VERBATIM PROCEEDINGS

HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

ADVISORY COMMITTEE

MARCH 15, 2010

DEPARTMENT OF INFORMATION AND TECHNOLOGY
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EAST HARTFORD, CONNECTICUT

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COMMISSIONER J. ROBERT GALVIN: Okay, we do not have a quorum so we can’t adopt the minutes and some other things, but we can start doing some updates and subcommittee reports. Warren, do you want to do those?

MR. WARREN WOLLSCHLAGER: Well, yes we can start with -- we can start with two of them. So, starting with, perhaps, Lisa, you could start off the Legal and Policy Subcommittee Report?

MS. LISA BOYLE: The Legal and Policy Subcommittee met last week, we’ve been meeting on every other week. The beginning of the meeting was an update on the meeting that we had with Gartner, which I assume you’re going to talk a little bit about as I see from here.

And I think there was a sense among out
committee that added a lot of clarity to our mission. Having met with Gartner and having had them describe what our committee should be focusing on and we were already on the right track, but I think it really helped to have that clarity of direction.

After that we talked a little bit about kind of the mission of our committee and the fact that it’s not just legal it’s policy also. And being a lawyer, I think I was a little more focused on the legal, so that was good to get us refocused on the policy as well.

We did talk about on the legal side, we were able to get a preemption analysis, which we were very excited about. It’s dated, but it’s better than starting from scratch. It’s 800 and some pages long. So, we have undertaken the task of organizing around that and trying to get some help from maybe some law students that have interned, and looking within the members organizations to try to find resources to bring it down.

So, the goal would be to bring down the law, make sure it’s still good law, and then add the new law that has been enacted since 2002/2003. And that will actually give us a sense of where there will be conflicts between Connecticut law and HIPAA so that we could go forward to what the post problems for EHR and an HIE. So,
that is a task that we’ve undertaken, and organized, and we’re working on.

The other thing that we’ve spent a little time talking about was sort of the two structural issues that are -- the two fundamental issues around an HIE. One was whether it’s an opt-in versus an opt-out model, and the other was the structure, whether it’s centralized -- a centralized repository for the data, or an edge system where there are, you know, agencies on the outside collecting data and there’s just a funnel through the middle.

In response to that, we had a very good discussion on that topic and there are a lot of people on the committee who are on the policy side and have a lot of experience with them at the federal level. Having that dialogue we cast ourselves with, each member of the committee is coming to our next meeting, which is next week, with a chart of the strengths and weaknesses of each of the models.

The strengths and weaknesses of the opt-in, the strengths and weaknesses of the opt-out, and the strengths and weaknesses of a centralized data repository versus an edge system. So, we’re taking -- we decided as a committee to kind of take the lead on trying to provide
some positive feedback in an organized chart formation to
this group. And so, those are our two factors at the next
meeting next week.

MR. WOLLSCHLAGER: Great, any questions for
Lisa?

COMMISSIONER GALVIN: We were beneficially
informed that we have our grant just this instant. So, we
have 7.2 -- hum?

MS. LYNN TOWNSEND: 7.29.

COMMISSIONER GALVIN: 7.29 million dollars
to work with. A good deal of that will of course go into
developmental functions. We had some conversations with
the legislators and I was somewhat concerned that they
raised some issues about Governance, but also about
oversight.

So, I don’t think -- we have not finished
our work and are going to meet privately with four
different legislative individuals and their staff.

For some reason they seem to think that
they need more legislative oversight, even though my view
of this whole project will be that it will either be
federally or privately funded. I don’t see state funding,
you know, funneling into this organization.

And I certainly think that there’s a fair
amount of control with the Commissioners involved -- departments in the state, but I’m not sure that we made our point that the legislative body and the Governor will be appointing the people eventually on the Board.

And that there’s plenty of oversight built in there, but they may want to have an Oversight committee to check every couple of months, or whatever.

I would say to this group that we had disbursed 40 -- this year’s session, 45 million dollars with stem cell and we have never had a single problem with transparency, nor have we had any problem with Freedom of Information. Everything’s been open to the public, we’ve never had a single complaint.

And the problem with the stem cell is money. It’s like many things that we do, it’s a very cumbersome and tedious process to get the money from where it is in the state treasury and move it to -- through the Office of Policy and Management to the people who cut the checks, and then subsequently down to the people who do the research.

And sometimes it’s a matter of what, Warren, three, four, or five months, to get the money out to the people. And it makes it an -- and I’m not going to go on and on about this, but it makes it a problem for the
people doing the research because most of the folks that
they hire usually want to be hired at the end of an
academic year or at the beginning of another academic
year.

And so, we’ve got people out there waiting
to get fund allocations so they can hire staff. And when
you -- the long and the short of it is, if you’re late
hiring your staff you can’t get your project going. So,
when we audit them the next year they say, you know, what
do you want from me?

I couldn’t get people -- you didn’t get me
the money until August and I couldn’t get people on board
until late September, and here you are you’re asking me
why I haven’t made any progress in February, well that’s
why. I think this is fatal to this project if we get into
this kind of arrangement where we have several different
stops for funding to go.

And -- because my personal opinion is that
the private industry will not tolerate this. If you buy a
million dollars of stuff from private industry and you
don’t pay them for six months, they’re not going to deal
with you and they don’t have to. The universities in
Connecticut kind of have to put up with us and -- but even
though it’s tedious for the people involved, it delays the
And we’re far enough behind that we don’t need to get any further behind. If -- and we’re going to talk to the legislators, if this stays as a Department of Public Health policy it will -- program, it will fail. Okay? And we will end up -- the hospitals don’t need us, they’re doing their own thing, and their docs are hooking into the hospital.

And Mr. Masselli has -- he already has electronic medical records, he doesn’t need anybody to show him how to have electric medical records. He already knows how to do it. So, what will happen, in my opinion, if we don’t move forward expeditiously is that the entities that I spoke about will be fine, and the state of Connecticut will end up buying their services from Massachusetts, or New York, Rhode Island, or whoever.

And I think therefore, of all the models that we could -- the worse model we could adopt is no model at all. But of all the other ones, leaving it in the Department of Health is not a good thing to do and it will basically make the effort fail to be a significant effort.

Putting the money out into a private entity, that may or may not already exist I don’t think is
the proper way to go because it leaves the interest of the
state not represented. I think what we all determined
here unanimously was that the best way to go is with a
public private coalition.

We will try to explain that to our friends
in the legislative body. We don’t mind if they build in
checks and balances, that’s fine, that’s they’re -- not
only their right, but it’s their duty. But we can’t have
money sitting around for four six months, having three
different entities looking for money because this is not
that kind of business.

It’s the wrong kind of business to do that,
and these people who we deal with are not dependent on the
state of Connecticut. And the Universities somewhat are,
and they have -- they can buffer that.

So, with that, I think perhaps we could
skip -- well, let’s -- let me call for review of the
2/22/2010 draft minutes. And if you need a minute to look
at those, I will give you a minute, otherwise we’ll take a
vote on that. And then, I think we need to go to the
Gartner presentation.

DR. KENNETH DARDICK: Did you want to get
an update of the Finance Committee before you do that?

COMMISSIONER GALVIN: Sure.
DR. DARDICK: Before you --

MR. WOLLSCHLAGER: Yeah, yeah. Kevin’s not here yet but we also have an update from the Business and Technical Operations Subcommittee comment as well.

DR. DARDICK: Okay, I’m not that person but --

MR. WOLLSCHLAGER: Right, so you want to do the minutes first?

COMMISSIONER GALVIN: Well, let’s do the minutes first. Is there anybody -- are there any additions, deletions, or changes to the 2/22/2010 draft minutes? If not, I will entertain a motion to adopt them as printed. I have a motion? How about you, Dr. Agresta?

DR. THOMAS AGRESTA: So moved.

COMMISSIONER GALVIN: Okay, and a second?

Okay, how about you, Mr. Masselli, would you second that?

MR. MARK MASSELLI: Sure, second.

COMMISSIONER GALVIN: Are you alright with that? I’m not rushing you, am I?

MR. MASSELLI: No.

COMMISSIONER GALVIN: No, okay. All in favor? We’re only voting on the minutes of the last meeting. All in favor?

VOICES: Aye.
COMMISSIONER GALVIN: Opposed? The motion is carried. And now we’ll go to the --


COMMISSIONER GALVIN: Okay.

MR. WOLLSCHLAGER: And that’s Dr. Agresta.

COMMISSIONER GALVIN: Okay.

DR. AGRESTA: We don’t have much to report from the Business and Technical Operations Subcommittee, because we were waiting to meet again. We had met the last time on the morning prior to the last meeting and we were waiting to meet until after we had met with Gartner, met as a leadership group.

And so I think what we’re going to take -- now that we have funding and we have a path forward, we will kind of take our next step and set up a series of meetings with that group.

COMMISSIONER GALVIN: I think, too, that I will say that if we bobble this badly this will probably be the last money that we’ll see from the feds. Or based -- I don’t think they will open their coffers very gladly if we blow the 7.2 million and don’t get any place.

DR. AGRESTA: No pressure, Commissioner, huh?
MR. WOLLSEHLAGER: Dan -- are there any
questions for Tom? Dan, do you want to -- Kevin is not
here, do you want to provide an update on Finance?

MR. DANIEL CARMODY: Sure. The Finance
Subcommittee met on March 8th, and there was a couple of
things I’d probably highlight from that conversation. We
talked about the Gartner conversation that had taken place
back on the 5th about the issues raised on opt in versus
opt out, as well as centralized versus the regional
repository.

And the group -- while those are very
important issues, there was still again some other
important issues that we felt that were important. Again,
we still felt that we wanted to raise that the -- you
know, what are we going to do, why are we going to do it,
and how does this fit into healthcare reform, are actually
more pressing issues.

Those are more how do you implement certain
pieces, but you need to have, again, a general sense of
what is our role, what’s the state going to do. We also
talked about the need to add additional subcommittee
members. We didn’t feel the committee had been rounded
enough, and so we were going to actually add some more
folks to the conversation.
So, we invited CHA, we invited CHEFA (phonetic) as well as we also got representation from the Comptroller’s office. So, they’re going to be joining us to add additional perspective. Once we decide what we’re going to do they’ll talk about how we’re going to finance it.

But the group agreed in general, or at least it wanted to come back to this over -- this larger committee, that if we do some of vision work that we wanted to stress the importance that whatever we’re going to finance it needed to be very specific and focused, that you really couldn’t boil the ocean.

And what we talked about was the need to you know, get some type of an exchange where, you know, that was maybe focused in the medical setting, the ER setting. We talked about the need to get patient medical conditions, medication, and their lab values into the hospital rooms.

