a big piece of that.

10 MR. GILBERTSON: Right.

11 DR. THORNQUIST: Because right now to go to  
12 for instance a Connecticut State Medical Society meeting,  
13 which by the way is not until September so you've got  
14 plenty of time, but if you just went up there and waived  
15 your hands and said well, we're going to have this you all  
16 should join it's going to be great, you're not going to get  
17 much response.

18 MR. GILBERTSON: Right.

19 DR. THORNQUIST: If you can show them this  
20 is what the portal will probably look like and some things  
21 you can do, you're going to get a much better response.

22 MR. GILBERTSON: Absolutely, absolutely.

23 DR. THORNQUIST: And I'm sure it's true for  
24 every group around this table. I mean, the hospitals

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1 aren't going to sign on unless they can see something  
2 tangible.

3 MR. GILBERTSON: Right.

4 DR. THORNQUIST: It's a cart before the  
5 horse issue.

6 MS. PARKS-WOLF: Did you talk about the  
7 status of the pilot, I was sort of wondering about that.

8 MR. GILBERTSON: Status of?

9 MS. PARKS-WOLF: We were trying to work on  
10 some pilots. There was a call for groups to do a --

11 MR. GILBERTSON: Pilots, yes. Yes, I can.  
12 We still have the 21, we have to get -- again, go back to  
13 them and meet with each of them and make sure that we  
14 understand what they're anticipation is, what they're  
15 expectation is, and then make sure that they're ready to be  
16 part of it.

17 I don't think we can do all of them at once.

18 I think we're going to have to phase that out. That's  
19 part of the sales plan that has to be developed, who are we  
20 going to -- what are we going to try to achieve first. And  
21 then the other thing we need is again, the participation  
22 agreement with an approved fee schedule that we can sit  
23 down sit down and say okay, here's your responsibility  
24 because we -- they've got to know what they've got to pay

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1 to be part of it.

2 And so that's work that we have to finish up  
3 and finalize. And it may not be -- everything may not be  
4 perfect. This is a startup rate. We have to go with what  
5 we have and then modify it and make it better over time as  
6 we get feedback. So I think the 21, I think they're still  
7 -- we owe them a follow-up. I just needed to get to a  
8 point where I felt we had enough information to follow up  
9 with them. But I think this week we do need to get back to  
10 all of them and let them know where we're at in the  
11 process. I think that is fair.

12 MS. PARKS-WOLF: Earlier you were talking  
13 about it in April. So what's in your mind now?

14 MR. GILBERTSON: We're still trying to make  
15 sure that the initial technology is ready by April and  
16 hopefully roll -- we have three organizations that have  
17 been working very closely with us to get their testing done  
18 and make sure that the information is flowing. Actually  
19 there's four, and we're hoping that they be -- they're also  
20 organizations that signed up to be part of the 21.

21 So the goal is to get them to sign a  
22 participation agreement and come onboard as early as April,  
23 early May. And that would be -- that's my goal and I think  
24 -- I won't speak for those organizations. We have to

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1 convince them that that's what they want to do too. So we  
2 need to sit down and -- the first step is to make sure all  
3 the technology works and this month is the goal to have all  
4 that done and make sure all the communications are working.

5 And it's not even just the organizations.  
6 It's their vendors, making sure that -- their vendors may  
7 tell them they can do something and then when you actually  
8 try to do it it doesn't quite work right. So there has to  
9 be some back and forth between their vendor and our vendor  
10 and that takes time because they're not necessarily being  
11 compensated for this. They're doing this to support maybe  
12 their customer, but it's not something -- we're not on  
13 contract with these vendors to necessarily do this. So  
14 they're doing it as a support for their customer, so  
15 Greenway or Allscripts. All these companies, they're  
16 working with us but we're not paying them to do it, so.

17 MS. PARKS-WOLF: Okay, thanks.

18 MR. CARMODY: So between now and the next  
19 Board meeting it sounds like there's going to be a variety  
20 of different conversations that you alluded to so would it  
21 make sense that between now and then, because we don't have  
22 a fee schedule to approve tonight, that we maybe bring that  
23 back to one of our working sessions at the Executive  
24 Committee. Get the commitment that this seems like it

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1       could be the right fee schedule and then in order to keep  
2       this at pace otherwise we're going to lose ground over the  
3       next month.

