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

CHAIRPERSON COMMISSIONER DR. JEWEL MULLEN:

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

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

And with that, I would ask for a review
and approval of the minutes from the December 19th meeting.

MR. STEVE CASEY: So moved.

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

DR. THOMAS AGRESTA: I’ll second it.

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

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

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

DR. AGRESTA: That’s probably the goal, that’s probably what I would suggest.

MR. DAVID GILBERTSON: The brochure.
DR. AGRESTA: It says website.

MR. GILBERTSON: Yes, it was the brochure.

DR. AGRESTA: It was the brochure, okay.

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

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

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

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

MS. KELLEY: And at the special pops meeting it was also discussed that, you know, we’re doing a lot of things in house but that we wanted to be very
careful that we got a professional translation because it
does matter, you know, in terms of the various dialects
of Spanish that we get this professionally done.

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

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

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

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

CHAIRPERSON MULLEN: Thank you.

MS. HOOPER: And who was second? I’m
sorry.

MR. CASEY: Second.

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

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

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

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

MS. HOOPER: Correct.

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

ALL VOICES: Aye.

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

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

MS. HOOPER: For the over 100,000?

MR. CHUDWICK: No, between 50 and 100, between 50 and 100 contract requires the CEO and either
the Board Chair or the Board Vice Chair. So that “and” should be an “or”. Is there a motion to approve that amendment?

DR. AGRESTA: So moved.

MR. CASEY: Second.

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

ALL VOICES: Aye.

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

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

MS. KELLEY: So moved.

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

CHAIRPERSON MULLEN: So all in favor?

ALL VOICES: Aye.

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

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

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

MR. CASEY: So moved.

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

MS. PAKULIS: Second.

MS. HOOPER: Thank you very much. Ms. Pakulis. Any questions or discussion? Those in favor?

ALL VOICES: Aye.

MS. HOOPER: Any opposed or abstaining?

Thank you very much.

CHAIRPERSON MULLEN: Treasurer’s report.

DR. AGRESTA: The next item on the agenda is the treasurer’s report and so for the period from July 2011 to January of 2012 I have a sort of different report that now is coming officially from our CEO. It’s a sort of full profit and loss statement that kind of goes through all of what has occurred during that timeframe.
And I gather now all of our reports, etcetera, are
generatable from Quicken, so from Quick Books, and we
have a number of different kinds of reports. So this is
structured in a slightly different fashion than our prior
treasurer’s reports. And we’ll -- we’re going to want to
kind of experiment with what’s the most effective means
of communicating this with folks. So I’m going to tell
you what we have and then I’ll work with Dave over the
course of the next month to try and come up with the most
effective thing.

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

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

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

So, that is our treasurer’s report. Any questions?

CHAIRPERSON MULLEN: Would you like feedback on the format?

DR. AGRESTA: I would love feedback on the format. Anything that is going to make it effective for the group would be helpful.
MS. HOOPER: We did not email that out to all, just to let you know.

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

MS. HOOPER: I’d be happy to.

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

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

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

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

MS. HOOPER: Any that you’re aware of — actually, Bruce, you would be the one. Have you received anything?

MR. CHUDWICK: No, I haven’t received anything. The notice was published in the Connecticut Law Journal on January 10th, I believe, so there is a 30-day comment period. And so people can comment either today at
today’s meeting or at the Board meeting on February 27th, which is when you will consider any comments to those operating procedures, which were reviewed at the last Board meeting in December. And based on those comments and your action you can approve those operating procedures at the February 27th meeting.

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

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

MS. HOOPER: Absolutely. That set are
still there and if you search HIE that welcome page will come up. I think it was a space issue on the DPH home page. You have the DPH Commissioner here to hear your points.

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

MS. KELLEY: Okay, thank you.

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

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

CHAIRPERSON MULLEN: For example would it
be the, and this is a question for the group, helpful to ask that there is a link on the health reform, the state health reform.

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

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

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

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

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

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

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

CHAIRPERSON MULLEN: CEO report.

