GOVERNOR DOUGLAS: I'd like the members
8 and advisors to turn your attention now to a handout
9 which should be at your place. There are some
10 Powerpoint slides that we'll refer to, I hope,
11 throughout our deliberations. They'll be very
12 important as we set our priorities later today.
13 Also, earlier, prior to the meeting, you received in
14 the mail a document entitled A Vision for Health Care
15 from and a Framework for State Alliance for e-Health.
16 I thought it was a very helpful discussion of what we
17 need to accomplish, the situation we're confronting
18 today, the lack of electronic connectivity within the
19 health care system, if it is a system or sector and
20 also describing the potential for adopting a national
21 exchange. I hope you've had a chance to review that.
22 I think it really lays out our responsibilities very

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1 well.
2 I want to take just a moment to look at
3 the visions and goals that are on this sheet and
4 Powerpoint slide that is being projected now.
5 (Slide.)
6 GOVERNOR DOUGLAS: The vision and goals
7 are set forth on that slide. The Alliance is a
8 consensus-based, executive level body of state
9 elected and appointed officials. They will address
10 the unique role states can play to facilitate
11 interoperable electronic health information exchange.
12 (Slide.)

13 GOVERNOR DOUGLAS: We have a series of
14 principles, as you can see, articulated as well. A
15 nationwide health information network will enhance
16 the efficiency and effectiveness of the delivery of
17 health care. Secondly, interoperable electronic
18 exchange will occur in a manner that protects
19 consumers' health information, obviously, very
20 important. That was a part of our discussion a few
21 minutes ago. Thirdly, health information exchange
22 networks will be developed to provide for the

1 portability and ready access to health information by
2 consumers and providers within and across states.
3 And finally, health information exchange networks
4 will allow for timely exchange of health information
5 to improve population health.
6 I think those are appropriate goals and
7 really set forth or tremendous opportunity to create
8 synergies between national and state level exchange
9 efforts. That's why the partnership with HHS is so
10 very, very important. It's my goal -- and I know
11 Governor Bredesen shares this -- but we want to work
12 in a way that complements efforts at the federal
13 level to also support ongoing collaborations between
14 public and private sectors and to support
15 coordination among several states.
16 (Slide.)
17 GOVERNOR DOUGLAS: That's why I asked
18 earlier about the appropriate location and type of

19 exchange that we want to focus on because there are
20 things that are happening now that are very, very
21 positive and we want to be supportive of them so that
22 we can move this agenda forward in a cooperative way.

1 That's our vision. Those are goals. And I think
2 we're in really good shape to move this important
3 agenda forward.
4 Phil?
5 GOVERNOR BREDESEN: Thank you, Jim.
6 We're going to talk a little bit about the
7 scope of work in developing the State Alliance's
8 activities and the work products here. It's really
9 intended to serve as the foundation for setting those
10 priorities and the support of taskforces here in the
11 Year 2007. If you follow along on the slides, the
12 State Alliance, obviously, is going to operate in an
13 environment of shared learning. There's a lot of
14 different points of view represented around the table
15 and with the members who we're consulting with. This
16 group -- and they certainly each represent a facet of
17 an important point of view and to identify
18 opportunities and advance recommendations to states
19 for facilitating the development of this health
20 information network.
21 Please note that the taskforces to the
22 State Alliance will advance recommendations to the

1 Alliance for discussion and consideration.
2 (Slide.)
3 GOVERNOR DOUGLAS: There's a listing in
4 the slides here of key areas that initially could be
5 emphasized. We're going to leave plenty of time for
6 discussing these here this morning. Obviously,
7 privacy and security -- Dr. Kolodner touched on the
8 complexity of that problem. The inconsistency that
9 exist in state privacy laws and probably in general.
10 Speaking certainly for myself, the general lack of
11 interest in having some overarching federal set of
12 requirements and finding some way to accommodate the
13 different approaches that the states are taking to
14 it, different ways, for example, that the states
15 implement consent processes for getting sets of the
16 data. States have different policies on the
17 secondary uses of data that need to be addressed.
18 The Alliance is looking at some of these
19 inconsistencies and how we can function in that
20 environment.
21 Also, there are obviously security
22 challenges to protect -- Jim pointed out a couple of