4                   MR. GILBERTSON:  Yeah, I think the fee  
5       schedule definitely because we need to have that.  We need  
6       to be able to sit down with somebody and show them what the  
7       costs are going to be.  The participation agreement I think  
8       is also something that -- I think if we get it done and  
9       ready for the next Board meeting It will still be okay for  
10      us.

11                   At least we'll be able to show the draft  
12      participation agreement with the fee schedule too to the  
13      early organizations that we want to bring onboard.  If we  
14      can get it approved at the next Board meeting and get it  
15      signed shortly thereafter by the participants, I think  
16      we'll be okay.  So yes, I would like to be able to bring  
17      these to the Executive Committee.

18                   MR. CARMODY:  I make a motion that we --  
19      that the fee schedule and the participation agreement be  
20      reviewed at one of the upcoming Executive Committee  
21      meetings for ratification or approval and then bring it  
22      back to the full Board for final approval.

23                   DR. THORNQUIST:  Second.

24                   CHAIRPERSON MULLEN:  Any discussion?  Okay,

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1 vote?

2 MS. ELLEN ANDREWS: Yeah, just I want to be  
3 sure I'm understanding that the fee schedule that you're  
4 going to charge physicians is going to the Executive  
5 Committee for approval?

6 DR. AGRESTA: Then coming back to the full  
7 Board.

8 MR. CARMODY: And then coming back to the  
9 full board just to try to keep pace so that if he has a  
10 schedule -- he doesn't have it here tonight for us to  
11 review, sort of say what does that mean because he's going  
12 to be talking with the CIOs specifically in the hospitals  
13 anyway to say guess what, this is what we're thinking,  
14 having some of the participation agreements.

15 MS. ANDREWS: Okay, thank you.

16 CHAIRPERSON MULLEN: Any other questions,  
17 discussion?

18 MR. LYNCH: Just to kind of compliment that,  
19 so the aim would be that we have a Legal and Policy meeting  
20 first week of April to go with the participation agreement,  
21 so you need to get it to us so that we can then have it to  
22 the Executive Committee on the 9th and the full Board on  
23 the 16th?

24 DR. THORNQUIST: Now this is the fee

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1 schedule for all the participants not just the physicians,  
2 right?

3 CHAIRPERSON MULLEN: Ahum, right, and the  
4 starting point from that would be -- what weeks do you need  
5 that for?

6 MR. GILBERTSON: Yeah --

7 DR. RONALD BUCKMAN: Because we're very  
8 early in what we're doing here, are you contemplating a  
9 phased fee schedule?

10 MR. GILBERTSON: I'm sorry, I couldn't --

11 DR. BUCKMAN: Are you contemplating a phased  
12 fee schedule?

13 MR. GILBERTSON: Right now we have agreed  
14 with the Pilot, the 21 sites. The initial call for  
15 participation had said that there would be some discounts  
16 to those organizations that come on board early in exchange  
17 for in-kind really support, which means they're going to  
18 participate in some of our key Committees, our Technical  
19 Committee, our Business and Operations Committee, our Legal  
20 Committee. And so they're going to have people that are  
21 going to give us in-kind support as a HITE/CT to sort of  
22 work out all the bugs.

23 So yes, some of the early sites that come in  
24 will have a reduced fee schedule, but they'll also have an

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1 obligation or responsibility to participate in flushing a  
2 lot of these things as part of our Committees. And so it's  
3 not pre, it's not -- certainly there's a return on that for  
4 us.

5 DR. BUCKMAN: That applies to those 21, but  
6 I'm asking in general. Are you planning a phased fee  
7 schedule? So for instance the first six months it's such  
8 and such, the next six months it's such and such. After a  
9 year it goes to full pricing.

10 MR. GILBERTSON: That's not right now.

11 DR. BUCKMAN: I would just suggest it might  
12 be more palatable if you phase in the full pricing as  
13 opposed to ask people who are signing up on day one because  
14 they're just going to say well no, I'll wait a few months  
15 and see how it goes.