MR. GILBERTSON: Okay. I will speak louder. I wanted to first introduce Chris Kraus, who is going to be supporting the ICT and she’s on, as is Lori, is now on as the interim CTO. Chris is filling in as the interim administrative officer or what I’m really looking at is overall kind of project manager, chief operating officer type of role. And so welcome to the staff. So we now have a staff of three and we’re growing, which is a good thing. And we all do everything so, you know, there is "no what's your role". Chris’ role is the same as mine, it’s whatever needs to be done, make copies, make phone calls, we do it all. But she’s primarily, she comes
from UCONN. I’ll let her introduce herself in a little bit, but she comes from UCONN where she worked with me. We worked very closely together. And we have a very good relationship in terms of complementing each other’s skill set. So I thought she would be a really good addition to our team.

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

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

CHAIRPERSON MULLEN: Welcome.

MR. KRAUS: Thanks.

MR. GILBERTSON: As I mentioned Lori is, luckily for us, is still with us as the chief technology
officer and her primary responsibility is to get the technology implemented and working. And so she’s been working very closely with the vendor and with our test sites to bring that up and she will have a report after me where she’ll give you the status of where we’re at with bringing up the health information exchange itself. So I’m not going to spend much time on that. Okay.

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

I’ll probably look at potentially outsourcing that function at some point because it’s just probably not a core function that we’re going to really -- it’s not going to require a full time accountant. So, it’s probably better to outsource something like that. Much like we have payroll right now, payroll is outsourced, the paychecks. And I am the only person on
the payroll, but we had to -- I had to make that a
priority to get paid. So --

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

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

I did a lot of work with, and I talked to
several of the folks on the finance committee this
morning, about our cash flow. And looking at when our
bills are coming due versus when we expect to have
dollars in our account. Right now our only revenue is the
grant, the only funding we have is the grant. So,
looking at when the grant money is coming in versus when
our bills are due based on our contract with Axway and making sure that we’re able to pay those bills. And so we’ve done some work with DPH to adjust some of the grant money timing and Axway is working hard to look at their timing of when they’re asking us to pay for certain things so that we don’t get in a situation where we’re unable to pay, unable to pay our bills. And so both are working on that.

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

A link to that is the adoption model and what we think we can do. How many people and what types
of organizations can we sign up? How fast and then how much are we going to charge them? And I think that’s the -- that’s the biggest issue and it really comes down to a couple of things. It’s a perception issue and it’s sort of discussion of who really should flip the bill and are we trying to push the bill off on a certain constituent, stakeholder group, more so than another stakeholder group. And, you know, how much can a stakeholder really pay? And some of this, some of the way this is designed is, puts a lot of cost on the licensing, the license fee, and the license maintenance. And if we try to just pass that off to a one provider office it’s going to be -- I don’t think -- it’s going to be tough. I don’t think we’re going to get a lot of providers on board because it’s high enough to where I think it’s going to become a barrier. So we have to look at how we’re going to do this.

We did look, meet with the Hospital Association. And, of course, you know I felt like that was a good meeting. Lori was there. Luckily Peter was there and Chris went with us. And we talked a lot about the funding and how it was allocated. I don’t think the hospitals -- there are hospitals that are actually asking us to come back to them with a different approach and we
need to flesh that out. But they have -- each facility, hospital is going to have a different value proposition. I think it depends on where they are and what they’ve already invested in or not invested in. And they’re very interested in how much of this are we asking the hospitals to bear versus others.

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

What the hospitals did commit to, a couple of things. One is come to us and tell us what you think is
the hospital's share of this bill and let us sit down as
a hospital association and figure out how we want to
distribute that cost amongst the hospitals. We could
certainly do that and I think that is an interesting
model. And let them as an industry figure out who the
payer is going to be instead of us trying to say large
hospitals pay this much and small hospitals pay that
much. They'd rather us just say how much do you want from
hospitals and let us figure out how we want to allocate
it.

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

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

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

Pete, do you want to add to anything?

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

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

MR. DANIEL CARMODY: Sure. I mean I think it's maybe bringing forward some of the stuff I had reported to the finance committee, but I would say that I
think there is a couple of things. We started off when we started on the finance committee we went through and we worked with Gardner and we came up with sort of the hypothetical, how does the value get distributed. And we came with a -- you know, using certain models we looked at sort of how value accrued, and we looked at certain -- you know, we came up with cohorts, I think, and distributed that. It’s on the web -- it’s on -- I think it should be on the website. If it isn’t then it needs to get out there.

