

DR. KOLODNER: Thank you very much,

4 Governor Bredesen, Governor Douglas and members of  
5 the Alliance. Thank you very much for the honor of  
6 being able to address you today and to actually  
7 engage in conversation, not just have a one-way  
8 conversation. And what is important we'll be able to  
9 join in the discussion later on this afternoon as  
10 well.

11 The leadership role that you'll be take on  
12 the State Alliance in order to facilitate the  
13 collaborative approach to increasing the efficiency  
14 and effectiveness of health IT initiatives is  
15 extremely important, but it's really to improve the  
16 quality and the value of quality center health care  
17 even beyond health care to the health of the  
18 population and the health of the individuals.

19 (Slide.)

20 DR. KOLODNER: This demonstrates the  
21 commitment you have improve the value of this health  
22 care through the use of health information technology

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1 and electronic health information exchange. It is  
2 both the technologies as well as the other exchanges  
3 that is a very powerful combination. And as  
4 Secretary Leavitt has said, by having those  
5 capabilities, it will enable us to achieve something  
6 we don't yet have, that is, a real nationwide health  
7 care system.

8 At the present time, we have a health care

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9 sector, but it would be a real stretch to call what  
10 we have, the pieces that we have a system. They  
11 really don't work well enough together and we need  
12 for all of us that we have that system developed and  
13 in place. Health IT is one of those enablers for us  
14 to organize the other pieces together to form an  
15 appropriate system.

16 (Slide.)

17 DR. KOLODNER: In talking about this  
18 health IT environment, there are actually several  
19 pieces to it. There are five I'd like to highlight -  
20 - electronic health records where a lot of attention  
21 certainly is focused, but also the personal health  
22 records, which have got a lot more attention recently

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1 and may, in fact, be the disruptive technology and  
2 enabler that catalyzes the population of consumers  
3 and individuals to actively engage in their health  
4 improvement and may, in fact, be the driving force as  
5 we've seen with the Internet and other things.

6 When the consumer population gets it, then  
7 business comes along after. We have not yet achieved  
8 that consumer-driven health care. This may be one of  
9 those enablers for it. The other piece is the  
10 population health infrastructure for a variety of  
11 public health sorts of things that we need to do.  
12 Those three end up being where the results of health  
13 IT touch various entities, whether that be  
14 organizations, individuals or the community. Then

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15 underlying, kind of hidden behind it so critical is  
16 the standards, whether it's data or technical and  
17 security standards. Without those we have a Tower of  
18 Babel and there are numerous other examples that  
19 Secretary Leavitt talks about that engage -- I think  
20 Australia still has two different gauges of track,  
21 whereas the U.S. agreed on a standard and, in fact,  
22 moved forward.

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1 We don't have those standards related to  
2 battles that delay moving forward. All of us, at  
3 least in the Alliance, are old enough to remember the  
4 Beta versus VSH, which delayed, ultimately, the  
5 consumer. We need to get the standards in place.  
6 After you have these isolated, standardized islands  
7 of information, you need to link them together in  
8 that network, a secure network. One that honors the  
9 privacy and confidentiality of individuals. Personal  
10 health information, that network, is what we want the  
11 nationwide health information network activities to  
12 be pursuing.

13 (Slide.)

14 DR. KOLODNER: Another way of looking at  
15 this, this is really something we grow into. This is  
16 not something we can design like a building and put  
17 in place. There are too many people as you certainly  
18 know in the state activities and some of the interest  
19 groups. We look forward to something that is lead,  
20 not built in a very methodical, predictable fashion.

21 It has lots of people to lead the way and become part  
22 of the process.

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1 Health IT in this view forms the roots and  
2 the basis for feeding the tree that will ultimately  
3 bear fruit. There are ultimately a lot of activities  
4 we're pursuing as part of the health IT agenda coming  
5 through with the interoperability standard, the  
6 networks, as I mentioned, the privacy and security  
7 that underlies all of this, the certification  
8 processes to decrease the risk for the adopting  
9 providers, for example, activities that foster  
10 adoption and encourage the interoperability and the  
11 buy-in. And we have at the present time a governance  
12 structure over that national agenda and over the  
13 America public information community that is a  
14 federal advisory committee -- and I'll talk about  
15 that a little bit more -- chaired by Secretary  
16 Leavitt and the intent is for that ultimately to be  
17 spread off into a public/private collaboration that  
18 will reside in the private sector. When those occur  
19 and mature, then you will achieve the outcomes that  
20 we're looking at, the higher quality, safer health  
21 care, the personalized health care. The consumer can  
22 be more empowered in managing their own health, a

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1 heal their population and added value for patients and  
Page 4

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2 providers.