Other initiatives as we look to branch out, could very well be very valuable you know, maybe even to the ambulatory setting. But we needed to keep the initiative focused, we needed to keep it small, we needed to keep, at least at the beginning in order to be able to say that we can accomplish it in a timely manner.
And then that way we would create distinct measures around what success was so that when we came back to ask folks to finance it, we could then demonstrate in a very specific way what we are trying to do and why we’re able to accomplish what we were doing. So, the visioning sessions can be blue skies, more or less talk to about where we want to go.

But we need to roll this out in phases, and we need to make sure that the phases are very scripted in the sense that we do get those quick ones. So, I think then we have to take away who’s going to reach out to the variety of these folks. And our next meeting is going to be held on April 5th.

MR. WOLL SCHLAGER: Thank you, Dan. Any questions?

COMMISSIONER GALVIN: No, I think -- but I think there’s a real kernel of organizational merit here, although the whole report is meritorious, is you want -- you know, if you -- this is a big meal that we’re going to have to digest. And the best thing to do is take small bites or you’ll choke on it.

MS. BOYLE: Just -- at the Legal and Policy meeting we had heard a little bit about the Finance Committee’s discussion, and I feel compelled to like,
explain that. The Policy folks, in particular in our
group were very concerned about the focus primarily on the
ED, and a concern that the docs will be left adrift, and
the ambulatory care pieces. That that was -- there was a
real concern that that was an immediate need, especially
because of meaningful use.

COMMISSIONER GALVIN: Yes.

MR. MOONEY: And the fact that the doctors
have to comply by a certain date.

DR. AGRESTA: I think that if we -- to be
honest -- this is Tom Agresta. If we looked at meaningful
use and what needs to happen for meaningful use and we
focused on those -- that being our use case so that we’re
leveraging the other Federal dollars that other people
might be able to achieve, then you know, that still would
probably need to get phased.

But I think that that would probably focus
out of the ED, quite frankly, and into the primary care
offices, and the -- you know, and the collaboration
between those places. But I agree, you have to have it
focused, otherwise you’ll not achieve it.

COMMISSIONER GALVIN: With respect, what
are the primary care guys going to do? So, they’re not
going to have electronic medical records? They’re not
going to connect to their hospitals? Come on.

DR. AGRESTA: They -- honest, honestly, I think that there are many folks who will retire rather -- if they --

COMMISSIONER GALVIN: Oh, they all say that.

DR. AGRESTA: -- can’t get assisted in achieving that they’ll sort of go through the stages of you know, retirement without --

COMMISSIONER GALVIN: Well, let them retire. What are they going to retire to?

DR. AGRESTA: Well --

COMMISSIONER GALVIN: Walking on the seashore?

DR. AGRESTA: You’ve got folks who were willing to wait out the seven or eight years to retirement, and you’ve got folks that are interested with guidance to move forward. And I think that --

COMMISSIONER GALVIN: That’s baloney. I’m going to retire if you make me do something. You’re trying to make me do -- this is what the doctors always say, I’m going to retire if you make me do something I don’t want to do. Well, we’re all going to be doing things that maybe we didn’t think we wanted to do, because
things are changing.

So, if you want to retire, just retire and go to Kiawah Island and walk along and kick at stuff in the water. And we’re going to have to have a new generation of physicians anyhow. And that stuff about I’m not going to cooperate. You know, I heard it all -- I said it most of my life, you can’t tell me what to do in my office. Yes, we can. And you can’t push me around. Yes we can, or the government will. And I’m going to quit.

Quit, but we’ll never attract new physicians, ever, unless we have a cogent and understandable way of exchanging information. So, I wouldn’t buy the -- I’m not worried about these guys, how are they going to deal with their hospital if they’re not connected?

MR. PETER COURTWAY: Commissioner Galvin, this is Peter Courtway. I think that the -- you know, probably what you’re hearing from the different subcommittees is all around the same which is, what is the vision for the exchange, what -- have one of the first use cases that it would be used for.

How do you actually develop that so that the different constituents as congress decide to leverage
the federal dollars for those that are ready for it, that we can help them be prepared to do it. I think that with the adoption of EHR’s inside a physician practices will take some time from --

COMMISSIONER GALVIN: Of course.

MR. COURTWAY: -- our point of view. But I think that we’re at this cross but maybe it’s you know, if the committees don’t know then maybe it’s time for the Gartner piece because it’s the vision piece that’s most important.

COMMISSIONER GALVIN: Of course.

MR. COURTWAY: And we have not started the Technical committee because if we start the Technical Committee the concern is we’ll get a technical solution to an undefined vision and problem. And it sounds like all of the groups, including Finance, are struggling with that.

Actually, I commend the Finance group for trying to grapple with that. But you know, I think that’s part of the work of the domain experts here and the facilitation by Gartner at this point.

COMMISSIONER GALVIN: Yeah, and I don’t mean to cast dispersions on physicians, some of my best friends are physicians. And --
MR. COURTWAY: Still?

COMMISSIONER GALVIN: Less so since I took this job. But I have -- there are some here and there. And I use some of the same arguments, you know? And when you use those arguments, with respect to Dr. Agresta who I think is a terrific person, when you use those arguments, those are the ones we always use.

You can’t -- and -- you know when you talk about moving away from a cottage industry to an integrated system, you can’t use those arguments, those aren’t potent arguments. Now, many of our physicians, particularly primary guys, are aged. I think our average primary guy is up there -- I forget what the average is.

DR. AGRESTA: In the late 40’s at this point.

COMMISSIONER GALVIN: Yeah, and -- but a lot of them are at an age where -- you know something, they’re going to retire in seven or eight years anyhow if they have enough money, which they may not because of some of the economic changes. But we have to look at the people who are coming up through the ranks now and in training.

And if we don’t have a -- it’s like the “Field of Dreams,” if we build it, they will come. If
not, we’ll be chronically short of physicians,
particularly primary care guys.

And I understand the struggle of primary
care guys, and having been one of them, and emergency guys
trying to get information. You know, having been one of
the guys who tried to figure out what was going on with a
patient at 3 o’clock in the morning. And trying to figure
out whether it was Hurlehy or Hanrahan, or whoever, you
know, all that kind of stuff.

And I think those things will fall in place. But I
think we got to kind of -- this stuff isn’t going to
really be in everybody’s office for several years. We’ve
got to look -- actually, the people we’re looking at are
the people who are probably just beginning college now.

And if we don’t have a good system here,
they ain’t going to come here. Or, we’re going to train
them and they’re not going to stay here.

So, with that I will shut up. And perhaps
this is a good time -- do we have any other reports?

MR. WOLLSCHLAGER: No.

MS. BOYLE: Just one more thing.

COMMISSIONER GALVIN: Yes.

MS. BOYLE: I think the way we’re
structured is we don’t have Governance committee. This
Board is the Governing -- the Governance Committee. And so, some of the things you hear people saying, I think it would -- we need to start making decisions and we need to start moving forward as a body, otherwise you know, we’re falling behind everyday.

So, I mean I think that’s why our committee, the Legal and Policy Subcommittee decided to like, you know, do the grid with the opt-in/opt-out and centralized. If every committee would spend a few minutes on that, and then we actually come back, at least then we could maybe make some decisions on those fundamental issues as a body. I see you’re nodding.

Because I’m really concerned that we meet at -- you know, in these public forums, and we don’t make -- we haven’t made decisions yet. So, I think the time is now to actually start making those decisions. And the only way we can do that is to actually come prepared with deliverables on how we see those issues you know, shaking out in terms of strength and weaknesses.

COMMISSIONER GALVIN: You are correct. And that’s what we need to do. And we need -- and I guess all my message today is we need to, as they used to say in the military, move out smartly, or we’re going to be so far behind it won’t be worth the effort and we’ll never be
able to catch up.

And I have strong opinions about the -- and I’ve never said anything in any of these meetings that I don’t truly believe. If you think I’m -- you know, if you think my opinions are wrong, that’s okay. But I’m not filtering anything, I’m talking -- I’m telling you just what I think. What else you got?

MR. WOLLSCHLAGER: Nothing. I think it’s a good time --

COMMISSIONER GALVIN: Did I put you to sleep?

MR. WOLLSCHLAGER: No, sir.

COMMISSIONER GALVIN: Oh, okay.

MR. WOLLSCHLAGER: No, sir.

COMMISSIONER GALVIN: Alright. I’m ready to step out smartly.

COMMISSIONER GALVIN: Yep.

MR. WOLLSCHLAGER: No, I think it’s a great time for the Gartner presentation, because it’s really going to talk about how we’re going to get to making those decisions sooner rather than later. I agree, we can’t move forward until we make the big decisions. So, let me turn it over to you guys.

MR. FRANK PETRUS: Good afternoon, all.
I’m Frank Petrus, Senior Managing Partner for Gartner, heading up our Health and Human Services Practice. And we’re pleased to be here, and as we go forward we’ll do some other introductions.

Just wanted to talk about what our agenda is. I do appreciate the discussion you just had because one of the things that we really wanted to place emphasis on in our discussion about our approach is that the keystone, the foundation of what you’re going to be doing in moving forward with this initiative has to be built on a consensus on what the vision is.

And that vision should be tested back to a compelling, achievable future. Something that’s compelling for all. For patients, for providers, for health systems, for payers. It’s got to be a compelling vision. Why would I want to opt-in, why would I want to participate, why would I want to fund it? It also has to be achievable, that you can do it, with current resources and anticipated future resources and a reasonable phased in process.

But all starts with having that compelling vision of where you want to go. And since this is your Governance group, as we’ll end today, we’ll be coming back to you to help facilitate that vision so that it could
provide guidance to the other ONC domain committees that
you have out there, Business and Technical Operations, and
Finance, and Legal and Policy, and so forth.

So, we want to talk about those domains
because we think they’re important, and Gartner has worked
with O & C, and CMS, and CDC about the development of this
vision on our federal practice side. So, we have some
insight to this, and we think they’re really critical.

We’ll look at our planning framework, we’re
going to talk about the logistics, and then Alistair’s
going to walk us through what the next steps are.

This is our understanding of your structure
and where Gartner fits in. A brief introduction about
myself. I’m one of the older guys that may be retiring
someday, but --

COMMISSIONER GALVIN: You’re not
threatening with that, are you?

MR. PETRUS: No, no.

COMMISSIONER GALVIN: Good.

MR. PETRUS: I don’t see retirement as a
threat.

MR. WOLLSCHLAGER: Galvin would like to see
you retire.