But the issue that we came back with is that it was a theoretical exercise. It was an exercise that was driven by the consultants that I didn't, you know, I think collectively as a finance committee we didn’t disagree with it. I mean it seemed to have, you know, any way you want to get there that it had a methodology to it. But we get into the issue around then you have to prove it out around well, if you build it will this actually manifest itself. So, you know -- so the rationale is that payers, whether it be commercial and/or ASO customers, the administrative folks, you know, a lot of it accrued to them which would then get passed through, you know, the expectations and rates down to the customer, which is fine if you could actually
guarantee that the cost were going to actually manifest themselves, which drives us to, I think, something that I’ve raised for a period of time which is how does this, how does this tool, how is it being used to solve the overarching health care reform issue.

And so one of the things that becomes important is that when we put any costs on the table or benefit on the table we need to understand how the moving pieces come together. So, you know, one of the things that we need to look at that when you look at this as a tool what business problem are you solving and can we come back to and figure out, when you look at those accountable cure organizations, and I know it’s sort of the unicorn that’s in the room because no one knows what an accountable cure organization is, but the context of it is, you know, you will pay for cost and quality and that people have to sign up for achieving quality targets, being very cost effective. And at that particular point in time you would then get reimbursed for doing things that would maybe see, let’s say, keep people healthy. That they normally wouldn’t do because the widget machine of P for service says I need to hit the widget machine versus not doing something, or not doing a test, or whatever that came back to.
But we don’t have a statewide ACO. And we need to think about it in terms of how does this fit into this overarching health care reform component. Some of the technology that we talked about recently at the last Board meeting was, you know, the platform that we’re developing, a master patient index, master provider index are all business functionality that’s required by the health information exchange. Which means the health information exchange needs to say, look at it, we only -- everybody gets some start up funds. If everybody pays for this multiple times we’re not going to -- it’s not going to be advantageous to us.

Now, the Lieutenant Governor’s office has been good around we started a meeting in December. Unfortunately, the meeting in January got cancelled and the next one I’m not sure if it’s been rescheduled yet or not, but, you know -- and I apologize for being a little bit late and I’m not sure if we hit the issues around where we are in a cash flow position, but, you know, unless we’re going to actually -- you know, some of these conversations have to be energized and fast tracked because we will run out and even though we’re making and taking some steps to sort of resolve the cash flow issue we need to get to a point where we’re putting certain
cards on the table around what we think is needed in
order to get to that next level of determining a benefit.

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

And I don’t think any business is going to
sign up for something that may be materialize unless we
have everybody at table, agreed upon metrics, and if
we’re not going to do that then going down the
distributed benefit path is going to be difficult. Which
is why we changed our thought process to looking at the
folks that would be most likely to use it, which is why
we came up with the adoption rate and the fee for service
-- not fee for service, but the subscription model, which said the folks that are going to use it would be the ones that would be willing to pay for it. I think the things that we heard out of the finance committee today, you know, based upon the conversation with the hospital association is that one of the -- I won’t say it’s a lynchpin, but one of the heavy weighting factors that went into that conversation when we went down that path was the fact that the hospitals would see value in the fact that they needed to connect to an HIE in order to achieve meaningful use.

Well, they all, in essence -- you know, and I wasn't at the meeting, but from what I gathered and from what we had today at the finance committee today was that was pretty much diminished. That that value of most -- you know most -- especially like let’s say approximately, and I know that these are ballpark figures that John would attest to in the back, if he’s not going to fall asleep, was approximately half of those -- of our hospitals or the acute care facilities may not see the value in thinking that this HIE is the gateway to achieve meaningful use dollars. Whether it’s half or whether it’s 40 percent, or 60 percent doesn’t make a difference, there is a component, and it’s not insignificant
component, that isn’t seeing us as a key factor in achieving meaningful use. Well, that was a component to how we developed the subscription -- so if we can’t get some of the hospital systems or a good portion of those hospital systems to step up and work with us to subscribe and act as a facilitator to the physicians that connect with them, I think then that subscription model is called into question.

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

So this comes back to is it a shared service model that the Department of Social Services, who is a key factor when you look at Medicaid, will they use us and do they see us as a lynchpin. Does -- will we create a statewide ACO? What ACO’s are out there that see us a, as the tool that they need in order for them to be successful. And those are some of the conversations that need to be fast tracked.
You know, one of the things that we may all consider, and I know I spoke with some folks on the Board, maybe we need to require that everybody that sits around this table represents a constituency. How have you engaged that constituency? One pager that says how are you going to enable this HIE or be supportive of this HIE. That would be incumbent upon me to go back to the health services company and the health insurers and say, as an association, just like CHA or the Connecticut Medical Association, or whoever else, the administration, how do they see the HIE, and how do they see us supporting it, and how does it factor into that overall approach.