16 MR. GILBERTSON: Right. No, you're  
17 absolutely right. And so I think that's -- if we had  
18 enough upfront capital to do that I think that would be the  
19 best way to go. But we've really got to get to a point  
20 where we have enough money coming in to pay the bills, so  
21 we may not have enough upfront capital to get us to that.

22 CHAIRPERSON MULLEN: We have a motion and a  
23 second on the table. The discussion I think might inform  
24 the conversations that go on in the Executive Committee and

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1 then your follow up Policy Committee, so -- but I'm not  
2 even certain that it otherwise modifies it anyway, the  
3 motion that's been seconded. And we know that the work is  
4 then going to come back to the full Board next month. I  
5 think that will be taken into consideration.

6 MR. GILBERTSON: Yeah, definitely. I mean,  
7 it's --

8 DR. THORNQUIST: And so then you would like  
9 to proceed to a vote with the proviso that we could submit  
10 our recommendations to David as to how to best structure  
11 that fee schedule or perhaps that --

12 CHAIRPERSON MULLEN: Well, I think people  
13 should continue to give the feedback but I don't think we  
14 need to do it in the midst of just saying this work will  
15 continue in between so they can keep it moving forward for  
16 sure --

17 DR. THORNQUIST: No, no, I understand that  
18 but I also don't want to have 25 minutes of discussion  
19 about how we all think he should do it.

20 CHAIRPERSON MULLEN: Right.

21 DR. THORNQUIST: I think it would be better  
22 if we just e-mailed it to him.

23 CHAIRPERSON MULLEN: Thank you. And e-mail  
24 it to him and not the whole group so we're not having a

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1 meeting.

2 DR. THORNQUIST: Yes.

3 MS. HORN: I'm so glad somebody else had  
4 said that.

5 CHAIRPERSON MULLEN: Okay, any other  
6 discussion? Okay, so a vote. Okay, you need to hear the  
7 motion again? You're all set, okay.

8 MS. HORN: All in favor.

9 VOICES: Aye.

10 MS. HORN: Opposed? Any abstentions?  
11 Motion passes. Thank you.

12 CHAIRPERSON MULLEN: Thanks. Okay, we never  
13 got to the Committee reports last month so Committee  
14 reports.

15 DR. AGRESTA: The Executive Committee met,  
16 there was some discussion going around a little bit about  
17 the legislation, which I've already shared. There was  
18 discussion around some of the information that David had  
19 already shared with us today in terms of the process and  
20 what he wanted to try to do for a program review.

21 And we spent some time kind of contemplating  
22 how to best prepare for that program review and what kind  
23 of information would be best kind of shared at that session  
24 and a little bit of time talking through some of the

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1 financial issues and just describing some of the processes  
2 that were going on with regards to trying to solve some of  
3 that including the collaborations that were beginning to  
4 take place. I don't know if there's anything else that we  
5 covered Marianne.

6 MS. HORN: No.

7 CHAIRPERSON MULLEN: Okay.

8 MS. HORN: Business and Operations.

9 DR. AGRESTA: We don't have Kevin again with  
10 us this evening. This is, I think, one of those issues  
11 where we need to kind of make some decisions at the  
12 Executive Committee level as to how we're going to proceed  
13 with our Business and Operations non-Committee because  
14 there currently isn't one that exists because it hasn't  
15 been fully formed.

16 So I think one of the issues that we  
17 discussed Friday really related to how do we functionally  
18 work through some of these issues that are important to  
19 work through and gather data about in a very short  
20 timeframe. And David mentioned the idea of going out and  
21 doing focus groups to do some initial data gathering. And  
22 so that was one of the action items and I believe that we  
23 came up with several types of focus groups that we're going  
24 to kind of incur, one being Ron with the physicians to try

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1 to understand what their particular needs are, etc.

2 Another being with the hospitals, and what  
3 were the other focus groups?

4 MR. GILBERTSON: One around a community,  
5 connected community and bringing in all the players  
6 involved. And those were really the only ones we talked  
7 about.

8 DR. AGRESTA: Right, so those are the ones  
9 that we realized were important to kind of think through  
10 and operationalize, these cases, and how to get them to  
11 that next stage. And then the other thing that I think we  
12 need to come back to at the Executive Committee level and  
13 need discussions on is how to get a Business and Operations  
14 Committee up functionally, with the right structure that  
15 is, so.