MR. PETRUS: I started working in the 60’s
so I’ve been doing this over 40 years and have seen a
tremendous amount of change and help in human services.
And in some respect we’re going back to our vision in the
60’s about a community based approach to practice and
integrated approach to practice.

Now, we’re going back to it with technology
that has agility that we never saw before. And so, not
only can we achieve the vision that we had when we had the
war on poverty with Office of Economic Opportunity and
Integrated Programs, some of which still exist like
"Headstart" and "WIC" that have been around that long, now
we’ve got technology that we can go further with it.

MR. JEFF PERKINS: Yes. Good afternoon,
Jeff Perkins with Gartner. I’m a partner in our state and
local government practice. Recently I’ve been doing work
in the area of electronic health records and health
information exchange. I’ve done that work in Alabama, as
well as Pennsylvania, so I’m very excited to be here
today. Also, done some prior work with CDC around health
results.

MR. ALISTAIR MCKINNON: My name is Alistair
McKinnon, I’m the project manager for Gartner, the face
that you will see most of, probably. And essentially I’m
an information management specialist, so I really come
more from a technical side of things and how you can
actually get computers to be agile -- the agile friends
that you need to work in the processes that you want to
work with.

And my recent background has been -- I’ve
only recently moved into health and human services while
recently working with Pennsylvania on this very same
process.

MR. PETRUS: And with the Women & Children
Program in Texas. And we imported him from Connecticut,
you can tell from his accent, a small town. What’s the
town?

MR. MCKINNON: Stafford Springs, that’s
where I was born.

MR. PETRUS: And you live now?

MR. MCKINNON: I live in Portland.

MR. PETRUS: Connecticut.

MR. MCKINNON: Yes.

MR. PETRUS: It’s the accent that I have a
little difficulty with. This is our project team, I won’t
spend a whole lot of time on this. This is how we divided
our responsibilities up. The whole team is not here
today, but will be -- you will be seeing them and working
with them as we go through the process.
Also, I want to talk about our research side. For those of you who may not know Gartner, Gartner is an extremely large global IT research organization with revenues of about two-billion dollars a year. Two-thirds of Gartner’s operation is research, and basically what we do is really look at where is information technology going, not as an end in itself, but where it’s going in support of your operations in business.

And we have specialists in our research area, Wes Rishel and Dr. Tom Handler, some of you may know, who have been sitting on national committees with Dr. Blumenthal, with Rick Freedman, and with folks at CDC around interoperability, HL7, the domains, and the cooperative agreement funding.

These folks are national thought leaders on the research side, as Alistair is one of thought leaders on the information exchange management side. We will be bringing in Wes and Dr. Handler as needed as we take a look at what trends are happening out there, lessons learned that might be helpful to you. So, where consulting and research comes together for us.

This is you and your colleagues, and want to get into the discussion of the five ONC Domains. I’m sure you’re all by now familiar with the five domains.
And I’m going to walk through each one of these in greater detail. But the real important thing here is that they’re not shrink-wrapped. ONC is not going to give you these domains and you fill in the blanks for Connecticut.

We have done this work in several other states, Arizona, Pennsylvania, and Alabama, and Texas, and now here, and it’s very important that you take a look at the context and culture for Connecticut. What’s going to be the best approach to fulfilling these five domains in Connecticut?

Yes, you can learn from your neighboring states and other states, but you have a unique approach to your legislature, you have a unique approach to your state designated agency for Medicaid, you have a unique approach on how you want to do the state designated entity for the operation of the HIE utility.

So, we’re going to be bringing to you our understanding of the framework for these, and we’ll talk about that in a second. But the real goal is for us to provide the support and the facilitation that you make sure it’s tailored here, because quite frankly you will not have success if you try to transfer something from another state without really modifying it to your unique context and culture.
The five domains we’re going to be walking through, it’s very important to understand that they’re not stand-alone, they’re interdependent. As we -- the Legal Committee made their -- Legal Policy Committee made their presentation regarding -- they’re beginning to think about opt-in, opt-out, whether or not there’s going to be repository data in the HIE itself or it’s going to be somewhere else.

Some of those are Legal and Policy issues, some of those are Business and Technical Operation issues, some of those are technical architectural issues, some of them are going to be finance issues. It’s important that all of you look at these issues through the lens of your committee.

The lens for the Governance Committee, I think is really a critical one. It becomes the foundation for your vision, your goals, and your objectives for HIE. And, when you talk about governance, obviously I wasn’t at the legislative hearing, but what I heard at an earlier meeting we had today and just now, it is important that there’s two levels of governance that you need to think about. And each state is struggling with this.

You need the agility and flexibility of a state designated agency, a public/private 501C3 or an
authority to actually run the HIE utility and to make
rapid decisions to respond to what needs to be done to
phase out the utility and being able to support the
exchange health data and information.

But you also need some kind of governance
that all the work that you’re doing now regarding the
vision, the goals, the imperatives, has the state
designated entity demonstrate fidelity to them. Like the
FCC oversees communications, the FCC oversees Wall Street,
probably not a good example.

But there is another arching, so however
you set that up, either through the membership or the
state designated entity, or the legislative review, that’s
not a bad idea, as long as it doesn’t become a barrier to
the flexibility and agility and the state designated
agency to provide the service levels that partners want to
manage effectively, to fund effectively.

So, how are you going to juggle that two
levels of governance that’s going to be necessary? When
we look at governance we need strong leadership, we need
an open and transparent process, and in Connecticut that’s
a given that you’re going to be moving forward with. But
what is important, and what I hear in the conversation is
the value proposition.
Why should you be doing this? What are the outcomes and benefits that are going to be achieved? How do I participate to achieve those benefits? And so, very clearly the value of proposition for patients, providers, whether it’s a one or two physician practice, or a large state wide health system.

For a payer, academics and the research necessary to push forward improvements and better outcomes in healthcare. What’s the value proposition? And I think that this group needs to come together to identify what is going to make that compelling, achievable future for Connecticut.

And lastly, you need a creative safe harbor, regardless of who’s in the legislature, who’s Governor, who’s Commissioner, whatever you establish, you want to make sure that that governance structure, that entity is going to continue long after the politics change in one way or another. And that you can address some of the folks who say well, we’re going to outlive this.

We’ll be here long after you be gone and we’re going to play benign neglect. How do you create a strong governance infrastructure with a values proposition that folks can buy into and own, that’s going to sustain itself well into the future? Any observations or thoughts
COMMISSIONER GALVIN: That’s very well put, and I thank -- I certainly, having come from a practitioner history, am very interested in this. But my term is up at the end of December, and my future is subject to whoever becomes the next Governor. Theoretically the next Health Commissioner may be a dentist, a psychologist, it may be someone without much interest in this.

And I think everybody running for Governor is interested in health informatics, or at least states that. But I think that right on, you’ve got to build something that -- I hate to use that word, but transcends you know political change and doesn’t falter when one individual who champions the cause changes or leaves, or whatever.

MR. PETRUS: And as I go through these imperatives for the five domains, the easiest one is the technology. The absolute easiest one. There’s no questions that a vendor could come here tomorrow and give you an exchange, and some machinations and testing, and it will work. But will it provide you at the end of the day what you want as a value proposition?

So, the hard work is with all the other
committees around, the Governance, the Sustainability, the Legal and Policy, the Business and Technical Operation, and you have the easiest job.

Finance domain. The finance domain is a very challenging one, I think, especially, and the current political climate nationally, as well as in Connecticut, is how do you put forward the value proposition and a financing model that can be sustained in the future without calling it a tax, and without putting undue burdens on any single population?

What’s going to work in Connecticut? And then this goes into the whole analysis of cost benefit analysis. What’s the return on investment? If we are able to invest an accurate and timely data sharing information sharing that produces better outcomes then addressing chronic disease for example, and preventing deeper end services, more appropriate responsiveness in the ED.

If we can demonstrate savings that could be then invested into the continuation of the health information exchange, goes back to the value proposition. So, Finance really has to take a look at what’s going to be for Connecticut the best approach to a sustainable, long-term effort to support the health information
exchange. And you have to think of it as a utility, like 
electricity, like water.

We have no problem providing support for 
water, and sewage, and electricity, because we see it as a 
vital utility to the quality of life. How do you set out 
a value proposition that this is a vital utility to the 
quality of your life and be provided appropriate, timely, 
and accurate healthcare.

I’ve seen what some best practices are, to 
improve and continuing to improve the model of practice in 
the managing of heart disease or diabetes. Or proving for 
early immunization, or responsiveness in emergency 
situations. Finance has to work with that, Governance has 
to work with that, Business and Technical Operations has 
to work with that.

And understand, you’re enriched with the 
ONC money, it’s not enough and it starts stepping down as 
you have to come up with the matched dollars. Thoughts on 
the Finance?

COMMISSIONER GALVIN: I think one of the 
problems with practitioners is that certainly there’s a 
been a fair amount written about this, is they can’t see 
where putting the system in is going to be of much benefit 
to them.
And as Dr. Tom says, if you’re near the end of your career you begin to feel like you know, I’m not ever going to get my money back out of this system, that other younger physicians at age 35 is going to get his money back or her money back at some time in the future. So, I think that’s a relatively -- a relatively hard sell.

And I think all of us who practice have had the experience when they first had electronic billing of systems that didn’t work or weren’t compatible with other systems. And we all did a lot of backing and filling, and most of us lost money initially on that.

And if you’re a small time operation in terms your volume, not your intellect, a primary care or a pediatrician, you know, a $5,000 dollar loss is -- over a year or so is a big loss.

I think the other problem is people feel that they’re going to get a piece of hardware which suddenly won’t talk to somebody else’s hardware or -- and they’ll get stuck with that and stuck with repairs.

So, the things that Dr. Tom brings up are kind of -- are realistic you know, particularly if you’re in a onesie, twosie, threesie kind of organization where you don’t have 20 physicians 15 APRN’s and PA’s so that
you have some cash to buffer the system.

MR. PETRUS: And that’s true, and as you know nationally I yet don’t know the Connecticut, but most of your providers are in small practices, three or less.

COMMISSIONER GALVIN: Same here.

MR. PETRUS: Three or less. And that’s why we’re taking a look at and we’re bringing to you lessons learned about how you can move forward and supporting the adoption of EHR. One key is mandated by ONC you work with your Medicaid agency. And they’re going to have CMS and senate dollars, 100 percent dollars to share with providers, Medicaid providers to adopt EHR.

Some states we worked with Arizona in developing a co-op for EHR procurement, because they can get a better price and they can get a common set that fits into the technical standards for the HIE.