3 (Slide.)

4 DR. KOLODNER: I mentioned the American  
5 Health Information Community. It is chaired by  
6 Secretary Leavitt. It's a federally-chartered  
7 advisory committee that is chaired by Secretary  
8 Leavitt. It has a variety of work groups. The  
9 nitty-gritty work is done for consideration.

10 (Slide.)

11 DR. KOLODNER: We actually at that point  
12 have seven work groups. The additional four were  
13 established back in November 2005 -- breakthrough,  
14 things we want to achieve rapidly. In addition to  
15 that, confidentiality, privacy and security work  
16 group was born because each of the work groups there  
17 are some issues and we don't want to have them  
18 stovepiped. We needed to address these at a higher  
19 level and then cross all of those groups.  
20 Additionally, we developed a quality work group. How  
21 we get the knowledge and how we give the support to  
22 the fabric of the health care system using the health

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1 IT technology as the enabler for that.

2 Then more recently we established a  
3 personalized medicine or genomic focus for our work  
4 group because of the power that that approach will  
5 have in transforming health care in what we do and  
6 how to properly deliver the right actions within the  
7 health care arena.

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8 (Slide.)

9 DR. KOLODNER: This slide gives you a  
10 stack of those, a variety of activities. The  
11 community, the one that we formed, many of those were  
12 formed through various grants and contracts -- the  
13 standards of the organization, certification  
14 commissions, and they have them become certified  
15 criteria for various products, starting with last  
16 year the health record issue and exploring whether  
17 there are other things that, by being certified,  
18 would help to move the agenda forward.

19 The idea is not to put a bureaucracy in  
20 place, but to figure out where having certification  
21 will, in fact, provide the right boundaries to  
22 encourage moving forward and not Brownian motion.

20

1 (Slide.)

2 DR. KOLODNER: I have a couple of slides  
3 that have listed a number of the accomplishments.  
4 Rather than going through those and spending the  
5 time, they're surely the ones that you can look at,  
6 at your leisure.

7 (Slide.)

8 DR. KOLODNER: More importantly, there a  
9 report that we just published on Tuesday that is out  
10 on the web of the major health IT accomplishments  
11 from 2004 through 2006. I talked with the Alliance  
12 staff. They'll be getting you a copy of that report.  
13 It's available as well on our website.

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14 (Slide.)

15 DR. KOLODNER: Just to show that there is  
16 a momentum going in the first few days of 2007, we've  
17 already had our share of accomplishments, starting  
18 with Secretary Leavitt's acceptance of the first  
19 round of health records standards, which was accepted  
20 at the end of December and was announced just a  
21 couple of days ago at a community meeting. At the  
22 community meeting, we agreed on the priorities of the

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1 description, the scenarios, the things we wanted to  
2 accomplish to set the second round of what we call  
3 "use" cases. That is descriptions of things to do  
4 around which we would then be able to identify  
5 standards that would advanced in order for us to move  
6 forward. We're doing that so that the vendor  
7 community can build that in over time so we can  
8 gradually advance the standards.

9 This is not something -- there's actually  
10 not enough experience in some areas. We want to see  
11 if we can establish those immediately for all the  
12 data elements that we need for health care and the  
13 next set of areas that we will advance emergency  
14 responder electronic health records and consumer  
15 access to clinical information, medication management  
16 and quality. We also had recommendations that we  
17 advanced regarding patient identity proofing. We  
18 know that the person is who they claim they are so  
19 you can release information to them in order to

20 empower them. It's very important that we get that  
21 right and then recommendations regarding how we do  
22 that were advanced as well as recommendations

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1 regarding personal health records.