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

I mean it’s interesting to me in a way to have so much conversation about the value contribution, the value, or the proposition, or who needs to pay what
share of it when technically health information exchange
is something that, from my perspective, everyone can
benefit from. So in a certain way it sounds like the
classic conversation around a public good.

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

So, I’m curious how we go forward. And
maybe this is an interesting way to start way to start
the year because we are staring at some specific fiscal
realities, but as the Public Health Commissioner I know
that there is a lot that the health information exchange
is intended to do, which doesn’t happen at hospitals and
within small provider groups. There is a large share of
stage one and stage two meaningful use, for example, that
resides within state health departments across the
country. And having had opportunities to talk to
commissioners from other states I understand that there
has been a lot of variation in the degrees to which
states have recruited their partners. But there has also
been, from what I hear from some of my counterparts,
willingness and support of hospitals and health systems
from the outset.

So, in addition to thinking about what we
have to do to help people feel that they need to
subscribe, maybe this is another piece of the
conversation about what else we need to do in the health
care climate in Connecticut for this to be a shared goal
that everybody can see some value in beyond the cost and
potential profit if what we’re really talking about is
improving people’s health. So, I look we have a number
of constituencies represented around this table and we
have a lot of people who are very, working very hard on
the business elements of it. But, once again, for what I
see in many ways as a public good there are some other
pieces of this that can’t fall out of a conversation or
we’re sunk. Sunk not in terms of not sustainable, but in
terms of reaching what all of the intended purposes of
the health information and technology exchange are by
state and across the country.

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

Brenda.

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

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

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

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

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

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

CHAIRPERSON MULLEN: Um, hmm.

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

I mean there is a committee, there is a cabinet that’s doing HIT stuff, but we were just talking today we have another -- Ellen and I were at another
subcommittee event, same cabinet, talking about the lack
of integration between the committees and the work that’s
going on. And this is one example.

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

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

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

MS. VELTRI: Yes.

MS. KELLEY: And I basically think that
what needs to happen is all of those groups need to get
together quickly and say, we don’t have much of a window
of opportunity here if we’re going to do something this
legislative session. And figure out what that is. And I
think Dan had a model. I’m not saying it was a perfect model, no model is I mean. And probably anything that we’re going to do will generate some opposition from somebody, but then that’s the way you’re going to get notice and somebody is going to find out you’re here.

But if we don’t do something I don’t know that -- and I don’t want this, as a consumer advocate, this totally driven by business interest. I really don’t. I want it driven by the public good. And I’m afraid that I don’t know that it’s going to succeed even if it was driven by business interest given what I’m hearing right now. But even if that was the case I’m not sure that’s how I want to see something as important as my health information, you know, that it’s only business interest. And if you want to talk about striking fear in consumers, and they have a lot of fear about this, it would be that it’s only to save money, figure out a way to deny me something I think I need for a business interest.

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

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

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

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

DR. ELLEN ANDREWS: I think that consumers
have the same questions that hospitals and payers do is
what is the value to us? Who is this really serving,
whether you call it corporate interest or whose bottom
line, but why should we support this and why should we, as voters, ask our representatives to support this in any way. And I think that's an open question that's not been made.

CHAIRPERSON MULLEN: Thanks.

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

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

I don’t think -- and by the time we get a consumer movement, if we even could do that, to demand this happen in Connecticut and put pressure on insurance companies, hospitals, doctors, and the government to pay
for it, you know, we’ll be -- we won’t have David anymore or Lori or anyone else. So I mean I think this is -- the time is now and it isn’t going to be consumers that’s going to be pushing it. It would be great if it would be, but it isn’t going to happen. It’s got to be the people that are leaders in Connecticut that are sitting around this table.

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

MS. KELLEY: And I’m not one of them.

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

MS. KELLEY: Right, right.

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

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

MS. PAKULIS: Right, I’m sure you’re not.
MS. KELLEY: But it may very well be that part of one of the government solutions is to help work out how do we make, how can we make this fair for providers.

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

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

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

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

CHAIRPERSON MULLEN: Well, let me just say, thank you. Wait, did you finish your sentence?
MR. GILBERTSON: I’m done.