The other things that we’re seeing now, and vendors are getting into is the software and the service, or an application service provider approach, or cloud approach. Where you actually use it through the internet and you don’t have it on you laptop, you don’t have to worry about it on your desktop, and the ASP provider provides all the maintenance and support and you pay a small monthly fee to be able to use it.
So, there’s a variety of ways that you can find an affordable agile approach to electric health record, electronic medical record adoption that is doable even for small practices, and with senate dollars I think well affordable in an ASP or SAAS approach. But you still have to convince them on the value proposition. And I think that’s the challenge.

MR. MASSELLI: But one’s the electric health record, one’s the exchange. Give us a sense of red box size of exchange cost that are -- in the country right now, what are --

MR. PETRUS: You mean the fees to the individual providers?

MR. MASSELLI: Yeah, any data points that you have.

MR. PETRUS: I couldn’t give you anything off the top of my head. But for an individual provider typically the use of the health information exchange is very minimal cost if anything to them, depending on how you finance it.

MR. MASSELLI: Um-hum.

MR. PETRUS: The cost to an HER, you know CMS is saying you could do it for about $40,000 dollars.

MR. MASSELLI: Sure.
MR. PETRUS: Whether they can or not. I have seen, though, with the SAAS approach, you know, you’re looking at a few hundred dollars a month.

MR. MASSELLI: Well, let me ask another question then. How about the cost of operating an exchange? What data is out there right now? And I know it may not relate to Connecticut, but do you have any versus what the --

MR. PETRUS: Nothing I can give off the top of my head --

MR. MASSELLI: Um-hum.

MR. PETRUS: -- we have some information on that, I can share but I’d rather not give you a number without actually looking at it.

MR. MASSELLI: Yeah. Good.

MS. JAMIE MOONEY: I think this is important we need to figure out who benefits financially. Because really it’s not the physician who benefits financially, other than the need for these (indiscernible). It’s not the hospital, it’s really the payers who are not having to pay for additional testing, or more seriously ill patients.

So, somehow getting them involved in the whole financing profession I think it’s very important.
because that -- the beneficiary and the user of the system really are two separate --

MR. PETRUS: You’re absolutely right, and most of what we’ve seen is through the payer, whether the payer is the Medicaid agency and/or the other third party payer that you may have in your community. And payers again, don’t know what I don’t know in Connecticut, payers are usually very supportive of this initiative if the costs are reasonable.

MS. NANCY KIM: Can I just make a comment?

COMMISSIONER GALVIN: Yes.

MS. KIM: It’s Nancy Kim. I think a lot of the provider push back is not about necessarily adopting new technology, but it’s about placing the clerical burden on the provider. Because when you have an EMR you no longer dictate notes.

MR. PETRUS: Yeah, physicians will say if it --

MS. KIM: And you don’t get paid for the time.

MR. PETRUS: -- if it takes me more than 10 seconds to use the machine, I don’t want to do it. And so, some of your EHR providers are creating PDA capabilities where you know, you’ve got certain diagnostic
codes, you check off boxes. And if you go -- and most physicians that you see that’s what they have on their clipboards is check off boxes.

They check off the certain specs that they’re looking at, stats that they’re looking at, and then they pass it forward to the clerk to enter it. With technology today and PDA it could be. But again, you’re going to have physicians that are used to dictating and doing their own notes that are going to have a real change management issue with this.

The other thing is you’re not looking to have all of your providers in Connecticut on day one have electric health records and connected to the HIE. You really are looking, where do we start, you know? And typically you’re going to start with the Medicaid providers on the Medicaid side because there’s incentives there starting in 2011.

And you’re going to start with your health systems, your hospitals and your larger clinics, you’re going to start there and then you’re going to get to providers. So, how do you reasonably sequence this? Assume by the time you get -- when you get to the health systems many of them have docs who are part of their health systems they already -- and we’re going to look at
your hospital association surveys, they probably already have EHR’s or EMR.

Or, they already have some kind of HIE like or E-prescription or laboratory, radiological -- they’re already doing some of that, they’re already sharing data. That may be where they’re doing it. So, start where you’ve already got something that you can build on, it’s not necessary that you’re going to get all providers day one. If you look at that as your vision then I think you’re going to set yourself up for failure.

MS. KIM: But don’t you think that should be our vision over time?

MR. PETRUS: Absolutely. Achievable -- a compelling, achievable vision should be that at one point in time all of Connecticut sees the value of the improvement of healthcare outcomes through the appropriate need to know sharing of information, or whatever words you want to use. Because there’s some real clear things here.

It needs to be informed consent, it needs to be need to know, it needs to be demonstrated benefit in the care management that you’re providing for your patients. I mean, those kinds of things have to be weaved in as you move through a larger picture. Which goes to
the whole question and why we -- from the experience that we have there’s two major questions.

One, are you going to be an opt-in or an opt-out state? And both work. But like anything else what it’s going to need is if you’re an opt-out state providers and patients need to be educated on what does it mean to opt-out. What does -- why are we an opt-in state, here is the benefits we seek but here are still your rights and responsibilities if you want to opt out. But also some risk and consequences that come from that.

If you’re an opt-in state we have a program that helps providers educate their patients on the importance of opting in. And the benefits that can be achieved, and the controls around privacy, and security, and patient rights, around what information is shared, when, and to whom.

Because right now a tremendous amount of information is being shared about each one of us. And many times we don’t even know it’s happening because we signed those forms. And we don’t really know that we’re signing those forms.

One of the things I’m hoping from the Regional Extension Center that ONC is funding, that we’re going to have a more educated provider and patient
community that they understand what they’re doing when
they sign those forms.

But now we’re going to also be educating
them on the benefits of Connecticut’s Health Information
Exchange, that if they are in a car accident, or if they
have a chronic disease that needs to be managed, the kinds
of benefits that can be achieved.

The next is the technical infrastructure.
I think this is, as I’ve said, with the technology we have
today on the whole enterprise information management, the
sharing -- exchange of information data, enterprise
content management, the management of documents, the
digitization and the indexing of documents, the technology
is there, it’s affordable more than ever before.

And I think Connecticut probably has, when
we look at the electric highway, the internet capability
and broadband, Connecticut probably is pretty rich. You
might have some rural areas that have broadband
deficiencies, you think?

DR. DARDICK: Yeah, out in the north,
northeast --

COMMISSIONER GALVIN: They had some
problems out there.

MR. PETRUS: Yeah, then you may -- part of
this needs to take a look at how is Connecticut using the stimulus money, the ARRA money for broadband development in rural areas. I think you’ve got a significant grant from the federal government for broadband capability, so you need to make sure that those folks are part of this process as well.

That your Medicaid agency, DSS, is a part of this, because they have the Medicaid Information Technology Architecture Framework 2.0, which is the service oriented architecture. And then you have ONC’s approach to the National Health Information Network, and then Dr. Blumenthal and Rick Freedman are trying to get this together with something called, “Connect.”

And then you also have what they’re doing with the new CMS HIT incentive dollars and how are they going to be using those dollars and what kind of technical architecture is going to fit there.

So, basically you’re really starting to take a look at, we’ll survey with you, what are the current technical capabilities, the technical standards that need to be considered as you built this utility and build the plugs necessary to have the capacity to share information among all the key stakeholders.

MR. MASSELLI: I should just note that we
have black fiber to every school in the state of Connecticut. So, there’s a pretty robust fiber system in Connecticut, the fiber tech owns the state leases on a 20 year lease. And so, we should have the sort of backbone for something if we could piggyback off of, that group CT has been very reluctant to open it up. But it’s got real capacity to build upon, so --

MR. PETRUS: And we will be surveying to find out where the technological strengths and gaps are that will be necessary to support this utility. Anything else on technical?

Business and Technical Operation. Business and Technical Operation has to focus on a variety of things, but this is really the nuts and bolts of the state designated entity that’s going to operate your utility. And going to the legislation -- legislators concern about you know, the oversight.

Part of that oversight starts with you creating the set of policies and rules and the operational framework for the SCE, and what’s going to make sense for them, and how they’re going to manage the business operations and manage the technical architecture to make sure the utility’s on 24/7, 365 days a year.

That you’re clear on what the service
levels are going to be. How are those service levels
going to be managed, what kind of project management
office are they going to have.

How are they going to make sure that they
can meet all of the reporting requirements that you want
to put on them for the State of Connecticut, ONC’s going
to put on them for the cooperative grade list. ARRA is
going to put on them with regard to the stimulus dollars
that are being used, and the kind of metrics and measures
that you want to have coming out of this utility to
demonstrate that proposition that you’re bringing value
and a return on investment.

So, it’s not just the business and
technical operations of making sure the utility is turned
on, it’s really the kind of framework and set of
responsibilities and expectations your going to have for
them through the full nuts and bolts of the operation of
the utility. And that also includes working with the
extension centers around the training and education of
patients and providers.

COMMISSIONER GALVIN: And I really have to
go back to some things that Attorney — Lisa was saying
that you know, we really -- when you get to the point of
this overall strategy it’s really almost a philosophy in
some ways. And the hard stuff is down three and four
layers below.

For instance, if somebody asks you what is
the mission of the United State Navy a lot of people might
say to sink other people’s submarines, or to make sure
that people don’t plug up the Straight of Hormuz or things
like that. But -- which is part of it. But the overall
mission of the Navy is to keep the sea lanes of

communications open.

And that’s almost a philosophical issue.

Then you’ve got to get down and think about what kind of
deterrents you want to have, do you want to have carriers
or air breathing bombers, or missiles, and the like.

So, I think probably one of the key things
that this committee has to do is to come up with an
overall philosophy about what is it that we want, because
we’re never going to get near where we want -- if you
don’t know what you want -- you know, it’s like going to
the museum and I say to you, I don’t know, I can’t define
art but I’ll show you some when I see it.

MR. PETRUS: And it does start with vision.

This compelling, achievable future with current and future
resources, really defining that. And you know, I’ve said
it earlier and I say it again, the technology is the
simplest piece of this. Building this together, and in creating the infrastructure, business and technical infrastructure necessary to manage it and meet all the reporting requirements.

And the other thing that I forgot to mention in the Business and Technical Operations, that one thing ONC wants the state to continue to do and have a finger, a hand, and foot in, is to make sure that the needs and requirements of your Medicaid agency and your public health agency are fully met. Very critical.

This is not just private/public, it’s private/public with a great emphasis on public health, which the state is responsible for and for Medicaid because of the large investment of dollars that go into Medicaid, we’re talking billions of dollars.