16 CHAIRPERSON MULLEN: Okay, Finance.

17 MR. CARMODY: There's actually been quite a  
18 few things happening on the Finance Committee. So today  
19 I'm going to bring -- I'm bringing forward and included in  
20 your packages, seven finance policies. We've been working  
21 on those. ONC gave us a structure, we put HITE/CT spin on  
22 it, we've modified it. It's gone through a couple of  
23 conversations at the Finance Committee level and now we're  
24 bringing them -- presenting to you them for approval.

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1                   So I'm making a motion that we adopt the  
2 financial policies as presented for adoption by the full  
3 Board.

4                   DR. THORNQUIST: Want to just do it as an  
5 aggregate?

6                   MR. CARMODY: Yeah, that's what I just did.

7                   DR. THORNQUIST: Second.

8                   CHAIRPERSON MULLEN: Any discussion,  
9 questions?

10                  MR. CARMODY: Just again, a lot of these  
11 were ones that we worked with -- you know, we worked with  
12 David. You talk about what the finance policy does, again,  
13 these are folks that are not day in and day out as to going  
14 through and understand HITE/CT. So they're a lot more  
15 engaged on the policy conversations than they are  
16 understanding sort of how the operations work because a lot  
17 of the folks that are on there are financial in background  
18 and understand these policies because they have them in  
19 their own place of work or establishment.

20                  So they actually were fairly engaged in the  
21 conversation, which is not always what has happened in the  
22 past. So I was actually very pleasantly surprised where  
23 they shared a lot of thoughts around how these policies  
24 come together, so. We also did align them with the

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1 operating policy. Remember we adopted operating policies  
2 prior to our really having the financial policies set? So  
3 we looked to try to make sure that these policies were  
4 something not -- either we could grow into because we may  
5 not be doing some of the same stuff today, but at least if  
6 we grow into them we have a firm issue.

7 MR. DEMIAN FONTANELLA: I just had one  
8 suggestion on one of the policies, which was the cash  
9 management procedures on No. 9. It ends with deposit slips  
10 will immediately be returned to the bookkeeper for filing.

11 I would suggest that it be for reconciliation and filing  
12 so that the bookkeeper actually matches what was deposited  
13 to what was supposed to be deposited.

14 MR. CARMODY: I think we admit that, I don't  
15 think there's going to be a problem with that. Which one  
16 was it, do you remember the number?

17 DR. BUCKMAN: No. 9.

18 MR. FONTANELLA: It's the cash management  
19 procedures --

20 DR. BUCKMAN: It's the very last sentence.

21 MR. FONTANELLA: -- No. 9.

22 MR. CARMODY: For filing oh, and  
23 reconciliation.

24 MR. FONTANELLA: Yeah.

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1 DR. AGRESTA: So are you suggesting an  
2 amendment to that?

3 DR. BUCKMAN: I don't know, do we have to  
4 amend it?

5 MR. BRUCE CHUDWICK: Yeah, it would be  
6 appropriate to make a formal motion to amend that policy,  
7 second it, approve the amendment --

8 DR. BUCKMAN: I move we amend that policy as  
9 stated.

10 MR. CARMODY: So amending 204 as described.

11 MR. CHUDWICK: So you vote on the amendment,  
12 all those in favor of the amendment please signify by  
13 saying Aye.

14 VOICES: Aye.

15 MR. CHUDWICK: Opposed say no. Then motion  
16 carries, now you're back to the main motion as amended.  
17 Any discussion? All those in favor of the policies as  
18 presented and amended please signify by saying Aye.

19 VOICES: Aye.

20 MR. CHUDWICK: Those opposed say no.  
21 Motions carry.

22 CHAIRPERSON MULLEN: Thank you.

23 MR. CARMODY: Well, there was a whole --  
24 there was probably like 17 or 18 of these. We decided to

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1 chunk them up so every -- you'll get swats of them as we  
2 get to them. So again, we'll also be working to go through  
3 the financial budget of 2013. David gave me a copy so I'm  
4 going to try and get the Finance Committee to move it  
5 forward too, so we can have that as a conversation.