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

What I wanted to say was that, one, I’m pretty confident that that meeting is going to happen that people are saying because I’m working on it. I don’t want to sound over confident. The -- but the other piece of it is my recognition that this Board and the Executive Committee need to really support you in your role because there is the reality that everyone needs to really see what the state government is doing to support this. And on the other hand, what the state government is supporting is a quasi public agency, the work of a quasi public agency, which you're the CEO of. So -- and that’s something that Betty Jo said about you’re being here
reminds me of that. You’ve been here for a couple of months now and you’ve been doing a lot.

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

DR. AGRESTA: So one thing that I’m hearing that may help is maybe that we can each commit representing our stakeholder group to come back with sort of the one pager. The one pager being what’s the value to our stakeholder group that we represent so that we’re helping to define that much more effectively, which makes us go do some work as Dan mentioned. But the other part
of that one pager is what is our stakeholder group going
to do to support this, which also makes us talk to the
leadership in that stakeholder group and start to get
them to think carefully about what they’re going to do to
support this and make it a high priority and value. And
if each of us committed to do that and we could actually
make that maybe part of our — we can rotate what we do
across time as part of our Board meetings, but that would
enable us to have a conversation that was an on-going one
and would make it a two-way conversation between each of
us as Board members and the groups that we represent.

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

DR. AGRESTA: I’ll make it a motion.

MR. CARMODY: And I second it.

MS. HOOPER: And can you restate it?
DR. AGRESTA: You want me to make it nice
and --

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

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

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

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

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

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

ALL VOICES: Aye.

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

Thank you.
Next on the agenda is the --

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

We had EHR’s testing with us and with Pennsylvania Keigh and in some cases they did not get a chance to fully test their system and they asked if they could continue testing with us after the fact, which I think is fully in our benefit. Alscripts, both My Way product and the enterprise product, we have worked with Alscripts to get their system on a local HITE CT machine so that we can not only test with it, but we’re looking
forward to being able to use that for demonstration in
association with Capital Community College. So they
finally did turn around and support and deliver on that,
which we have been actively working with over the last
week.

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

Greenway Technologies, they tested with
us. They were partially successful and they're looking
forward to continuing with us. NextGen was primarily
testing with Pennsylvania Keigh, but they said that they
very much would like to test with us although it may not
be until after the big HIM’s conference, which is coming
up in February. Lawson, which is an interface engine, successfully tested with us. And Orion Systems, which is the interface engine for the Department of Public Health, successfully tested with us.

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

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

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

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

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

MS. REED-FOURQUET: It was a very --
CHAIRPERSON MULLEN: -- it sounds
fantastic. It sounds fantastic.

MR. GILBERTSON: One of the things I was
supposed to give back to the Committee today is high
level idea of where we’re at and some schedule. So Lori
has been working a lot with Axway and, of course, our
implementation schedule will always depend, it takes two
to tango, so Axway has to do their thing, but then we
also need to make sure that our testing partners have put
enough resources and priority on getting the testing done in a timely manner. So from our perspective we should be ready to have the production environment up by the end of March and bringing our initial providers on in the beginning of April.

CHAIRPERSON MULLEN: Okay. Committee reports.

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

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

MS. HOOPER: Dr. Carr were you able to hear Tom asking if you're still on the line? I’m getting the phone over to them now.
DR. KEVIN CARR: I did not hear, but I am on the line.

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

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

DR. AGRESTA: -- I haven’t had a chance to look at it.
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DR. CARR: Tom suggested we try to do a little bit more homework prior to bringing the group together and make sure that we're adequately communicating the stakeholder value and the technology implementation as it relates to that, achieving that value.

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

DR. AGRESTA: I think we had a -- we had a very good session and we really talked about setting the stage effectively for starting a new subcommittee and trying to give them guidance, direction, etcetera and utilizing a lot of the work that’s gone on in other states and a lot of visual information because this is a complex task that we’re going to ask a new group to take on. And I think one of the key issues was, as we’ve talked to potential members, they’ve said, well, what’s the specific -- what am I specifically going to work on. And so what we were able to kind of really do is leverage what other states have been doing around HIE and I think we have a pretty -- well, in the next week or so have a pretty good sort of outline of the type of tasks that need to get taken on, that the processes that need
to get taken on, and how to help this group prioritize for the entire Board what are the use cases and how they get rolled out, and what are the operational pieces that need to occur in regards to that, etcetera.