MS. MOONEY: Can I just ask a question? I’m sure it’s in the presentation somewhere, but I’ve heard from Dr. Galvin, he already said it a few times, what is the approach to getting the vision held down? How -- I imagine that some fundamental first step --

MR. PETRUS: It is in this presentation, yes.

MS. MOONEY: Okay.

MR. PETRUS: And why we’re going through
all of this is because we’re going to charge you -- we’re going to have a meeting -- and the next meeting is going to be a facilitative meeting around the vision.

    MS. MOONEY: A visioning session.
    MR. PETRUS: Yeah. The Governance. I mean, --

    MS. MOONEY: Is that going to be this whole group, is that going to be a smaller group, what --

    MR. PETRUS: Well, you don’t have a separate Governance, we’re told this is your Governance group.

    MS. MOONEY: Um-hum.
    MR. PETRUS: So, we --

    MR. MCKINNON: It’s this group, in the specific instructions for the people who represent state constituencies to take away some homework and then bring it back to that meeting.

    MR. PETRUS: That’s right.
    MS. MOONEY: And does that mean the next Board meeting or is there another -- because that’s a month away.

    MR. PETRUS: We’re anticipating that we have a lot of work to do and you do, that’s -- if you -- I doubt if you could get it done faster, but you need to go
back to the constituency that you represent and answer some of the questions we’re going to give you today. And then we’re going to come back and facilitate that.

In the interim we’re going to be doing some surveys and looking at what’s out there and what’s been documented, and we’re going to leverage the work that was done on the June -- June or July, 2009 HIP strategic plan for Connecticut. We’re going to go through that and all that background material.

So, we’re going to bring back to you what we see as a straw man vision, mission, goals and objectives for you to react to. So, we’re not going to come back with a blank sheet of paper. From all the interviews that we had in the last month, all the research that we’ve done, here’s what we see, and you’re going to come in and say, well here’s what my constituency sees.

And it will be a working session, it’s not going to be a presentation. It will be a facilitated working session out of which we will sculpt a division, mission, goals and objectives, and send them back to you for validation.

MS. MOONEY: I’ll ask you one more question and I don’t see it in the presentation. Is there again, a
timeline of the things we’re --

Mr. Petrus: Yeah, yah.

Ms. Mooney: So, that’s coming.

Mr. Petrus: We have a high level one in here. We made some assumptions before we had any meetings of what we thought you had in place. Some should simply be modified and so at the end of this week you will get a Microsoft project work kind of structure depth chart. More details than what’s in here. Good question.

Mr. McKinnon: And different.

Mr. Petrus: And different.

Mr. McKinnon: More detailed and different.

He’s glossing over the assumptions. The other thing is that as a whole group you may think this is too large a group for the session. From our experience this is as large as you can -- you can still do it with a group this large. Any larger would be terrible, but this is -- it can be done with this kind of size of group.

Mr. Petrus: And we’ve done it with larger groups.

Mr. McKinnon: It was terrible. It was painful.

Mr. Petrus: But it was very difficult.

Ms. Mooney: Painful?
MR. PETRUS: It’s like herding cats, you know. I mean, I think the Chair of your Legal Committee probably has a similar job. When you have very strong personalities and you try to herd them around, the more of them that you get, the more challenging it is. And if they’re all lawyers, God help you.

MS. BOYLE: Thank God, they’re not. Actually, most of them are here, this is how dedicated my group is.

MR. PETRUS: Oh, good, good. Okay, Legal and Policy domain. This is also an extremely challenging one. And I’m glad you’ve got an 800 page document to look at. We’d like to see it, just to see what’s in there. I’ve done a lot work in the whole areas on confidentiality in clinical settings from the 70’s forward, when the National Privacy Act of 1976, I think it was.

And from that came the legislature around mental health, substance abuse, later HIPAA, and what you really find is that many states have created more rigid infrastructures around those confidentiality policies than were actually the intent of the original legislation. And then the USA Patriots Act also built in some other kinds of challenges for us. And then HIV Aids, and STD came in.
The real issue around Policy and Legal is that the confidentiality, privacy and security legislation, and rules that had been established were never to be established as barriers to improving healthcare. They were established to make sure that the appropriate process of informed consent and need to know, because that was getting the patient involved.

And when I was a clinician and I would -- all the times that I’d want to share information on behalf of my client, I never once had someone say no you can’t do that. Because you do it through information and referral, you do it through education, referral readiness. And if they know what you’re -- why you’re doing this and the importance of having that test, and the importance of me getting back the rest results were such that it was beneficial, there was never a problem.

If you take a look at Legal and Policy and harmonizing the federal and state, you also need to take a look at how do you work with the Business and Technical Operations group and the Governance group and educating the community of clients and patients on how important this is and what the rights and responsibilities are.

I am very concerned that the HIE initiative in this country hasn’t got a lot attraction from media and
visibility yet. There’s other things going on in Washington, as you know, around healthcare reform.

But I’m very concerned when we saw what happened with the initial discussions around end of life counsel, and the legislation that basically said that providers should get paid for having this conversation, what you wanted to do if you were critically ill and it was towards the end of your life. And that got turned into death panels.

And if any of you had read the legislation you’d know that they were basically good physician practice. What’s going to happen if certain sound bites get out there about Big Brother having all this information on you and exchanging it? And I think you need to get ahead of the curve, Legal and Policy, Business and Operations, the Extension Centers, and start to educate people what this is really about.

In fact, it’s going to be more organized and have clearer policies and understanding the law that we have now with the sharing information that goes on. And there’s no health information exchange knowledge out there, and there’s not this kind of governance structure in place to provide the vision and the direction for the appropriate sharing of information.
So, this is a very critical domain. And the primary responsibility I think of Legal and Policy is not just the harmonizing, how do you build the trust of the patient community and of legislators who may want to get sound bites that this is -- got a value at the end of the day, and the rights and responsibilities of the patients will always be respected. How do you get that message out? I think that’s really going to be critically important. Questions on this?

MR. PETER COURTWAY: This is Peter Courtway. Quick question, in regard to the harmonizing, we talked about harmonizing federal and state, but is there also a process that actually takes place in states that have done this, you know, that actually harmonizes local health information exchanges also?

Is it important in regard to the chain of trust if you will, trusting about that flow of information that all of the local exchanges as well as the state exchange, operate with the same informed consent?

MR. PETRUS: If they’re going to be part of the utility, yes. Because you could have health systems that say we’re going to keep our exchange but we’re never going to send anything through the state utility.

And that’s why I think this group has on it
private/public participants from NY, I think, working with your Connecticut Health Association or Hospital Association and your Society of Physicians. It’s going to be really important that they come to the table.

    I think there’s three, maybe four pieces here. One, I think you have a very important job of awareness, making your community constituents aware of what’s going on here and as much transparency as possible. The second thing, once they’re aware that you really helped them understand as you start sculpting out some steps and directions and start to flush out what you’re going to do in each of these domains.

    And that you provide opportunities for them to participate, and they cannot participate well until they are aware and understand. Then, the hope would be, the fourth piece would come, is ownership. Hey, I’ve been aware of this, they provided the information, I see the facts here, I’ve had opportunity, they have input, I’ve been able to participate.

    And yeah, in my health system or in my practice I’m going to champion this, I’m going to support it because it’s been transparent from the awareness piece to my own participation. I think that’s how you try to harmonize the separate entities of it. Other thoughts on
Legal and Policy?

Planning framework, I won’t spend a lot of time. This is something that we’ll be using in our next meeting with you. But really here’s what we think you should start considering, this is a takeaway for you as you work with your constituents.

Is that when you think of the set of goals for the vision, is it enough that you’re just going to have a utility out there that shares data in a raw form, like plugging into a plug to draw electricity, or do you want to have the investment of these dollars in your time to really be a part of -- you talk about new generation coming up, a part of really transforming healthcare in Connecticut.

A real improvement in how we share information, but also how we take a look at information into knowledge into action. The simplest health information exchange could be data exchange. You’re sharing raw data and someone else takes a look at and does something with it. You could be sharing information, you’re sharing the electric health record.

But you could also be sharing knowledge because you could start tracking information if you create some kind of data repository, with de-identified
information to say people in this ZIP code with these
demographic characteristics with regard to the kind of
support that the provider -- managed care they’re being
provided around diabetes, are demonstrating significant
improvement and outcomes than we’re seeing over here in
the management of diabetes in this other ZIP code, what’s
the difference.

And start to communicate what may be they
be doing here that is on the knowledge level that they
could act on here or that the Public Health Department
could improve their education and wellness promotion here
because it’s been really successful here. Or, other kinds
of prevention, or early intervention services need to be
done here.

Then you’re really talking about the health
information exchange and partnership with health systems
and payers with Medicaid and public health in the academic
community, really looking at how do we improve practice
around very specific healthcare issue. And that means
really developing a broader enterprise approach of how
that data and information become knowledge.

That could be acted on by all of you that
are participating in it. Acted on by the Public Health
Department, acted on by the Department of Social Services,
acted on by the health systems and hospital that participate or providers, acted on through the research focus that happens in the academic community.

So, when you think about where you want to go, this achievable future, is it just that people are using a health information exchange, then that makes our task and your task a lot simpler. If you’re talking about really a transformational approach to health information exchange, which we know is the vision that HHS has for ONC and CMS, then that’s a different set of criteria.

Thoughts on this?

DR. DARDICK: Well, I have a thought that sort of goes -- this is Ken Dardick. Be careful what you wish for with respect to this aggregation of data. First of all, it certainly raises immediately the “Big Brother” spectrum and the “Big Brother” question that you raised earlier. If all of that data is there, even if it’d de-identified, who’s going to look at it?

MR. PETRUS: Yeah.

DR. DARDICK: As you were talking I was thinking about a couple of things. One of them was the development of the story of Lyme Disease. It was essentially, as I understood it, you know, a group of families, a group of mothers, who identified clusters of
cases of what was said to be Juvenile Arthritis among their kids in a certain neighborhood or a certain community in Lyme.

And one of them in particular was quite active about it and trucked them all down to Yale, and one thing led to another. I served for a while as the Director of Health and I would get phone calls with concerns about cancer clusters. My neighbor has this, and another neighbor has that, and you know, you’ve got to look into it because we’re concerned that there’s something in the air, something in the water.

My concern with that much data is that you’re going to be putting out a lot of fires, and I’m not sure that the promise of our being able to act upon that data. I mean, I think of the government’s Atlas project, which clearly demonstrates that certain parts of the country have different degrees of health utilization than other parts of the country.

It’s not yet clear that that’s actionable. I mean, we can look at it, and we can say wow, costs here and here or cost there or here, isn’t that a big difference. But we don’t quite know what to do with it. So, my concern is that that may be too big a vision.