6 CHAIRPERSON MULLEN: Is there anything I can  
7 do to help? Going back to the conversation around the  
8 90/10 and Medicaid is there anything I can do to help just  
9 keep the -- I know the work is ongoing, but to help pave  
10 the way for some the other communications you might want to  
11 have?

12 MR. CARMODY: Okay, the answer would be so  
13 understanding what type of money is sort of there for us,  
14 what they were talking about so that there's a general  
15 dollar amount that says look, the 90 percent represents --  
16 like if you go through this it frees up this amount of  
17 money. And then understanding what this amount of money  
18 would actually mean would probably be important.

19 So I'll just touch upon some of the comments  
20 that David alluded to. So I do think that as we go through  
21 this when we talk about in our response to CHA as to what  
22 types of services they want to see, I think that that's  
23 really important. So as we communicate back to them and  
24 respond to that letter there is still, I think, a dialogue

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1 that is going to take place between the health plans, the  
2 CHA, and maybe at some point maybe with the administration  
3 at some level around when we talk about what our structure  
4 is. I mean, it's either going to be value-based or fee-  
5 based.

6 The issue with the value-based conversation  
7 is, is that the value-based conversation as presented to  
8 the Gartner report which I think I presented a little while  
9 ago, was all based upon medical cost savings. So it  
10 created a percentage-based allocation with payers paying 60  
11 percent of the cost of the HIE. And as we've described in  
12 certain dialogues that continue to evolve, that would  
13 require the medical community and physicians to sign up for  
14 \$50 million worth of savings. So if the expectation is, is  
15 that the payers are going to pick up 60 percent of the HIE,  
16 that's going to equate to the cost that we're expecting to  
17 pull out of the system you need to be signed up for in some  
18 way shape or form.

19 And at that point in time, you know, I don't  
20 think we've had alignment in that folks would sign up for  
21 that type of cost savings because that means that the  
22 ability to generate those cost savings are completely in  
23 somebody else's hands which they need to actually say yes,  
24 we would agree, which brings us back to some type of

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1 service-based system, which I think is the right way to  
2 approach this for now. And as the conversation evolves to  
3 evaluate base conversation, I think it's going to take a  
4 little bit more discussion and dialogue between the  
5 parties. So, that's where that is right now.

6 DR. AGRESTA: I think the question you  
7 raised, is there something you can do to help that process,  
8 I think that we're going to probably get to answering that  
9 by saying we're going to have to pull together all the  
10 stakeholders that have the capacity to get engaged in the  
11 Medicaid IAPD around the HIE. And each one of them is  
12 going to, you know, have some potential benefit, potential  
13 need to kind of collaborate. In that regard I think  
14 there's going to be more opportunity for DPH to collaborate  
15 with what's going on at Medicaid.

16 CHAIRPERSON MULLEN: Yeah, but that wasn't  
17 my question.

18 DR. AGRESTA: Okay.

19 CHAIRPERSON MULLEN: My question was --

20 DR. AGRESTA: Your question is different  
21 than that, okay.

22 CHAIRPERSON MULLEN: -- yeah, it was just  
23 really the nuts and bolts of -- and that sort of truncated  
24 the discussion a little earlier. And if for no other

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1 reason then I'm a little bit curious about the timeline in  
2 which we can at least address this piece of State  
3 government participation through DSS. If there's a way  
4 that I can help ensure that the conversations go on in the  
5 way that help you get the answers that we need  
6 understanding that there's just work that has to be done,  
7 then let me know.

8 MR. CARMODY: So yeah, if we can answer  
9 those questions and I'll put them in writing and I'll just  
10 go back to them on it and say this what we're trying to do  
11 -- I mean, it will help the dialogue as we have people to  
12 say that other people are ponying up knowing, understanding  
13 what type of money is on the table, the general timeline  
14 that we're working under. Sometimes that creates an  
15 impetus but for others who have to make a stated position.

16 DR. AGRESTA: Yeah, that would just kind of  
17 -- what made me think when you asked that question was is -  
18 - are we having this value-based or fee-based discussion at  
19 the right level. In other words, I feel like we're not  
20 really looking at it from a strategic perspective at the  
21 statewide, not the State government but the statewide, with  
22 the people that really own those cards and can make those  
23 decisions.