2                   This meeting that we're having today and  
3 yesterday and today, we're also having the third  
4 nationwide health information network forum. At that  
5 one, the core vendors that we have contracted with  
6 are actually doing very in depth demonstrations of  
7 what they've developed from this. It will be  
8 extracted what is the important functions and  
9 characteristics and security measures. That will  
10 then form the basis of what we require in the next  
11 round of contracts. The first round was for the  
12 vendors. It was on technology. The next round is  
13 with the states and regional health information  
14 exchanges, providing money out to you, to the  
15 elements within your state in which they will  
16 contract with vendors and begin setting up the  
17 competition among very competent vendors of the  
18 health information exchange and deliver solutions for  
19 the very basic boundaries in which we can play.

20                   We have more information out on our  
21 website at [Interjest.gov](http://Interjest.gov). Health IT is the area  
22 where you can go for more information. There are

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1 issues we will be talking about here as well as other  
2 places and you'd like the interoperability and the  
3 standards and overcoming barriers to adoption. We're  
4 really very excited that the State Alliance will be  
5 working to access and develop a consensus solution to  
6 resolve state-level IT issues and challenges to this  
7 interoperability and will provide a forum in which  
8 the states may collaborate so as to increase the  
9 efficiency and effectiveness of the health IT agenda.

10           As you know, the federal government can  
11 lead, but really where the work will occur is in the  
12 states and communities. We haven't been doing this  
13 before in health IT -- listing challenges in terms of  
14 differences. The states have in their statutes and  
15 laws that are there at the state level and forming  
16 the basis for the work that you'll be doing in  
17 discussions. We're looking forward to have that  
18 collaboration move forward and we'll really be  
19 working at the national, state and local level for  
20 health information exchange. Each working our own  
21 way to see what we can do in order to achieve that  
22 robust interoperable health information environment

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1 that will, in fact, help us to catalyze the health  
2 and care.

3           So with that, let me stop and see what  
4 conversation we'd like to have.

5           GOVERNOR DOUGLAS: Thank you so much, Dr.

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6 Kolodner for joining this morning. We really  
7 appreciate the leadership of Secretary Leavitt. We  
8 talked among ourselves at the NGA that is was very  
9 valuable and helpful to have a former governor as  
10 Secretary because he understands what the states are  
11 facing. We appreciate his working with us toward  
12 accomplishing these goals. I mentioned in some of  
13 opening remarks and you hit on it just a minute ago  
14 about exchanging of information. I guess I'm  
15 wondering what the right level of exchange is --  
16 local, regional, state, national, overall working  
17 toward accomplishing the goal that we all share? Is  
18 there a preferred approach in terms of the level of  
19 which the information is exchanged do you think, at  
20 least, initially?

21 DR. KOLODNER: I think it is an evolution  
22 that occurs. Certainly, when you think about health

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1 care is one focus. All of us end up getting health  
2 care from multiple providers. So we know we need to  
3 have movement across the pharmacies as well as  
4 primary care specialists as you go up from the  
5 pediatrician to the internist, OB/GYN and the  
6 information there tends to be local and many people  
7 think in terms of a relatively local area, but the  
8 problem is what happens if something happens? Don't  
9 you want to have that information available and you  
10 would end up in an emergency room. Because there's  
11 enough movement just in our daily lives, we need to

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12 move that information across states, across the  
13 country, and in fact, internationally is something  
14 that -- is a very practical need that comes up more  
15 often than not.

16 GOVERNOR DOUGLAS: We have some physicians  
17 in the room in case Governor Bredesen and I need some  
18 attention.

19 (Laughter.)