I mean, yes, it may be achievable, and it
may be doable, but I would have some concerns about putting that out there too early.

MR. PETRUS: And that presentation is exactly what you need to be discussing about what kind of data, stewardship, ownership, and data use you’re going to have, phase I, phase II, phase III, if you’re going to have any kind of repository de-identified data. Because I would take a look at it for example, what I’ve seen other states do in our counsel would be around chronic diseases.

Very specific things that we’re doing with heart disease, and diabetes is a good example. Are there patterns there that might be helpful in improving the care in management of those chronic diseases? But that’s what you --

DR. DARDICK: Until you can start matching that with genome specific information --

MR. PETRUS: There you go. But those are the kinds of things you take a look at, or you say we’re going to have a utility that shares data and there’s no repository anywhere.

MS. KIM: I have a -- oh, I’m sorry, go ahead.

MS. MOONEY: I was just going to say, I
think as we walk through this piece we should pay careful
attention to what the man per use goals are around for
information exchange, because they’re all about
transforming data.

MR. PETRUS: Yeah, they are.

MR. MOONEY: A fact which we were saying a little bit earlier. So, I think we have to pay attention to what those goals are because there may be some things that we can go over directly here. My first point. My second point, is I sit on the Substantive Board for the state and we had a discussion last week -- the Childhood Obesity Task Force had a discussion. And they started talking about the same idea, de-identifying data, looking for patterns in certain parts of the state.

And there was a very big concern raised suddenly using that data to say that certain children are not -- because they’re heavy they’re not as intelligent or they don’t -- all these other things that really don’t have any basis of fact, but people are very very worried about it. So, I understand your concern there that that kind of thing and other pieces that come popping up.

MR. PETRUS: And that has Business and Technical Operations components, and that has Legal and Policy components, and it has Governance components.
They’re very interdependent. And comment on the meaningful use, very true. Those rules are out there, they probably will be finalized in June or July.

They’re not that onerous but it -- I think they’re a good place to start because they are pretty innocuous. And I think, Mom and apple pie.

MS. MOONEY: And a bad transformation, if you really listen to what they’re saying.

MS. KIM: I think there is an opportunity to transform clinical care. I think we can take our lead from CMS, they have quality metrics out there that are already processed and being measured, a lot of them around chronic disease. And there are clinical decision support things that we could do to improve processes of care and outcomes. Intermediate clinical outcomes.

I think what’s not actionable is changing mortality, thinking that we’re going to change mortality with some proximal IT intervention. But I think there are process measures that we can look at that will matter.

MR. PETRUS: And there’s the harmonizing that has to happen, because you don’t want to over promise, and you don’t want to also get information out there that’s going to raise sound bites that can be tremendous barriers to you regarding “Big Brother” having
all this information on you.

COMMISSIONER GALVIN: And just to add onto Ken’s comments, we’ve been doing some work with the Genomics Department out at — up at Storrs, and they really — they really have come along way very rapidly with testing that can elicit the human genome and understand things about how pharmacology affects different individuals.

So, I don’t think the — I was surprised they’re much more close to clinical you know, common clinical application that I previously thought. But I think you bring up some very interesting things from a practitioner’s point of view. And kind of one of the things is, well what’s in it for me? I mean, what — how am I going to use this information? And if I get, I think what you bring up, is if I get a lot of information and I don’t have any good use for it, what’s the point?

Or, if — I mean, suddenly somebody — if suddenly you could get a printout which would tell you the exact time of death of everybody currently in your practice, would you want that? Probably not. Certainly not your own, but you know — and it’s the old public health thing.

If you knew somebody — if you could get
data saying somebody is going to -- has a terrible disease
which will kill them in 10 years and it’s incurable what’s
the point? Do you want to be the guy who has to tell him
that?

MS. KIM: I think the benefit providers
have to pay for performance, I mean that’s --

COMMISSIONER GALVIN: Yes.

MS. KIM: -- what’s in other models --

COMMISSIONER GALVIN: Yes.

MS. KIM: -- and certainly practice
measures or performance measures. It’s more difficult, I
think to have outcomes measures such as mortality and
death, because again there are so many other factors that
predict that beyond what we can change. But 40 percent of
chronic disease is behavior.

COMMISSIONER GALVIN: Yeah.

MS. KIM: That’s a lot of kind of health
that we can affect as primary care providers and providers
in general.

DR. AGRESTA: I wouldn’t underestimate what
good information with process change can do.

MS. KIM: I agree.

DR. AGRESTA: And collaboration between
providers, collaboration with community. I mean, when you
provide good information the capacity to change things, you know, such as when it becomes clear that having soda machines in a school increase the obesity rates.

And there’s a lot of things that can be, with good information, you can figure out there’s no parks, and a safe park in a safe area, and communities can make changes. There are different --

MS. MOONEY: And supermarkets, we learned about --

DR. AGRESTA: And supermarkets.

MS. MOONEY: -- in New Haven. They said there’s no safe supermarkets in New Haven.

DR. AGRESTA: So, good information leveraged correctly can actually have tremendous benefits to populations at a much greater rate than just the care of patients. And we need to think about that, we need to be able to plan towards that, and we need to be cognizant of the fact that information can be used inappropriately, it can -- you know, data can be misconstrued what it’s used for, and we need to be very careful about that. I think that’s important.

COMMISSIONER GALVIN: Good thought.

MR. PETRUS: Next, is the objectives that we’re laying out for the strategic and operational plan.
We very strongly try to come forward with this as a consensus process and interim consensus process working with this entity, the Steering Committee, and other groups as we gather information.

We’re going to start way out here and get down to an environmental scan, what’s out there, what strengths, what capabilities, what are the gaps around the strengths, weaknesses, opportunities and threats. What you need to do to go from where you’re at now to the future state, and then actionable recommendations for moving forward starting with the strategic plan.

And we’re trying to do it in parallel so that the strategic plan is going to be a little bit out ahead of the operational plan but not a whole lot. Because you have a June deadline of the strategic plan, and the operational plan we’d like to follow that as closely on the heels as we possibly can so that you can start with your cooperative agreement drawing down those dollars quickly.

Key questions that we’re going to try to answer, and I think that you should be thinking about as your work with your constituent group too, is the whole question that you all raised at the beginning of this, is the adoption of electronic health records and provider
practices and clinics and electronic medical records in hospitals.

And where are you, we will share with you some of the landscape that we’re seeing regarding vendors. And answer the questions regarding Governance, Technical Architecture, Business Technical Operations, Legal and Policy, and Finance, and working through these questions.

What we do is we start at the bottom and defining the ONC five domains aligned to the target state vision and goals. What we will be bringing to you at the next meeting will be the straw man. We think it goes a lot faster than having wax sheets and newsprint on the wall and doing brainstorming. We’re going to --

COMMISSIONER GALVIN: No brainstorming?

MR. PETRUS: No brainstorming.

COMMISSIONER GALVIN: Awe.

MR. PETRUS: I’m sorry. If you had -- if this could be a 30 week engagement, yes we could do brainstorming.

COMMISSIONER GALVIN: I love the butcher paper.

MR. PETRUS: We’ll do some, we’ll do some, alright, we’ll do some. We’re going to bring you a straw
man and you could butcher it.

COMMISSIONER GALVIN: Okay.

MR. PETRUS: So, we’ll bring a straw man of what we see as the Connecticut centric approach to the five domains. Some filled in and some not. Once we go through the work with you next week around that and around the vision goals and objectives as you see them, then we’ll go forward with the following workshop, which is really going to look at the current capabilities, strengths and initiatives and the gaps.

Once we do that, then we will work with you on an alternative analysis. We’ll say for this gap here’s two or three different ways you can skin the cat. Here’s the pros and cons, similar to what you’re doing with opt-in and opt-out, that’s what we’ll be doing with you and trying to fill in those gaps. And than, that will lead to the documentation necessary for the operational plan.

So, it’s like building a layer cake, and we’re in a transparent process moving forward through these four steps with you. And each one of these steps, we will be coming in with straw men directions, recommendations, and you can butcher them, you can say it’s off base. We find it’s very helpful to come in with something that we can do ready, fire, aim with.
This is the steps that we’re taking, this is a takeaway for you. We also think that you should be taking a look at some of these as well as with the information that you have available. Now do you all have a copy of the June, 2009 HIT strategic plan? Okay.

Critical success factors, these I think are really important, and I think that they’re present in Connecticut. You have strong political support from the Governor’s office, the legislator may be asking a question. You’ve got the funding in place, you need to define what the incentives are going to be.

I think that from what we looked at that it’s currently the technical infrastructure, and then what we heard today about the fiber capabilities that you have out there. That’s much further ahead than many states, whether you can leverage it or not is another question.

But these are the kinds of things that as we go forward we’re going to keep bringing back to you and we’re going to be testing back to these as the critical success factors. And I’ll turn this over to Mr. McKinnon.

MR. MCKINNON: So, there are some details on here you can read in your ledger. I think we should think about the four phased approach. So, following that
same model, that same layer cake from the bottom up. So think of that in terms of as we move forward the very first thing is really to get our hands around the vision and strategic goals, which is what the next meeting is about. And more on that in a minute.

And then -- and parallel with that we will be doing a lot of information absorption, a lot of things that we really need produced, a lot of information that’s available, easy to get a hold of, filling in the gaps so that we can go and get all the information we need.

Because we need to bring that together with the vision and objectives into the second phase where we begin to identify current capabilities versus the needed capabilities and the gaps that are there. The thing that you really need to blend to give you.

So, the second phase is to establish, essentially what’s going to be in the strategic plan by comparing the needs versus current capabilities. And then the last two phases is pulling it together in a digestible form from the -- both from NRG’s point of view and also from ONC’s point of view as to fit with the particular guidelines or it won’t do us any good at all.

MR. PETRUS: And when we look at developing the strategic plan in the phase III, we will give you the
 strategic plan for vetting and then submission to ONC. At
the same time we’ll be giving you the roadmap for the
operational plan.

We would -- that will -- at least that
you’ll be one, taking a look at the strategic plan and
then you will be taking at a high level roadmap for the
operational plan, the nuts and bolts necessary to get
there.

So, you’ll be betting two things at one
time. Then you will, whatever finalization we need to do
the strategic plan goes onto ONC, we’ll do a workshop
around the roadmap for the operational plan, lock that
down, and then flesh out the operational plan while we’re
waiting for ONC’s feedback on the strategic plan.

At some point we need to have conversations
with ONC to see if we could submit the operational plan
while they’re still reviewing the strategic plan, because
it may have an impact on the operational plan. And right
now ONC is significantly understaffed.