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1 times already that this is not something that our
2 nation has developed a wonderful record on in this
3 area of centralization of information. We obviously
4 don't want a situation where people's health records
5 are wondering around on laptop computers and all the

6 things that could happen as a result of that.
7 There's also the issue of addressing policies to
8 ensure appropriate access by external organizations
9 to patient data.
10 Another area is election of clinicians.
11 The State Alliance, I hope, will identify the scope
12 of that and possibly some solutions to enable the
13 clinicians to operate in a telehealth manner,
14 consulting across state lines. These certainly can
15 take the form of state compacts or policies. They
16 can take the form of model legislation that we could
17 propose to states allowing it to be addressed.
18 Liability is going to be a significant issue and the
19 whole topic of the information area and certainly the
20 State Alliance should talk about practices that have
21 the potential to increase the reliability as we
22 develop these networks. Provider liability -- the

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1 provider has immediate access to information. What
2 is its obligation to access it? There's a rich set
3 of issues around these issues as well.
4 Jim?
5 (Slide.)
6 GOVERNOR DOUGLAS: The next slide talks
7 about some key areas we need to emphasize. Both of
8 the Alliance and the taskforces -- speaking of
9 technology, I can't remember to push the button.
10 GOVERNOR BREDESEN: There's no liability,
11 though, for that.

12 (Laughter.)

13 GOVERNOR DOUGLAS: I should note as well,
14 speaking of technology, that our colleagues who are
15 participating by teleconference, I believe, have a
16 method by which they can signal to the operator that
17 they want to ask a question. So they should take
18 advantage of that if they would like to.

19 The one key area, the integration of
20 public programs in health information exchange and
21 the states roles for the integration of public
22 programs and health information exchange we might

1 examine opportunities for states to enhance existing
2 public programs, cooperative activities with the
3 private sector. We might want to examine the value
4 proposition for public programs like Medicaid to
5 participate in our system in new HIE efforts. In our
6 NGA meetings, Medicaid often dominates our
7 discussions because it's the 800 pound gorilla,
8 budgetary, and from a policy standpoint, forcing for
9 most of us at the state level. That's something we
10 might want to think about. We might want to address
11 how to better integrate public health into HIE
12 efforts and Dr. Sundwall made that important point.

13 We need to enhance disease surveillance,
14 preparedness efforts. Governor Geringer talked about
15 the potential for pandemics and public responses.
16 That's certainly an important consideration in this
17 area, too. Quality measurement has enabled, by

18 health information exchange, can play a role in the
19 quality assessment of the population. We might want
20 to examine the role of states as purchases of health
21 care as funders of community-based initiatives as
22 regulators of health care settings, as protectors of

1 consumers. You might want to explore state actions
2 in these activities.
3 I expect that a lot of programmatic and
4 technical issues that fall within or outside of these
5 broad categories may come up as the Alliance and its
6 taskforces begin their deliberations. That's the
7 value of the group that we've assembled. We have
8 some tremendous experience around the table and
9 beyond. And a lot of people can bring their various
10 experiences to these deliberations and be very
11 helpful as we establish priorities and move the
12 Alliance's work forward. So we've got to keep in
13 mind, and I'm sure we will, the vision and goals that
14 we've established for the Alliance as we set our
15 priorities later today.
16 We've got some time now to talk about
17 these issues now, if you'd like, before we go to the
18 next session.
19 GOVERNOR BREDESEN: Jim and I have been
20 given a long set of talking points about these
21 issues. We've been good guys and run through these
22 so you could actually open up these around the table.