20 GOVERNOR DOUGLAS: Governor Geringer.

21 GOVERNOR GERINGER: It seems that we need  
22 to perhaps differentiate a little bit what we're

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1 talking about. I don't believe we're aiming towards  
2 a national database of all people on patient  
3 information. Obviously, we wouldn't want something  
4 like that. We haven't demonstrated any ability to  
5 control central databases yet. For this Alliance, it  
6 seems that a method to assure greater  
7 interoperability and data exchange so when we need to  
8 discover -- whether it be clinical information or  
9 perhaps surveillance information involving a pandemic  
10 or some kind of epidemic, for the states to have  
11 policy option. It's not going to be a single,  
12 uniform system of patient care or health care in  
13 every state. There are going to be variations that  
14 every state wants to follow. So policy options that  
15 we can adopt that are still within an overall  
16 framework of an interoperable system and health  
17 information that can be provided on an "as needed"

18 basis or "discoverable" basis. We may not know what  
19 we need to discover, but if there's a data source  
20 that we can track, for instance, for syndromic  
21 surveillance, if a governor wants to choose a policy  
22 option, if there's an opportunity to do that from

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1 whatever the source it, if you could comment a little  
2 bit on how the agency is establishing this so it's  
3 not just perceived as a national database that all  
4 patient information is deposited in.

5 DR. KOLODNER: An excellent point,  
6 Governor. The intent is not to establish a national  
7 database. I certainly wouldn't want my data in a  
8 national database joined with everybody else's. I  
9 may very well want a personal database that I choose  
10 some service provider to establish for me. As much  
11 as I put my money in a bank and I can choose which  
12 bank I want or I can deposit my money in different  
13 banks. But that's only one of the solutions --  
14 having a personal account. My mother may not choose  
15 to establish that and may trust that the different  
16 people who have been taking care of her can provide  
17 that information when asked for much as we pull  
18 together information using search engines off the  
19 Internet and can move it forward. There are a number  
20 of policy issues that we need to explore. To what  
21 degree does the individual get to say whether or not  
22 their information does or doesn't flow? Certainly,

1 technology, the demonstrations that occurred  
2 yesterday at the NHIN forum showed that you could, in  
3 fact, have the individual set the parameters as to  
4 whether they would allow certain types of information  
5 to flow or stop it from flowing to certain entities.  
6 So the question is what is the balance between the  
7 individual's privacy and the community need, the  
8 public health needs as well. Those will be some very  
9 robust discussions that we'll be having.

10           The intent is that the network is actually  
11 a network of network. If you think about your phone  
12 network or your Internet providers, there are lots of  
13 different providers out there. They interconnect.  
14 There isn't a single provider that we all have to  
15 belong to. The data itself there are advantages and  
16 disadvantages to having it fully dispersed or having  
17 it community-based databased. There are some places  
18 like Indianapolis that are saying no way. They're  
19 not going to do it. So I think we like the  
20 technology support, the Harvard model, and let the  
21 community decide what values they want to advance and  
22 how we move that forward.

1           When it comes to the public health needs,  
2 the population needs, the whole idea of how we  
3 identify and how we do it properly is something is,  
4 again, going to be a very robust discussion. There

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5 are certainly advantages to the community to be able  
6 to roll up a certain level of information and if we  
7 eliminate all of the identifiers, it's in my best  
8 interest that they keep that information. Then I can  
9 find out what's happening in my community and I'm  
10 contributing to that and I'm also benefitting from  
11 it. But I expect that there will be different  
12 policies and different decisions made in different  
13 local e.

14                   What we need to do is make sure that the  
15 technology that we put in place doesn't inhibit the  
16 policy choices of what we need to do.

17                   GOVERNOR GERINGER: Thank you.

18                   DR. KOLODNER: There are a couple of  
19 policy things that I think we need and I expect that  
20 we'll be exploring like the licensure issue,  
21 providing licensure, what that does for telehealth.  
22 The description that I certainly heard from some of

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1 professional colleagues a patient comes across the  
2 state line to the hospital. They get treatment and  
3 when they go back across the state line the provider  
4 can't talk to them and give them advice because of  
5 licensure issues. That's not even getting into  
6 actually being able to support telehealth and  
7 providing emergency services. There are issues at  
8 both the federal and state level in terms of the  
9 release. State laws that say only the provider who  
10 ordered tests can get that result. That makes it

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11 very difficult if I'm not that provider and I need to  
12 get that information. So again, there are a number  
13 of issues that I think will be ones that you'll be  
14 wrestling with.

15 GOVERNOR DOUGLAS: Very interesting ones  
16 on the telehealth question. That's certainly come up  
17 in our state and I'm sure in others practicing  
18 medicine. If you're reviewing an x-ray or some other  
19 information online and consulting with a practitioner  
20 in another state, that will have to be resolved.