And all of these plans are going to be
coming in at the same time as did the grant applications,
and you went through that. So, we don’t know what we
don’t know about their capacity to turn around the
strategic plan so you can finalize your operational plan.
So, we’re going to be very flexible and we
built that into our work plan to work with you all that
if, you know, we got to put more time here or less time,
that’s okay.

We’re going to do whatever is needed to
meet ONC’s guidance on when to put in the operational
plan. If they want us to wait until they finish the
review, or they’re willing to take it and review them
simultaneously, that would be great.

MR. MCKINNON: So, on page 25 you can see
against each of the tasks the -- the mean outcome
deliverables that are related to the (indiscernible). And
then there’s a question not all of it is scheduled. This
is the thing when the imaginary timeline that was part of
a proposal.

It’s correct in a sense of 15 weeks, but it
isn’t correct and needs to be corrected in the sense of
the details now that we understand better the structures
that we’re working with, the people we have to speak to,
the documentation available, the process that we’re going
to do for visioning.

That changes some of the internal things
and that’s my task for this week, is to come up with a
version of this that’s actually meaningful and has real
MR. PETRUS: We had thought, and based upon the June HIT strategic plan, that you had already come to some consensus on the vision and goals for the HIE. So, that’s why we anticipated the front would be a little faster than it is. We’re okay with that because it’s not going to stop us from doing the environmental scan and the inventory of capabilities.

But we will you know, revise this, but the outcomes will still be the same at the end of the day for the strategic and operational plan.

MR. PETRUS: We want the information absorption, we’re looking for documentation. This is a piece of detail that’s on here that we don’t need to discuss you understand, but that’s part of the current tasks is to find as much documentation.

MR. PETRUS: One of the things, though, if you know of anything that Warren may not be aware of, or the Commissioner may not be aware of that in your association, in your academic setting, through your health system, that you have data regarding, or information regarding EHR adoption regarding technical architecture.

We’re going to do surveys, but if there’s already been some studies out there that you know of that
you don’t think the state now has, if you would please
give them to Warren, that would be really helpful.

    We will be meeting with key players around
the Hospital Association or Medical Society, BSS around
Medicaid, and public health around their initiative. But
if you think of anything out there, any research that’s
been done, especially in the academic area, if there’s
anything that’s been done that you think would have an
impact on this, that would be really helpful to bring
forward.

    DR. AGRESTA: and that’s primarily sort of
state specific research you’re really looking for?

    MR. PETRUS: Yeah, Connecticut specific.
But if you have something that’s national that you think
would be helpful to this state, and helpful to us, around
lesson learned, absolutely.

    DR. AGRESTA: Okay, so even lessons learned
and things like that?

    MR. PETRUS: Yeah, I would think so. We’re
bringing in our repository of research. But understand,
this is new stuff. In an organized process for a national
health information network, this came out in August of
2009. There’s been a lot of work on it, obviously, but
it’s fairly new.
I don’t -- informatics has been around since the 60’s, the HL7 group has been working since the 70’s. But when you really put this all together in a unified approach to the National Health Information Network, we’re talking about something in reality, tangible reality, is less that a year old. So, we may not have all of it, so if you have something, bring it forward.

MR. MCKINNON: Yeah, any information related to this at all. We don’t care if we end up not using it because we really use it or it’s too much, too detailed, we’re very open to seeing everything, just to see what we may need and what we don’t have.

MR. PETRUS: And especially the 800 pages of --

MS. BOYLE: Actually, there’s a lot of documents our committee has actually, you know, collected that I’ll give to you.

MR. PETRUS: Well, we also hope that you’re going to give to us your synthesis of what it all means.

MR. MCKINNON: So, another part of our process is to do individual interviews with many key players so that we really find out what we need to know and what else we need go and find out from other places.
So, we’ll be arranging those in the next as well. Many of you will be involved in those.

MR. PETRUS: And we’ll do those both individually and by group, and if they have to be done by phone we can do them by phone as well.

MR. MCKINNON: I hope most of the people whose names are on this recognize why their names are against what they’re against. But this is our understanding of how the statehood of constituencies are represented in this group.

And the reason for even mentioning it is that as part of our visioning work when we do the consolidated workshop, we’re going to be looking to the named individuals here to, between now and then, have taken the questions that you’re going to see on the next page to their constituencies to come back with possessions on those questions.

MR. PETRUS: And understanding that you may not be able to -- a person’s that’s, for example, representing the consumer, not necessary to be able to speak for all consumers, but give some sense of what you see as the concerns, the strengths, the issues, the value proposition. And the same with all the rest of you.

We understand you were not elected
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representative of the group that you’re the lead constituent of, but we need to at least tap into you and your network, and that we’re not able to do, you know, five, or six, or seven, or eight forums around the state with different constituents.

MR. WOLLSCHLAGER: If I may, the only point of clarification up there is that Dr. Carr actually both letters of appointment from your appointing authority, both mention public health. I don’t know if you -- when there were actually two different areas.

So, my -- I’m not so sure that you were the public health designee, but you may been. It also has Josh Riser down as the Public Health designee as well.

DR. KEVIN CARR: I wasn’t the Public Health designee, but I worked on public health reporting in other state.

MR. WOLLSCHLAGER: I know you know the subject matter, but in terms of your actual authority --

DR. CARR: And I will rely heavily on the Department of Public Health.

MR. WOLLSCHLAGER: My point is you have two areas you have to represent, not just one.

DR. CARR: Okay.

COMMISSIONER GALVIN: Excuse me, where are
we in your presentation?

MR. PETRUS: Almost done. One more slide and we’re done.

COMMISSIONER GALVIN: Okay, because we’re coming up on the magic hour, what happens is people start to disappear out the door.

MR. PETRUS: We have, I think, only one more. Two more.

MR. MCKINNON: This is the important one, these are the questions. So, when you know what your stakeholder constituency is, and see you actually think it’s something different, by all means let us know. It’s not meant to be restrictive. The only thing I would say is that we have astonishingly high expectations about the quality we’re going to get back.

MR. PETRUS: Well, this is Connecticut, after all.

MR. MCKINNON: Oh, yes, it is.

MR. CARR: Do you say that to all your states?

MR. PETRUS: Quite frankly, no. There are some states who are -- the state and us both knew that there was going to be big challenges.

MR. MCKINNON: So, I mean, we discussed all
the plans already, so that’s we are and where we’re heading.

MR. PETRUS: Also, as a takeaway is an appendix in this document so that you would have what our task plan is and how we’re going to go forward with each of the individual task. You have the details from the approved work plan with the state, we will be moving to modifying and updating the work plan, but the task will remain the same.

If you have any questions or concerns about the task plan, or you see any red flags or any gaps, this is a transparent participatory process, let us know. And we’re really flexible, if it’s something that’s really outside the scope of work, we’ll go to Warren and say what do you want us to do.

MR. MCKINNON: And there’s also a sales pitch for the wonderful (indiscernible). And there’s these contacts so that you can find people.

MS. MOONEY: Would it be possible to get an electronic version of these questions?

MR. PETRUS: We can send you a PDF file, absolutely.

MS. MOONEY: I was even thinking something that we can --
MR. MCKINNON: You want to be able to -- supply the PowerPoint version of it, yeah.

MR. PETRUS: Yeah, we can do that, yeah.

MS. MOONEY: Yeah, thanks.

MR. MCKINNON: Just of interest, what -- we always supply a PDF version, and that’s the version that we presented. We’re quite happy to give you the slides and you change them, but that’s not the version that we presented.

MR. PETRUS: Yeah, the question is, just version control. If someone -- if it gets out there and someone starts changing our scope of work and expectations and --

MS. MOONEY: I’m just imagining going back to the office and me having to type these things up.

MR. PETRUS: We can do that, we can do that.

MR. PERKINS: If just -- like a word document or something.

MS. MOONEY: That is exactly what I want, just so we can put our answer in and then give it back to you.

MR. PERKINS: You got it.

DR. AGRESTA: And that raises just sort of
a separate question in working in groups like this and projects that have -- are complex like this.

Is there going to be a structure in which we’re going to collaboratively submit information, a witkey of some sort, a means by which we can kind of -- you know, things that are being worked on in the Legal and Policy group can be already sort of available to us. I mean, we need an infrastructure.

MR. PETRUS: We did talk about a collaborative site, either a share point site, and the Commissioner is not here now. But we’re looking to do it to see if we can provide a collaborative site that you can all have access to, where all the project artifacts would be and that you can add your stuff to it and look at other folks.

MS. MOONEY: Not wanting to reinvent the wheel, take a look at the Substantive site, because they’ve done a really good job of having all the subcommittees work up, there are the minutes, there’s a common place for all the documents and stuff, so we could just --

MR. PETRUS: Yeah, and several states have done that. California has done a very superior job on it. I think that would be good because then if it’s out there,
except for things that might have an impact on your
procurement in the future, any stakeholder, anybody in the
public, anybody in the legislature wants to go out there
and look at it and submit comments to you, they’d have the
ability to do that.

DR. AGRESTA: Yeah, it needs to be thought
out, carefully thought about how it’s set up, structured.

MR. PETRUS: That’s right.

DR. AGRESTA: But we need it to be able to
communicate with each other, too, just as much as
anything, I think.

COMMISSIONER GALVIN: You’ve got to be a
little careful of that. If more than two individuals
communicate it constitutes a public meeting and you’ve got
to notice it, and that’s how we tread -- we thought about
that with stem cell, but you’ve got to be very, very,
very, very, very careful with that.

And it’s got to -- it should be completely
transparent, Lynn has a lot of experience, that’s your
bag, is in transparent communication. She’s just
finishing up an advanced degree in that discipline. And
the meeting -- the minutes of course, are published, and
the public is always welcome. And I think with any kind
of a website that it’s got to be available to every
citizen in the state.

And so, if you have to, you know, I mean if you want to be able to say hey Tom, let’s go to lunch, I want do that on that kind of site.

Now, we’re coming to the end of our time together and this might be a -- we are required to solicit public comment and this is -- will be as good a time as any for us to allow these learned gentlemen here to solicit public comment or questions while we’re all still here. No? Okay. Very clear presentation.

MR. PETRUS: Thank you. That’s our resident. She also lives in Connecticut.

COMMISSIONER GALVIN: Okay, the next meeting --

MR. MASSELLI: So, you are experienced in herding cats?

COMMISSIONER GALVIN: The next meeting is at the same time of day, 12 to 2, 19 April. Yes, sir?