24 So I feel like we're sort of trying to push

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1 this discussion from the bottom up and me trying to  
2 convince -- and Dan and whoever, that our fee schedule  
3 makes sense instead of looking at it from -- strategically  
4 with the real decision-makers on the ground and saying how  
5 do we as a state really want to fund this thing.

6 CHAIRPERSON MULLEN: Right, and I don't at  
7 all disagree with you but you just took us back to a  
8 conversation we come back to every month because it's  
9 important. And in the meantime I -- you know, in hearing  
10 the discussion today about Medicaid participation, I  
11 learned some new things because I think many of us were  
12 under the impression that this notion of the 90/10 wasn't  
13 going to take as much back work as still required.

14 And that might just be that I was unclear on  
15 that, but I was working with some assumptions that there  
16 wasn't a lot of other work that had to be done for us to be  
17 able to prognosticate. We've been instead having a  
18 conversation of a level of when will we learn about the  
19 Medicaid participation with I think some people just  
20 thinking that it was the -- identifying the DSS  
21 contribution, that 10 percent, which would help us leverage  
22 the rest without understanding the rest of the pre-work  
23 that was required for that to happen.

24 And, you know, perhaps I just missed that

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1 before a few times, but it's a lot clearer now. You know,  
2 because even in our conversations around the timeline and  
3 accelerating the payment from the grant and thinking about  
4 where we would be for September, I think some of us were  
5 hoping that by then some of the State contribution that  
6 might come forward would actually come from DSS. And now -  
7 - so part of what I'm trying to once again respond to is  
8 your question about where -- what can we expect and when  
9 and what quantity. Am I with you?

10 MR. CARMODY: No, that's -- whatever may  
11 help grease the skids around the parts of a conversation.

12 CHAIRPERSON MULLEN: Okay. Alright, great.  
13 Anything else from the Finance Committee? Okay. Legal and  
14 Policy.

15 MR. LYNCH: Legal and Policy has not met. We  
16 were planning to meet this coming Wednesday but that has to  
17 be cancelled as well. We need to have a participation  
18 agreement ready and ready to go out in advance so the  
19 Committee can see that -- you know, be able to read before  
20 we leap.

21 CHAIRPERSON MULLEN: Right.

22 MR. LYNCH: So at this point were talking  
23 today prior to the meeting start that aiming and hoping for  
24 Wednesday, April 4th, as the next meeting but we need to

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1 get that participation agreement out well in advance of  
2 that.

3 CHAIRPERSON MULLEN: Right.

4 MR. LYNCH: And I'm told by Dave that  
5 there's supposed to be a meeting tomorrow. I think they  
6 have to over some of that with the lawyer, whatever, so  
7 hopefully we can get that out in advance and give proper  
8 notice with that out so that people have a chance to read  
9 it and have our next meeting on April 4th.

10 CHAIRPERSON MULLEN: Thanks. Any questions?

11 I know that Brenda is in Cleveland this week. Is there  
12 anyone else that has any report with regards to Special  
13 Populations? Mark, are you still with us?

14 MR. GILBERTSON: I did attend their meeting  
15 so they did have a meeting and they went through the  
16 website and they went through a lot of the things that we  
17 talked about in terms of how are we going to get the word  
18 out. There's a marketing message that needs to be crafted  
19 for each of the different constituents or stakeholders and  
20 that group is working on that.

21 And so I do know that that was covered in  
22 the meeting and there's work that's going on towards that  
23 end.

24 CHAIRPERSON MULLEN: Alright, thank you.

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1 Did you get any feedback on the different logos?

2 MR. GILBERTSON: Not much, no. I think  
3 they've asked a couple of times and we haven't gotten much  
4 feedback. So I'm going to have to just pick one and go  
5 with it because it's holding up our website.

6 CHAIRPERSON MULLEN: I'll let you know which  
7 one, they're nice.

8 MR. GILBERTSON: Okay. Okay, Technical.

9 MR. COURTWAY: (Via telephone) Okay, the  
10 Technical Committee has not met since the last Board  
11 meeting. We are waiting for some of the ongoing materials  
12 to be wrapped up and we expect to wrap those up by before  
13 the end of this week and getting them out to the Technical  
14 Committee. The Technically Committee is actually one of  
15 the Committees that's been blessed with a lot of new  
16 participants, those that signed up for the participation  
17 agreement for the test with (indiscernible) that they have  
18 provided in-kind resources to the Technical Committee to  
19 help us with that.