1 We've got until about 10:30 until the next panel of
2 experts session begins. I think the most important
3 thing to come out of today with is some sense of
4 direction. This is such a big and morphia subject
5 that we could easily spend a year or two years just
6 round and round in the inners of it.
7 I would love to hear from some of you in
8 this next half hour we have a little bit about what
9 you think from what perspective what things that
10 ought to be focused on. So just talking about this
11 in the afternoon, we can really get some meat to work
12 with. What should we do?
13 Doctor?
14 DR. TUCKSON: I was glad to hear Governor
15 Douglas say at the end there that an important
16 emerging area is this idea of quality and performance
17 assessment. Clearly, at least that I'm aware of,
18 there are almost 35 different state initiatives
19 around performance assessment of clinicians and/or
20 hospitals. Each of those will require and do require
21 their own data collection and aggregation
22 initiatives. I think Senator Moore commented on

1 cost. These are enormously expensive activities for
2 every stakeholder in the system to participate in.
3 The good news is that AHIC, under the

4 leadership of Secretary Leavitt, are trying to get
5 some national standards, not only for the performance
6 assessment with good national physician input as to
7 what those ought to be so everybody doesn't invent
8 their own kinds of measures and drive the doctors
9 crazy. But also, there's an attempt to try to figure
10 out how you actually aggregate what are the standards
11 for collecting the data efficiently so that you only
12 have to hopefully do it once and you do it well. But
13 there are challenges around urgency. So I would hope
14 that, also given that CMS is going to be doing this
15 as part of a national effort, you have the local
16 doctors evaluated on a national scale with national
17 standards so that the danger could be that Mr. Smith
18 with insurance gets one set of information from one
19 insurance. The model gets -- her doctor gets
20 evaluated by CMS and you can sort of see the
21 confusion that could happen and then the extra costs.
22 Without going any further, I just hope

1 this would emerge as to what are the major issues
2 that we're going to look at.
3 GOVERNOR BREDESEN: Doctor, to bring it
4 home, what is it that you want this panel, this group
5 to do specifically regarding that? We have a limited
6 number of meetings.
7 DR. TUCKSON: I think the easiest focus is
8 Secretary Leavitt is moving around the country now
9 getting, in fact -- is moving aggressively around to

10 all of the private sector CEOs to get them signed
11 onto the four-point document that asserts that you
12 will get involved with adopting the national
13 standards for data collection performance assessments
14 and those things and then work together. I think if
15 the governors could look carefully -- if we could
16 provide some input as to the positives and negatives,
17 but having the governors decide to be a part of that
18 initiative. If the states would agree, to the extend
19 that they could control it, have the state
20 aggregation initiatives decide to use national
21 standards for performance assessment that have been
22 advanced through the processes and be able to move

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1 quickly to be on board with common data collection
2 activities around clinical performance, thereby
3 economizing and saving money and having everybody on
4 the same page.
5 GOVERNOR BREDESEN: Representative
6 Conaway?
7 REPRESENTATIVE CONAWAY: I just have to
8 comment as a practicing physician working on
9 liability living in an environment where liability is
10 so important. This question of national versus local
11 standard, should the physician practicing in the
12 Midwest be held to the same standard as a physician
13 practicing in New Jersey? We had an example in New
14 Jersey where health data, data collected
15 electronically was actually used to establish

16 standards in that particular area. It was actually
17 very important in the outcome of a medical
18 malpractice case. I had to comment on that.
19 In terms of this committee, you know, I
20 think this tension is pointed out by Governor
21 Geringer there about how many aggregations of data
22 ought to take place. You can go on the Internet and

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1 find because of a sort of haphazard system, paper
2 driven, people getting insurance exams, data all over
3 the place with very little protection or control.
4 There's far too much data out there available on
5 people in the current environment and I see these
6 advances in putting together global types of security
7 bases as actually preventing a lot of the stuff that
8 we have out there now. So you know, you look at this
9 question of if the national database is there, does
10 that mean that a centralized database at the state
11 level is good? I suspect that it is.
12 We just looked at the example raised by
13 Dr. Kolodner. If you are a patient perhaps getting
14 health care at different institutions, wouldn't it be
15 more efficient for you on a centralized directory,
16 decide and get permission once on how your health
17 information is going to be used, how your HIV
18 information is going to be used. So a database or a
19 system that's disparate without centralized control
20 and what that means for the patient and managing his
21 or her data and what it means for collection of data