MR. COURTWAY: Peter Courtway. So, the takeaway for the advisory members is to look at the constituent slide that Gartner presented and slide 30, which has the list of questions to be answered and be prepared to present their constituent’s answers to those questions at the next meeting?
MR. PETRUS: Yeah, we will facilitate a discussion and there won’t be a formal presentation you’ll have to make, but as we start to answer some of these questions you provide that input based upon what you’ve got.

If there’s formalized things you want to also document and submit -- and you can submit them to Warren any time, you don’t have to wait until April 19th to do that. That’s also another way we’ll gather information.

COMMISSIONER GALVIN: Okay, and this is critically -- we’re at a critically important stage and we need you all to participate. I think we’ve been at a critically important stage ever since we began. But now we see some daylight, we’ve got some funding, and we need to decide which way we’re going to go.

We can’t go and -- it sounds like a lot of money, but you can blow 7.29 million dollars very rapidly and end up backing and filling and not getting a significant product, which I don’t think Gartner would put up with.

But we want to make sure we get maximum use out of this because I think I will use the first to determine whether the feds are going to give us more, or
how much more they’re going to give us. Any further
comments, questions?

MS. BOYLE: I just had one thing.

COMMISSIONER GALVIN: Yes, Lisa?

MS. BOYLE: At the public hearing on the
legislation the issue that came -- one of the issues that
came up was apparently -- and I wasn’t there, so this is
what I’ve learned from outside, that apparently E-Health
Connecticut has offered to have their whole Board resign
and deliver the 501C3 entity and the tax exemption to this
-- to the state to serve as the -- you know, as the 501C3
that’s contemplated in the legislation.

You know, my understanding is they’re going
to walk away completely, no strings attached at all and
the whole Board will resign. Is that something that we
should as a group consider, given that savings of time? I
mean, I just think it’s a savings of time and money in
terms of not having to form a new entity and get a tax
exempt entity for --

COMMISSIONER GALVIN: Well, we already have
our foundation which is a tax exempt entity, which
apparently the legislative body doesn’t want to deal with.
I find it inexplicable that E-Health would have their
whole board resign. And if their whole board resigns who
are we dealing with?

MS. BOYLE: Well, my understanding is that the board -- the took -- they passed a resolution to basically give -- donate the entity.

COMMISSIONER GALVIN: To basically?

MS. BOYLE: Donate the entity.

MR. MASSELLI: So, as this legislation --

MS. BOYLE: The proposal would be that they

MR. MASSELLI: Propose that we have a non profit --

MS. BOYLE: -- would come -- we use that entity.

MR. MASSELLI: -- we’d use that entity.

MS. BOYLE: Because I guess my understanding is that their purposes were similar when they were formed, and that’s the basis on which they got their tax exempt status.

MS. BARBARA PARKS WOLF: But hasn’t -- haven’t they qualified for federal funds in that -- at the extension?

MR. MASSELLI: They have an application.

MS. BOYLE: They have an application.

MR. MASSELLI: I think you’re right.
MS. BOYLE: A regional -- a health regional section.

MR. MASSELLI: Exchange.

MR. MICHAEL PURCARO: If I may, if I may? I think that it’s worth looking into, I’m sure there’s a lot of legal concerns with transferring that over, if that’s something that this body wants to pursue. Maybe that’s something the Legal subcommittee could explore and look at it from that perspective as a starting point.

MS. BOYLE: And we’re happy to do that. I mean, we’re happy to do that, the question was is that something we’re willing to entertain? Because the Legal Committee has a lot on its plate already, and if that’s something that we’re not willing to entertain, then we won’t spend time on it.

MS. MARIANNE HORN: Yeah, I think we could -- Marianne Horn, we’d need to get clarification on just what the action was that was offered, and they’re looking to put into the framework that we’ve put forward, and then how that exchange would take place, and a number of different issues.

But if we could look at that fairly quickly I think this legislation piece is going to be rapidly moving and continuing, so we ought to look at it.
COMMISSIONER GALVIN: Doesn’t it mean that if your whole board resigns that your organization ceases to function?

MS. HORN: But they would still --

MS. BOYLE: They’re going to convert it. What they would do is we would modify the entity -- or governance documents to make it this entity that we’re talking about forming. So, we would just modify, we would basically convert it over.

MS. HORN: Could potentially save us --

MS. BOYLE: It could save us time and money. I think we could come up with a list of questions to ask them and have them formally respond if that’s something we’re interested in doing.

MR. MASSELLI: Makes sense.

MR. COURTWAY: This is Peter. I guess the only concern that I would have, the legal machinations are fine and whether or not it could be done or not is great. The question is whether or not the brand, E-Health Connecticut is a damaged brand that people would ascribe to.

You know, it’s been around for a long time, it’s been fairly inactive, you know, it’s -- there probably is a reason why they are disbanding, you know as
part of it.

So, the question really is, does that give us the fresh start and is it worth it? I can’t answer the question, but it is a question to be answered.

COMMISSIONER GALVIN: Yeah, there’s also been a couple of ethical complaints.

MR. MASSELLI: We can simply change its name.

MS. BOYLE: Yeah, you would change the name, change the purposes, it’s just an entity.

MR. MASSELLI: It’s just an entity, it’s a shell. But it’s that six month process for the IRS that you’re worried about?

MS. BOYLE: Right, yeah. It’s the timing, the saving, and the money, and the time. Because you know, we’re behind already so, you know -- and the reason I asked honestly is for that very reason, what Peter said, because I don’t know.

So, I bring it in this open forum forth to ask is there -- you know, is that something that you know we would look at, or is it, you know tainted and we wouldn’t -- we’d have to start from scratch.

DR. AGRESTA: Seems to me like it would be logical to explore it. And rapidly.
MS. BOYLE: So, can I suggest that maybe we will on behalf of the Legal subcommittee come up with a list of questions for them that we ask them to respond to regarding what their intentions are and what their plan would be, and then we come back and talk about it at our next meeting?

COMMISSIONER GALVIN: Lisa, I’m -- maybe I’m -- I don’t understand it. And I’ll do what my friend used to do this when he didn’t. I’m not -- I don’t understand what they’re trying to do.

MS. BOYLE: What they have -- I guess, what they have come to a place in their -- and I’m not on the board, so I’m just telling you based on people coming forth --

DR. CARR: Maybe I can.

MS. BOYLE: Maybe you can.

COMMISSIONER GALVIN: Okay.

DR. CARR: So, the group is -- the organization is very supportive of what this particular committee is trying to do.

And so, -- and they’re supportive to the point where they say, okay if someone else besides us is you know, championing a health information exchange in the state or championing HIT adoption and small office
providers and large providers, then we want to make sure
that that organization, whatever that organization
becomes, is successful. Even if it doesn’t include those
that are on the board as it stands right now.

So, the -- so they know that there are
several assets within E-Health Connecticut. There is a
Chartered Value Exchange Recognition by AHRQ, there’s the
Regional Extension Center Application, which is going
forward in the process, and there are -- there’s also the
history, kind of call so to speak, of working on the DSS
pilot and we do -- I do think it will be successful
because of the efforts of many -- even outside of E-Health
Connecticut.

And so, the concept is that those with --
you know, they want to make sure that those are still
leveraged in the future. And if needed, you know there
are some that are on the board that would have to go away
in that process. And so, the internal process within the
board was, is everyone really committed to the over
arching vision or are we -- or is the board committed to
individuals.

And so, the decision was made that the
committee was -- I mean, that the board was more committed
to the over arching vision than they were to individuals
being on the board long term. So, they would turn over
those assets to the state as opposed to maintaining them
as a separate entity.

COMMISSIONER GALVIN: Sounds strange.

MR. COURTWAY: It sounds strange to people.

MS. BOYLE: My understanding is they formed
a tax exempt and they always envisioned that that would
eventually become the HIE. Now that it’s not becoming the
HIE, they want to further that mission but they know that
they’re not the vehicles.

DR. CARR: Correct.

MS. BOYLE: What they’re offering is to
deliver what they’ve got to the state to become the 501C3
and those members of the board would disappear. And we
would have the same constituency, we would just use that
as the entity that’s contemplated in the legislature.

COMMISSIONER GALVIN: Okay, all the members
of the board --

MS. BOYLE: Yes.

DR. CARR: Every single member --

MS. BOYLE: Every single member of the
Board resigned.

COMMISSIONER GALVIN: And then are some of
them going to get reappointed?
MS. BOYLE: No, it --

DR. CARR: No.

MS. BOYLE: -- would be subject to the legislation that we are actually talking about.

COMMISSIONER GALVIN: It’s very odd.

MS. BOYLE: It’s just, that’s the proposal. I mean, I understand that we would want to jump over a number of legal hurdles if we’re going to do that. But the concept is, is it something that we’re willing to consider, given the savings of time and money, if we can make the legal hurdles work.

MR. PETRUS: It does happen in a non profit world --

MS. BOYLE: Yeah, non profit --

MR. PETRUS: In a community based -- I’ve not heard it in the HIE, but it does happen in the nonprofit world. Their mission fails but the entity can save the time for this new non profit to pick it up.

DR. CARR: But I think it should seem odd, right? Either like everybody on an organization’s board is willing to resign to give that organization and all the assets of it to someone else that’s not them. And so, that was part of the discussion is, you know, is everyone willing to do that, and the answer was yes.
COMMISSIONER GALVIN: Yeah, and we had several people in the department subject to ethical complaints for quote, “colluding” with E-Health. And so, I’m very gun shy, having been one of the people and having to employ private counsel, I’m pretty gun shy about that -- about the name.

MS. BOYLE: Yeah, and we could change the name, and I guess this is where you have to make a decision here. Moral -- I mean, do we feel uncomfortable if there’s too many strings attached, so that we should just put it -- you know, start from scratch. Or, is it worth for them, you know, what they’ve got to take that on and change the name and change the --

COMMISSIONER GALVIN: I don’t want to get, you know, selfishly I don’t want to get -- you know, I don’t want to have to go get another private attorney to represent me again when somebody says well, that’s the same organization that we complained about.

And I think there were two or there others in the department that were in kind of a shotgun -- from someone we didn’t -- I don’t even know who this person was, nobody could find out who the person was, but I need to stay as far away from that as I can.

MS. BOYLE: Okay, so then we won’t move
forward with them, that’s fine. We’ll start fresh. Thank
you.

COMMISSIONER GALVIN: Anything else? A
motion? Dr. Dardick, would you motion to adjourn?

DR. DARDICK: Move we adjourn.

COMMISSIONER GALVIN: Thank you, Dr.

Dardick.

(Whereupon, the hearing was adjourned at
1:57 p.m.)