20 So they'll be looking at two things. One is  
21 for them and their individual institutions to part of the  
22 testing of the outgoing materials clear and complete, are  
23 there (indiscernible) in the materials that are different  
24 between the different EHR vendors that are involved. And

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1 also (indiscernible) at the top level to say are these the  
2 materials that are completed after those who aren't in the  
3 know. Certainly the people who are participating in the  
4 Technical Committee have a technical background. They're  
5 the most engaged, you know, stakeholders that we have but  
6 is there something that's in the material that we should be  
7 brightening up or changing to get the most technically  
8 competent or technically advanced people on so they would  
9 understand how they would onboard and what the  
10 responsibilities are.

11 And using that packet we'll also put out our  
12 tables for the invitations. Of course we're testing as we  
13 go on, so that's the basic Committee report. In the  
14 meantime Axway is working with each of the EHR vendors that  
15 are involved that keep (indiscernible) so that all these  
16 nuances of what's in the standard versus how they can get  
17 the EHR vendor implemented can be sorted out and we are  
18 keeping track of all those individual items so that we can  
19 use that if we need to get the frequently asked questions  
20 in the future or whatnot. But meanwhile, the main work is  
21 getting the files up and going as well as onboarding  
22 material.

23 CHAIRPERSON MULLEN: Thanks Peter. Does  
24 anyone have questions for him? Okay. Public Comment.

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1 MR. COURTWAY: Any questions that I didn't  
2 hear?

3 CHAIRPERSON MULLEN: No, thanks.

4 MR. COURTWAY: I'm sorry, were there any  
5 questions?

6 CHAIRPERSON MULLEN: There were not.

7 MR. COURTWAY: Okay fine, thank you.

8 CHAIRPERSON MULLEN: Thank you. Alright, so  
9 we do have someone new joining us from DSS Medicaid. Do  
10 you want to just introduce yourself?

11 MS. UMA GANESON: Oh okay, sure. My name is  
12 --

13 COURT REPORTER: If you can come up to the  
14 microphone.

15 MS. GANESON: -- Uma Ganeson. Actually I'm  
16 --

17 MS. HORN: You'll have to come up to a  
18 microphone so you'll get recorded. Thank you.

19 MS. GANESON: My name is Uma Ganeson and I'm  
20 actually the Associate Director at DSS. And Mark and I --  
21 he has been catching me up to speed and actually medical  
22 operations is part of my responsibility. And one thing I  
23 can say is I will work very diligently with Mark and to  
24 make sure that we get this IAPD pushed forward and try and

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1 kind of understanding a little bit of exactly what the  
2 requirements are, how you kind of want the 10 percent  
3 aspect of it. So I'll work with him and I'll try to  
4 expedite this process.

5 And I know tomorrow we're meeting with David  
6 also on try to start rolling out the tools as part of the  
7 HIE process, so. And again, my background is I'm a finance  
8 person and I used to work for the Aetna as part of the  
9 Medicaid Health Plan.

10 CHAIRPERSON MULLEN: And we're really glad  
11 to meet you and see you.

12 MS. GANESON: Thank you.

13 CHAIRPERSON MULLEN: Probably not as glad as  
14 Mark.

15 MR. HEUSCHKEL: You don't know how glad.

16 MS. GANESON: Well thank you.

17 MR. GILBERTSON: Both Marks.

18 CHAIRPERSON MULLEN: Any other comments?

19 Okay.

20 DR. AGRESTA: Can we adjourn?

21 CHAIRPERSON MULLEN: It's too early to  
22 adjourn.

23 DR. THORNQUIST: Second.

24 MS. HORN: We have a motion to adjourn.

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1 DR. THORNQUIST: Second.  
2 MS. HORN: Seconded, all in favor?  
3 VOICES: Aye.  
4 CHAIRPERSON MULLEN: Thank you everyone.  
5 MS. HORN: We're adjourned.  
6 (Whereupon, the meeting was adjourned at  
7 6:30 p.m.)