21 You've raised a lot of important points,  
22 Dr. Kolodner, about the policy choices that have to

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1 be made. Another that came up in another  
2 conversation was whether authorization to share  
3 information would be permanent or of a limited  
4 duration and subject to renewal by the patient from  
5 time to time.

6 Other questions? Senator Moore?

7 SENATOR MOORE: On the work groups that  
8 you listed in the American Health Community, I didn't  
9 notice any that we're looking at -- the cost of the  
10 system. There's a set of issues regarding finances.  
11 We did a study in Massachusetts on seven different  
12 technologies. CPOE, we estimated that we could save  
13 about \$2.5 billion a year in what we were doing. We  
14 need to be able to show the costs and benefits  
15 probably on a state-by-state basis. The smaller  
16 hospitals in our state have told me that their

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17 trustees really won't approve a capital investment  
18 for the technology unless they can show a return in  
19 the same budget year. So how we can show that the  
20 investment really provide, hopefully, fairly quick  
21 returns? And then the alignments of payments and  
22 reimbursements. If a physician invests in the

32

1 technology and he doesn't get paid for electronic  
2 transmission between him and the patient or her and  
3 the patient and we force the patient to go to the  
4 doctor's office in order to get reimbursement when  
5 some questions could be discussed over the Internet,  
6 is the economic aspect of that being looked at by all  
7 the work groups? Or is there going to be a separate  
8 focus on that?

9 DR. KOLODNER: It really cross-cuts all of  
10 the work groups. It actually is a discussion at the  
11 community level. Remember that the work groups do  
12 some of the work, but there are some other issues for  
13 the community itself. And when you look at the  
14 electronic health record, at the group that's looking  
15 at that -- in fact, some of the people who did the  
16 studies that you're talking about are on that work  
17 group. So they're looking at whether the issue is  
18 whether the policies, whether the barriers to  
19 adoption that are there -- this issue of who pays  
20 versus who benefits -- how does that get evened out  
21 and shared?

22 And the other is, as we had a discussion  
Page 16

1 just on Tuesday, there was a presentation that was  
2 very provider-centric in its focus and one of the  
3 members who is a former CEO of a large technology  
4 company said you left out one of the major entities  
5 here. Who is that? The consumer. Then he pointed  
6 out that at least in retail world the idea of return  
7 on investment is dwarfed by what the consumer demand  
8 is, so that the idea of me as a consumer saying I  
9 want to gather my information. I want it  
10 electronically. Can you give it to me  
11 electronically? Oh, you can't. Well, maybe I'll  
12 seek my care elsewhere can be much more powerful and  
13 wipe out any of the arguments about return on  
14 investment as was stated there. So yes, we do get  
15 into those discussions. We know it's not simple. We  
16 know these are some of the factors that we need to  
17 get right and part of the role that I see for our  
18 office is to help identify these factors so that we  
19 help encourage and foster the environment where  
20 various market forces will, in fact, do this the way  
21 they need to. To be fair, the market forces have not  
22 worked well for all these many years. We're not

1 going to force it to happen, but enable it to happen.  
2 GOVERNOR DOUGLAS: You've hit on a key

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3 issue that a number of us have been wrestling with in  
4 connection with the mission of the Alliance. Will  
5 reform come, as you suggest, from consumer demand or  
6 will some level of reform need to be imposed from the  
7 top down? Maybe it's a combination of the two that  
8 will develop a policy objective that will work for  
9 all of our states and consumers. A very interesting  
10 point.

11 DR. KOLODNER: I suspect in different  
12 markets it will be different combinations, so we need  
13 to participate as we learn where that mix is. The  
14 mix may be different in some different marketplaces.

15 GOVERNOR DOUGLAS: Dr. Sundwall?

16 DR. SUNDWALL: Thank you. I'm David  
17 Sundwall, head of the State Department of Health in  
18 Utah. I just want to thank Governor Geringer for  
19 mentioning something that's really important to all  
20 of our efforts to improve the business and practice  
21 of clinical medicine. We cannot forget public  
22 health. Real time data is lacking. It's essential

35

1 if we're going to protect the public from whatever  
2 harm might come, either bioterrorism or an emerging  
3 infection. We have the good fortune of having the  
4 CDC Centers for Excellent Grant in public  
5 informatics. However, what I learned from having  
6 that grant is what we don't know, not how well we do  
7 what we do.