22 and using that data. So looking at the structure and

1 how states ought to go forward, I think, and how
2 states are setting this up, I think, states are going
3 to be the laboratories for this for the nation. It
4 will be very difficult to achieve.
5 But secondly, as a practicing physician
6 who's invested in his own EMR system, how do we get
7 ubiquity in a system? A lot of the public acceptance
8 of this is going to come through the usage of these
9 important databases by physicians in the office. My
10 patients know they don't have to go to a pharmacy
11 because I've sent their prescription. I've saved
12 them a trip and they talk about that in the
13 community. So how do we get ubiquity in a system to
14 drive this technology into the physician office, I
15 think, is an important thing. Is the federal
16 government looking at a standard? Can we take a
17 database that we basically give away the position to
18 get over the financial barrier? I recognize that
19 physicians are going to pay money for highly
20 specialized systems to meet their own needs. Getting
21 ubiquity in the system, driving this technology down
22 to the doctor's office, I think is something we

1 should focus on.
2 MR. RODGERS: I appreciate those comments.

3 Another group we need to talk about is the new
4 physicians. We're training the next generation of
5 physicians. It's not part of their training process
6 to be able to use this technology appropriately. So
7 someone -- I don't know if it's part of this group's
8 scope -- but someone has to realize that unless
9 they're ready for this technology to use it
10 effectively, we're creating an obsolete generation of
11 physicians and nurses, for that matter.
12 GOVERNOR BREDESEN: Wayne?
13 DR. SENSOR: Good morning. Wayne Sensor.
14 My apologies for my tardiness.
15 A couple of comments, if I may. First
16 off, to start of a bit philosophically about the work
17 that's been done. I congratulate and appreciate the
18 staff's work to put together some background
19 information about the roles of health care.
20 Something that I think the entire country is trying
21 to grapple with and I think you're doing a great job
22 of encapsulating what the major drivers are.

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1 I would just offer this, given the work
2 plan of this particular group, I certainly think this
3 is hugely important to work on the national level.
4 There's a tremendous amount going on at the state
5 level and for us to percolate something meaningfully
6 to the federal level that would permeate the country
7 and provide guidance and some logical direction for
8 e-Health would be wonderful thing. I would simply

9 submit, if I could, that rarely in my experience has
10 IT been a fix for a complex problem and I think in
11 this case the effort we embark on can certainly
12 improve patient safety. It can certainly improve the
13 quality of care we are providing Americans and
14 certainly help to make it more efficient.
15 But I would acknowledge that as I read
16 through the staff's overview of what ails the health
17 care system in America, I would sort of reprioritize
18 that and I would acknowledge that, at least from my
19 standpoint, to incentivize individual responsibility
20 in one's health care to reward and support
21 prevention, reward and support preventive care and
22 the transparency that is alluded to by the provider

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1 community on cost and quality from my vantage point
2 are the really large plays and this sort of IT
3 initiative is an enabler, which would therefore allow
4 the health care system to be the enhanced system we
5 want it to be.
6 That being philosophical, let me jump to a
7 quick specific point about the work of this
8 committee. The Representative made a comment a
9 moment ago about the import on the primary care
10 physicians across the country. As a practicing
11 physician, I appreciate your presence and your
12 knowledge that you bring to this table. The more I
13 sit we really need to not forget primary health care
14 delivery across America as one of the absolutely key

15 components. If we don't get EMR in the primary care
16 physicians offices, if we don't have e-Prescribing,
17 the whole issue of interoperability of large health
18 care systems could, indeed, adjoin and be a powerful
19 part of data exchange. But that's not where most
20 health care is delivered in America. It's delivered
21 in the primary physician's office. While that may be
22 outside the work of this group, we may want to

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1 indicate or at least acknowledge that that's a
2 problem if that doesn't happen. If we don't have
3 electronic information delivered to primary care.
4 The last thing I'd say while I have the
5 microphone I read with great interest as I looked at
6 the mission and goals for this group. I noticed that
7 we would like to have access availability and
8 capability as well as interoperability to both the
9 provider community and the consumers themselves. Far
10 be it for me to say it isn't right, although I would
11 say that in most of the states that I've observed
12 thus far, it really speaks to a consumer releasing
13 their health information between providers at their
14 request, not necessarily accessing directly
15 themselves. That, indeed, may be very powerful and
16 very important, but I would suggest we want to be
17 conscious about that. It has a lot of ramifications.
18 Thank you for the opportunity.
19 MR. DeVORE: Governors and fellow members
20 of the Alliance, actually I read through these -- the