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

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

CHAIRPERSON MULLEN: Anything else, Kevin?

DR. CARR: That's it. I think we’re going
to get very close to being ready for the first meeting
and I hope that given the pre-work that we’ve done we’ll
have a very effective first meeting and kick-off. So I’m
looking forward to it.

CHAIRPERSON MULLEN: Thank you.

MR. CARMODY: So finance committee met
today and so we made progress on a couple of different
things. One, we talked about there were -- at the last
Board meeting there was some administrative procedures
that we had voted upon in order to put a framework so
that David, as a CEO, could sort of function. Those
operational policies or that authorization that we gave
really should be supported by financial policies and so
we started down the path of locking what O&C had
submitted as draft policies by other HIE’s. And what
we’re going to be doing as a finance committee is
reviewing those, making modifications to them so that we
can make them Connecticut specific, looking at the other
quasi’s, just much like we did when we created that. And
then what we would plan to do is review them, there is
about 17 of them, review them in chunks at a time over
the course of the next few months and then make
modifications to them, and then bring them back to the
Board. Or go through the process that we had outlined
before of getting public comment around what they should look at and so we’re going to start to sink those up. We spent a lot of time on the conversation that we had just articulated that David gave us so I won’t go into that again around what -- the conversation went with CHA and what we need to do. And I think we already voted upon that as the far as the one pagers. I think will help start to frame that conversation on how everybody is going to be supportive of that so that we can get to the value conversation sooner rather than later.

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

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

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

So, I would make a motion that the Board either direct the CEO and/or maybe the Executive Committee or put together another committee to engage with the E-Health board to figure out how we can more
collaboratively govern ourselves in this HIE space as well as explore how to capitalize and maximize and optimize our expenses.

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

MR. CARMODY: It’s a motion.

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

DR. AGRESTA: I’ll second that.

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

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

MS. HOOPER: Any discussion?

CHAIRPERSON MULLEN: I’m still trying to get what optimizing on the government structure means and I’m also trying to read the room with even the lack of a second, to make sure people understand what you’re talking about.
MR. CARMODY: So a good portion of the Board sits on E-Health, a good portion of the Board is redundant with this Board should we collapse the Boards together, explore around how do we better govern. Again, this goes back to how does the HIE, how does the state actually intertwine themselves so that we’re most effective and start a dialogue around how do we optimize how we’re governing the small amount of resources that we have. So, I know we want to push this forward on the state level around what the Commissioners are doing and how that’s taking place, and while that’s working its way through the state system, you know, is there a way in which, you know, either from our quasi public perspective and/or from how the regional extension center is working how can we better optimize so that we can streamline the decision making and not have so many meetings where there is redundancy from a Board member’s perspective as well as from, you know, making sure that we’re looking at all of this collectively. And I would just go from expenses on either side of the -- where we’re looking how to maximize the small amount of dollars that we have.

It’s an exploratory conversation. I didn't say that we would I think that it just has to be explored to see if there is interest on how to do that.
MS. HOOPER: And you said maximizing operating costs or --

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

MS. HOOPER: Thank you.

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

MR. CASEY: Wouldn’t leveraging resources and looking for efficiencies be the responsibility of a CEO?

MR. CARMODY: We could, but that’s one thing to -- I think that we can do that, but that’s why I think it needs to be both. I think it has to be at the governance structure. I think if you set it at a governance structure piece as well as at the CEO piece I
think you can do them both simultaneously. I don't think it’s one or the other, but sending them down the aisle at the same time.

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

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

The worst thing that happens is nothing
happens and we continue down the path that we’re already on. I mean does it make -- are we any worse for it?

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

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

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

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

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

MS. KELLEY: I just have a question, who is doing the meeting?
MS. HOOPER: It was for the Board to engage with the E-Health board.

MS. KELLEY: But the Board being?

MS. HOOPER: Well, that wasn’t part of the original motion.

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

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

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

DR. AGRESTA: -- the risk is, I think, the same there for E-Health. I think the risks are similar.
There may be some solutions that come out that are unique and opportunistic and there may not be. I don’t know the answer to that.

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

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

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

MS. HOOPER: May I ask for a clarification? The E-Health board or the REC
responsibilities from that board because they are two different -- there is a regional extension center responsibility and then E-Health as its own operating entity.