8 We have a long ways to go. I'm grateful

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9 that Secretary Leavitt, our former governor, is  
10 focusing on this. But I would just make a pitch for  
11 a parallel to all of our efforts in patient data.  
12 Somehow we visit in improved capacity for real time  
13 information. It's a public health venture.

14 DR. KOLODNER: Certainly, one of the  
15 original groups was on bio-surveillance. It was just  
16 renamed population health. I haven't memorized the  
17 full name. If you look, we're looking at all three  
18 levels or three communities -- the provider, the  
19 consumer and the public health of the population. We  
20 need to advance all of them. The idea of the  
21 interoperability -- that information can serve  
22 multiple purposes. We need to get the most out of

36

1 it. The challenge certainly is how we do that,  
2 allowing privacy and confidentiality for individuals  
3 certainly. We need to get that right. Because if we  
4 get it wrong, we'll lose the trust. It will set us  
5 back for years. I agree we need to move it forward.  
6 We probably have a few more challenges in terms of  
7 getting the voices to the table and finding that  
8 balance. But it's vital that we do so.

9 GOVERNOR DOUGLAS: Excellent point. There  
10 have been some breaches of confidentiality in both  
11 public and private sector recently and we need to get  
12 the trust of the consuming public if this is going to  
13 work.

14 Dr. Tuckson?

15 DR. TUCKSON: One of your slides described  
16 a flurry of activity under the AHIC about seven  
17 taskforces. I'm relatively familiar with some of  
18 them, more than some of them. Then you had another  
19 slide where you started to list the Certification  
20 Commission of Health Information Technology and then  
21 at the bottom there was us. Can you give us a little  
22 more input from your office's perspective on how our

37

1 committee is designed to fit into the overall schema  
2 from your office's perspective?

3 Also, what resources and services can we  
4 expect from your office as we go forth? What's the  
5 dynamic there?

6 DR. KOLODNER: The first year was the  
7 start-up year and so we wanted to get David Brailert,  
8 who preceded me, was a master of working with the  
9 Secretary to put together a set of activities and a  
10 set of contracts. If you look more recently, there's  
11 been renewed emphasis on the need to engage at the  
12 state and community level. Obviously, the states are  
13 the ones that allow us to link up with the governance  
14 structures in order to move things forward and it  
15 needs to be bi-directional. In fact, one of the  
16 early contracts that was there the final report was  
17 presented on Tuesday was about the need for the agent  
18 to go into the private space, which Secretary Leavitt  
19 certainly reinforced. And whatever structure is put  
20 in place to have almost a fractal like connection

21 with the states so that they are part of the overall  
22 governance of how we tie that up.

38

1           It's clear that the action occurs locally  
2 and regionally, and those are venn diagrams overlaps  
3 of circles. We can certainly indicate some of the  
4 areas that we think where things need to be done. We  
5 expect that from your deliberations you will identify  
6 areas that we need to take more action. The  
7 intention is to open up channels of communication.

8           One of the things that we'll be looking at  
9 is when will it be appropriate, for example, for you  
10 to or your chairs to present to the AHIC to open up  
11 that discussion and look at how can we, in fact, make  
12 sure that this is a robust channel of communication.

13           GOVERNOR DOUGLAS: Dr. Kolodner, we really  
14 appreciate your time and commitment to this important  
15 effort and your partnership with the states. We  
16 really need to all work together if we're ever going  
17 to be successful in accomplishing the goals of this  
18 Alliance and the goals that you've outlined for the  
19 Department.

20           I think in order to stay on schedule we  
21 should move on to our next agenda item. But I want  
22 to thank you very, very much for your time this

39

1 morning, for the Secretary's Leadership and we

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2 certainly will be in touch as this process goes  
3 forward. Thank you so much.

4 DR. KOLODNER: A pleasure to be and I look  
5 forward to participating later on, on the priority  
6 setting as well.