21 scope and goals -- and was very pleased to see that
22 this could go a variety of ways, given the year

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1 charter we've got. It's probably good for us to draw
2 some sort of invisible fence at some point,
3 otherwise, this could lead to multiple topics,
4 quality figures and important topics and central
5 health care. I'm not sure that's a goal or that's an
6 optimum.
7 I would just like to emphasize the fact
8 that we build this on states have ultimate control.
9 They've got the power to change and they can draw
10 that as a reasonable line around that to work around
11 the issues of licensure and tort reform. That's
12 within the parameters that you've been talking about.
13 Of course, liability. I've seen a number of state
14 commissions -- as a technology company, people would
15 obviously like to figure out if this is a technology
16 issue. I think to Wayne's point, technology is just
17 a tool. The reason health care hasn't changed is
18 because of the barriers that states are well-
19 positioned to knock some of those barriers down.
20 I was really focused on very specific
21 things that we can do that are measurable, well-
22 defined and not allow the conversation to get into

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1 let's launch the next rocket to Mars.
2 GOVERNOR BREDESEN: All right, what is it?
3 What do you propose?
4 MR. DeVORE: I think it's working on
5 issues around privacy and security. I work on
6 secondary issues of that information. The
7 assumptions I'm going to make -- the customer, the
8 consumer has the right to that information, to
9 control that information. What can a state do around
10 secondary use of the information, not the entire
11 privacy and security for all health information?
12 Again, very measurable rates, very limited in scope.
13 Licensure, I'd love to see a document that could be
14 passed out to the states. One of the discussions I'd
15 love to have -- I'm that well-versed in licensure
16 rules. I assume, probably to cut to the chase, I
17 think it's a revenue issue for the states. I'm not
18 sure that's the case. Maybe it's not. Maybe it's
19 just a quality issue. I'd love to learn about that.
20 Being maybe somewhat of a skeptic, if it's a revenue
21 issue in the sense that physicians practicing inside
22 the state line, is his revenue in this state or is

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1 his revenue in that state? I don't know.
2 I think technology is a key component in
3 the system, but it's a small piece of the puzzle.
4 GOVERNOR BREDESEN: I certainly concur
5 with what you say. There's a whole host of subjects.
6 Education is one that's always talked about. Every

7 time you talk about improving schools it spends off
8 into what you need to do in the community, what you
9 need to do with this and it never gets useful until
10 you actually bring it back to something real that's
11 happening that you can affect. So I'm totally in
12 support of that. There are things related to the
13 health care industry that could be discussed. There
14 are probably different views. Dr. Sensor was
15 speaking. I happen to agree with you, IT is a tool
16 that probably needs to be in the toolbox and one that
17 we've been charged with helping to design in some
18 what and what can we realistically do in the area?
19 Others may have different views on that.
20 This panel is about IT and the issues
21 surrounding it for better or worse. I'd like to just
22 push a little more and hear a little more about the

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1 security and access issues. I think they touch in so
2 many places the fundamental things that we're trying
3 to get at. When you have those solved, I can't
4 imagine that the IT part of becomes overwhelming
5 complex, but I think those are very complex.
6 Any thoughts about that? Governor?
7 GOVERNOR GERINGER: Representative Conaway
8 brought up a point that I think we need to
9 acknowledge. That is we're talking about privacy and
10 security. Records that we believe that we own, yet
11 there is a lot of information out there that others
12 believe they own and the best example of that was I

13 just recently had some dental work done in a
14 different state. The x-ray was taken and placed
15 digitally in an electronic record immediately.
16 I went back to my home dentist who could
17 not access that. The question was who owns that
18 record and I said I do. The dentist in the state
19 said, no, I do. So the question of ownership of
20 medical records, I think, is pretty important for us
21 to establish. I believe anything pertaining to my
22 health I own. I don't know whether we even have that