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

I mean if it is then I’m going to put it on the table because, again, this is a small state. We are not that big. You know, going back to what David said, it doesn’t make a lot. I mean to be able to say, what’s the role of these boards in relationship to the state government. I mean, you know, we talked about the one pagers, but, you know, at some point what is the vision from the administration on how health insurance exchange, E-Health Connecticut, or the REC, if you want
to -- you know, are they one in the same or not? I don’t know. Put it on the table as well as the HIE, what’s the way to maximize the way that this is working? You know, going back to what Victoria had to say, if this is the best kept secret, you know, we have cameras at the table then lets it make it not the best kept secret and let’s force the hand that says, drive our governance structure, drive our operating mode.

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

CHAIRPERSON MULLEN: I appreciate a few things one of which is you pointed out how many of us go to so many different meetings to do the same thing. I mean that’s just one piece of it. And I’m one of those people who has many times wanted it all to make perfect sense. So I hear you. And I also understand that a lot of your recommendations are geared to be thought of as solutions to a series of different issues or
inefficiencies not all of which are within our control to fix, or even at our control as Board co-chairs. But I think there are within all the conversations we’ve had today there are some immediate issues for the Board to tackle.

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

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

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

MR. HEUSCHKEL: I would say that if you listen to this conversation and you listened to the earlier conversation about governance within state government and these different -- I think some of it is even before you get to questions of efficiency or inefficiency it’s just understanding. You can’t even get there without the basic understanding. I think there is a
lot of confusion and just, again, lack of understanding amongst the different constituencies in part in terms of the governance. And there is, as you say Commissioner, some of this is by design in a sense because that way you make sure all of those voices get heard.

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

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

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

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

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

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

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

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

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

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

MR. CARMODY: I’m not sure I understand that.

CHAIRPERSON MULLEN: So the point would be to have people understand the substance of the conversations that have gone on up until now so that they would be able to vote on whether or not they would like to continue. So, everybody would be up to speed on what's gone on thus far and I think basically that was the basis of your question, what's happened this far.
MR. COURTWAY: So I’m not sure if this is
the Robert’s Rules way to do it, but is it that to make a
motion to table the motion pending clarification of the
conversations that have already taken place.

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

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

DR. BUCKMAN: If I may, correct me if I’m
wrong, but there is nothing in our bylaws that prevents
our CEO from having conversation with the CEO of E-
Health. And if any conversations have occurred already, as you say you’ve had a conversation, there is nothing to prevent those conversations from continuing to occur. What we’re saying is is that those conversations should come back to the Board and there should be a report to the Board on what those conversations have been so that we can know what’s been talked about and whether or not, at that point, we want to move forward. Now, that doesn’t stop you from having more conversations between now and the next meeting. Right?

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

CHAIRPERSON MULLEN: And I think people will be better prepared to do that after we get the
update on the conversations up until now. So, the February 27th conversation --

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

CHAIRPERSON MULLEN: I haven’t been meeting with the --

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

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

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

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

DR. ANDREWS: I guess I’m concerned about taking it -- for the same reason that you want some definition from this Board and some go ahead, I’m really concerned about that. And a decision by this Board to start looking at that I see as a movement toward doing that and not just the discussion that you’re talking about because a lot of -- I mean a lot of here what
happens in Executive Committee, not everybody comes to every meeting. I feel like I could show up in two months and, oh my gosh, we’re merged. And that worries me. So for the same reason that you want that definition I’m worried about it.

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

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

DR. BUCKMAN: Angela --

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

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

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

MS. KELLEY: -- I’m not saying -- all right, but what I’m suggesting is I tend to -- if I’m overworked, which I generally always am, I tend to prioritize where do I think I’m going to have my best success. And I personally believe the timing of what’s
going on right now is the Commissioner needs support to have that government discussion with her colleagues on the state level. And I also personally believe that if that can’t happen I think the state has a lot of risk down the road because they’ve, face it, we’ve created an agency, we have hired people, we have hired a vendor. We’ve taken federal money. And so if I -- I have worked for state government. I would want to say we need to get our act together to make certain that this succeeds. Part of that conversation, by the way, could incur what do we do about looking at this resource called E-Health Connecticut. But I personally think we should trust our Commissioner, because she is the Chair of the Board, because I think -- and Tom to hear what’s been said and figure out what needs to come first. And I think you’ve articulated. I’m not disagreeing with you at all really.