1 concept established. Until we establish who owns the
2 record of my data or the data pertaining to an
3 individual and who can control that, we don't know
4 what privacy and security we're protecting. The
5 security for the dentist who owns my record he said I
6 paid money for the equipment that took this. We see
7 that in so many ways between and among our state
8 agencies where they want to charge each other for
9 data or information in a broad area. So I think one
10 of the things we ought to do is establish who owns
11 the data that we're trying to protect and secure.
12 COMMISSIONER CLINE: I think that's a
13 really valid point. When you start looking at it, we
14 have much more payers out there and so the same
15 individual could have three different care providers
16 on any given day. They could be in a hospital on
17 that day as well. In addition to that, they could
18 have multiple payers that are providing for their

19 health care. So you get into this argument, and
20 you're exactly right, we find that among agency-to-
21 agency when we're trying to deal with issues or
22 addressing consumer needs or fraud issues, which all

1 tie into what we're trying to resolve here.
2 MS. PRITTS: One of the specific things
3 that you might be able to do through the taskforce is
4 actually look at how states treat the ownership of
5 medical records. At this point, most states do have
6 laws on the books addressing that issue, either
7 through statutes, regulations or through caselaw.
8 The question becomes, after you have that information
9 in your hands, whether you think that that kind of
10 framework still works if you're trying to move out
11 electronic records and possibly compiling a virtual
12 medica record where a person's record will consist of
13 different pieces from different providers.
14 GOVERNOR DOUGLAS: I just want to ask Joy,
15 do you know if there's a prevailing law on ownership?
16 MS. PRITTS: Yes, I do. I actually looked
17 at this issue. In most states, the standard is that
18 the person who created the record -- in most cases
19 the provider -- has technical legal ownership of the
20 record. The individual, the consumer, has in some
21 statutes, but mostly by caselaw, has been determined
22 to have what they call an "equitable" interest in it.

1 So it's almost going back to the English common law
2 really. They have an interest in it. What that
3 means is, for example, when a patient and a provider
4 decide to part ways, the patient never has the right
5 to say to the provider give me the entire record. I
6 don't want you looking at it. That' can't happen for
7 a variety of different reason. It becomes a very
8 thorny issue partly because of malpractice issues and
9 the need for them to keep their records. It's a
10 multi-dimensional issue. Ownership is part of it,
11 but it does branch off into other areas of law.
12 MR. CARTER: I'm looking at the last one
13 on the list, state goals. When we talk about privacy
14 and security, one of the things I think we could do
15 that would be of significant value a little bit
16 further along in the process is sort of doing a
17 reality check with regard to the preemption issue.
18 We spend so much time at the state level working on
19 initiatives that we feel are of great value to our
20 citizens, but then after these programs are
21 implemented, if somebody has a problem with it, they
22 say maybe there's a crack between the federal and the

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1 state law and the preemption issue comes up.
2 I think if we could look that before
3 rolling something out to a state as a model that
4 should be developed, it would be a good idea to do
5 that. Maybe one of the taskforces can take that on.

6 I think NAAG has done some significant work on
7 preemption issues. We could give some counsel on
8 that issue because it's very disappointing when we
9 adopt programs and initiatives at the state level
10 only to have them tied up in a fairly lengthy
11 judicial and litigation process and expect to come
12 out with a result that really is good for the states.
13 If we'd known that beforehand, we would have saved a
14 lot of time and energy and had really come out with
15 an issue that isn't good for the states. So if we
16 identify something that we really is in the state's
17 role, we need to be very clear about that and need to
18 seek federal acknowledgement of that.
19 And if we're going to have a federal view
20 that that is not the state's role, that, in fact,
21 it's been preempted by federal action, we might as
22 well know that early in the process. Then we can try

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1 to alter that decision or lobby people that can
2 affect that decision. But it would be helpful to do
3 that somewhere in the midst of this process.
4 GOVERNOR BREDESEN: I couldn't agree more.
5 I think when we talked about this taskforce coming
6 together in the first place, taskforce committee,
7 whatever it's called, one of the rationals for it was
8 that this a very fluid area right now. The Congress
9 tried and failed to come up with a common solution
10 here relatively recently. So the reason this is
11 exciting to me is I think there's a vacuum here. And

12 certainly the involvement of NGA -- my experience has
13 been that if NGA, across partisan lines, can agree on
14 something, it has enormous force in the Congress. It
15 just becomes a solved problem in a way.
16 So I really think while we obviously
17 should be aware of what they're doing, I just think
18 there's an opportunity here to kind of step into the
19 middle of the ring and do something sensible and do
20 it in a way that is broadly shared among the states
21 and we can, in effect, preempt that kind of action.
22 GOVERNOR DOUGLAS: It's interesting, Phil

1 -- and this is a very important point. When the
2 Congress was looking at federal legislation on health
3 IT last year, each chamber passed a bill that they
4 couldn't come to an agreement. One of the issues
5 they were hung up on was federal preemption. The
6 House wanted more. The Senate wanted less federal
7 preemption and I think our general view is we'd
8 prefer the Senate approach and will convey that to
9 the Congress this year.
10 MR. MOORE: One of the things we were
11 attempting to was to figure out what states are
12 spending now to develop IT. Part of that was how to
13 define what we're talking about to what the state
14 university health systems are doing, things that we
15 always don't know about. The Department of Public
16 Health is doing some things. If it would be helpful
17 to understand what their resources are, what are the

18 secretaries that are being directed to it in health
19 IT and where are the gaps and where are the needs.
20 Some of us think the federal government will give us
21 all the money we need. I don't think that's probably
22 going to happen. None of the states really have the

1 capacity to do it all on their own. The private
2 sector certainly has a role in helping us, but we're
3 trying to figure out how can the states use some
4 resources, perhaps, as a catalyst knowing the gaps
5 and knowing what's around and knowing what else
6 people are spending on and a lot of other things that
7 probably are not very effective and we see if we can
8 come up with some road map, perhaps, as to how to get
9 to the levels we need.
10 What are the resources we're going to
11 need? Where will they come from? Where should they
12 come from to get to the point to some of those
13 objective?
14 MR. PALMER: Thank you, Governor.
15 Just a couple of quick points. One
16 regarding the state role in health information
17 exchange. In the spirit of the states being
18 laboratories for innovation, it may be useful to
19 discuss and perhaps here from the Office of the
20 National Coordinator and some other groups about
21 what, if any, additional setting of data standards
22 could or should be done at the state level. Then

1 before we leave the issue of privacy and security of
2 health information, one of the major initiatives
3 under the Office of the National Coordinator is
4 around health information security and privacy. It
5 might be useful while we have the national
6 coordinator and the staff here to hear about that
7 initiative so that we don't wondering into areas that
8 are already being covered in another initiative.
9 MR. RODGERS: In setting standards or
10 looking at this, one of the areas you may want to
11 consider is that the record is a layered set of
12 information. There's information that's
13 controversial or sensitive and should be kept
14 confidential. There's information that we readily
15 share on our patients. And as we look at this, the
16 technology would allow you to create standards for
17 the type of information in the record that can be
18 shared openly and across state lines versus the kind
19 of information that has to have additional consent,
20 et cetera. That would be something, I think, the
21 committee should look at.
22 DR. SUNDWALL: Just to follow up on that,

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1 I want to agree, especially in times of emergency. I
2 think we need to consider that our privacy there may
3 need to be exceptions. We're not quite sure. I

4 can't tell you now what kind of information I would
5 like you to exempt from privacy, but I can tell you
6 it's a barrier. It could be. So from the public
7 health perspective, I would hope that we might
8 consider some of ASTHO's guidance, the Association of
9 State and Territorial Health Officers. For example,
10 in a state of emergency, we might want to exempt some
11 privacy to score with the public good.
12 GOVERNOR GERINGER: To add to that, the
13 Public Law Data Consortium is another good source for
14 that I think we ought to be checking on. One point
15 to make, I think, regarding disasters, we talked
16 about cross state licensure for issues such as
17 patients moving from state to state. I think in
18 disaster, more than anything, we're going to be
19 hearing from Louisiana about lessons learned there.
20 One of the more significant items was for
21 people who came down to volunteer for assistance,
22 physicians of all kinds. They had some difficulty of