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

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

DR. AGRESTA: Sure.

MR. CARMODY: I only ask that a conversation happen and somebody needs to have it as a takeaway. So my motion was intended to put that on the
table. The withdrawal of that motion doesn’t require anybody to come back if they’re not going to engage in a conversation.

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

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

    CHAIRPERSON MULLEN: Thank you.

    MS. HOOPER: Is John Lynch still on the phone? I heard somebody hang up. I know that they met
once to talk about the legal implications for implementing the operating procedures based on comments that come back. I don’t know if there was more that John was going to add.

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

CHAIRPERSON MULLEN: Thank you.

MS. KELLEY: Special populations met in December but did not have a scheduled meeting in January. They have been having working meetings with Lori on a regular basis. Unfortunately I was on a lot of travel at this time and my husband -- I’m involved in a major medical issue with my husband, so I have not been able to be part of that. But I know that they’re happening and I
know that they’ve moved pretty much from the brochure stage because we pretty much have consensus on a brochure, which is great, to the website and what the website is going to look like. And, Lori, I think you had a meeting on Friday. I was going to call in from Cleveland, but unfortunately couldn't. So you might want to fill people in on the nature of those conversations.

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

We looked a little bit deeper. There is a very interesting video that was identified from Colorado’s HIE and in looking into that further and when we played it it sounded extremely familiar to me. It was actually part of an ONC project that Connecticut was involved in a few years ago, the security and privacy
collaborative. And one of the groups that was multi-state
had prepared some very nice videos that the core material
was reused across multiple states and then they tailored
it for the -- so that struck up some interest. And in
going back to that website there are a lot of other
consumer focus materials that were created. And so the
homework assignment for the group now is to go back and
review all of those materials to see if there is anything
that we can adapt here.

CHAIRPERSON MULLEN: Great.

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

And so it’s not perfect by any stretch of
the imagination because immediately when I had the chance
-- when Tom and I had the chance to see the patient
portal we immediately signed up to get on his patient
portal. And one of the things we discovered was that
certain things were there, all of his appointments, a
record of what he had done, his medications. But then we
get to all the tests and even though there is space for that none of them were there. And so we raised the issue with the doctors and with the translink coordinator and they said, well, the doctors are kind of reluctant to make certain that that information is there. And we’re having more trouble with this part of the Cleveland Clinic then we are with other parts.

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

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

So even though I wasn't at the meetings, Lori, I was doing my homework at the Cleveland Clinic and getting another model that we could take a look at.
CHAIRPERSON MULLEN: You’re always doing your homework. I mean I think so many instances in which whenever you’re doing in your personal life there is a part of you that still refers back to these other bits, whether or not it’s an AARP or here, and I really appreciate it.

MS. KELLEY: Thank you.

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

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

CHAIRPERSON MULLEN: Okay.

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

So in terms of getting to that, we are working to finish up with Axway and its partners on the access control use case and sort of the securities in there, and how do people get access to the information so that there is transparency to what the security is, following up on the policies and procedures that have
already been written and approved by the Board.

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

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

I find it interesting that even though there is a lot of discussion on the hospital CIO group in regard to the value and how much is too much, we have
four of the hospitals who are committed in a participation agreement to sign the papers and want to go forward. And I think that's an important step. I think that the gauntlet is down. I think it’s up to us to execute with the stuff we do and to execute well and I think that really is the focus of moving forward because as those four come up and see the value others will see the value and this thing will move forward.

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

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

CHAIRPERSON MULLEN: So technically the patient privacy group is not one of the Board committees so we don’t have a committee report from patient privacy. I can add that I know that the committee, advisory
committee that was created through legislation did have its first meeting on January -- earlier this month, chaired by Michelle Wilcox. Ellen is a member of the committee. Anybody else here? Anything you want to say.

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

CHAIRPERSON MULLEN: Anything you want to add?

DR. ANDREWS: We’re getting lots of information and boxes full.

CHAIRPERSON MULLEN: Great.

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

MR. CASEY: The 25th.

DR. ANDREWS: Yes.

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

Motion to adjourn?

DR. AGRESTA: So moved.

CHAIRPERSON MULLEN: Does everyone want to
second it together? Thank you. All in favor?

   ALL VOICES: Aye.

   CHAIRPERSON MULLEN: Okay.

   (Whereupon, the meeting was adjourned at 6:35 p.m.)