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1 who could practice and who could not. At times of
2 major disaster or anything that's in our region then
3 crosses our state boundaries needs to be considered.
4 As we talk about telemedicine somehow just being the
5 future of rural America or even some of our island
6 participants, if you will. The concepts of
7 telemedicine are the same as portability across,
8 between and among any two institutions or providers.
9 They have the capacity, through

10 technology, for monitoring, for diagnosis, for
11 treatment, for follow-up. All of those things relate
12 to telemedicine, at least conceptually and I think
13 the relate to medicine in general. I would hope we
14 wouldn't differentiate too much thinking telemedicine
15 is simply the domain of rural America. I think it
16 has to do with transmitting from door-to-door the
17 prevention of medical errors in a single hospital.
18 When my brother was being treated at a
19 hospital, the fourth floor didn't know what the main
20 floor was doing because they weren't transmitting
21 information back and forth or they were misreading
22 what was in the written record. So I think

1 telemedicine has a role to play within and among
2 providers as well as within and among states. But
3 I'd like to see the issue of public health and
4 disaster management included, too.
5 REPRESENTATIVE CONAWAY: It's been
6 mentioned by Senator Moore and I just wanted to focus
7 on it a little bit more. This is a question of
8 things we might consider doing as we think about
9 structure is to think about how states, in putting
10 their health information system together, are going
11 to find that. I believe that health information is
12 sort of like a heat pump. You invest in it. It may
13 cost a little bit up front, but you're going to save
14 a lot of money as you go down the road. There are a
15 lot of interested parties who will stand to gain

16 quite a large benefit from the institution of these
17 kinds of systems and that benefit ought to be used to
18 help fund the system in the first place. What we
19 might discuss is what funding mechanisms the state
20 might long-term employ as they put their systems
21 together.
22 GOVERNOR BREDESEN: We've come to the end

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1 of the allotted time for this and we want to move on
2 now into the next panel session for the meeting. I
3 think, just to summarize, there have been a lot of
4 things talked about in here, but there's an
5 underlying piece which cuts across two or three of
6 the items that are listed up there, which is, if you
7 have information stored away electronically somewhere
8 lots of atoms of information about lots of individual
9 people, who can access it when, under what
10 circumstances? What are the implications? What are
11 the liabilities of it? There's an underlying piece
12 there that obviously is key to this and different
13 probably in this field than in most kinds of IT
14 applications.
15 I'd like to maybe just have people think
16 throughout the rest of these sessions and into the
17 afternoon, be thinking about how we pull that
18 together into some sort of a charge or set of
19 questions that we can ask the taskforce, which can
20 come out of this. I think that would be one of the
21 great results of today would be to pull it together

22 into something fairly specific. So if you could be

1 working on that at the back of your mind.
2 Now we're going to start the expert panel
3 sessions. These sessions will be moderated by some
4 of our State Alliance members. As the speakers
5 present, certainly, people should pose questions to
6 the speakers and engage in discussion.
7 I'd like to turn the meeting over to the
8 first of the discussion chairs, Commissioner Jane
9 Cline of West Virginia and Dr. Russell Ruffin.
10 COMMISSIONER CLINE: Thank you, Governor.
11 We'll begin the discussion on the health
12 information exchange for this session. Our panel of
13 experts will provide another view of the current
14 environment of electronic health information
15 exchange, looking at the critical issues for states
16 in electronic health information exchange and
17 identifying opportunities for states in this arena.
18 We will have both speakers present and then engage in
19 discussion. I would like to turn it over to Dr.
20 Ruffin to introduce our speakers.
21 DR. RUFFIN: Thank you very much,
22 Commissioner Cline.

1 One of the joys I have as a consultant is
2 I have a chance to meet very interesting people and

3 I've had the privilege of working with both of our
4 speakers and it's good to see you again.
5 Mark McCourt is in charge of business
6 development and interoperability for IBM. He's been
7 involved in health IT for more than 20 years. Dr.
8 Townsend is deputy secretary for hospitals and health
9 in Louisiana and before that a medical director for
10 the Department of Health.
11 Mark, you're going to speak first, then
12 Dr. Townsend.