

A F T E R N O O N S E S S I O N

(1:10 p.m.)

GOVERNOR BREDESEN: Why don't we go ahead and get going. I think there are a couple of people still struggling down from upstairs. I want to welcome everyone back from lunch.

This next hour is about examining the landscape of business models for electronic health information exchange. We're going to follow that by the role of publicly funded programs in e-health exchange.

Just before we start with our presenters, a bit of background and a reminder on this. This issue of sustainable business models was something that was considered to be important. We did not assign it to a taskforce because we decided to do three taskforces and I took our priorities 1 through 3. This certainly was No. 4. We agreed that we would take it up as a group. This is something at we can decide to take up as a group ourselves. This is something we could make a fourth taskforce or this is

something we get some sort of study going and come

back and report to us.

One of the things I would hope to accomplish today is that we might get some direction as to how we would like to attack this issue, if, in fact, we carry forward with it. We've got less than an hour at this point. We'll call it 45 or 50 minutes to do this. We have a couple of speakers whom I'm going to introduce, then I think we need to have some serious discussion about how we pursue and if we pursue this particular subject as a group in this first year.

I'd like now to introduce our next speakers. Viki Prescott is the principal investigator of a project that looked at sustainable health exchange services. We'll be hearing about that work today.

Ann Chapman with the digital health group at Intel will talk about private sector employer's efforts to come to the development of an infrastructure for gathering and securely storing information and health records.

Viki, if we could start with you, we'd

like to do that and then Ann will come after you.

MS. PRESCOTT: Good afternoon.

(Slide.)

MS. PRESCOTT: Thank you for the opportunity to be here today. I've been asked to give you a brief overview of financially sustainable business models that were found in ONC funded study to the AHIMA Foundation of Research and Education.

(Slide.)

MS. PRESCOTT: It was just a two-month study last fall. And also to give you some ideas on how possibly how state government can support and encourage financially sustainable HIE.

(Slide.)

MS. PRESCOTT: Some of the organizations that were interviewed are listed here. Other RHIOs, as we call them, were contacted but none really felt like their HIE services were to the point of financial sustainability for the purposes of the study or they did not meet the parameters of the study in particular. For instance, we looked at HIE

services, not necessarily an entire organization and

supporting that, but looking at an actual service and the cost of that.

We looked at the exchange of clinical or administrative data between multiple stakeholders, not just a couple and we didn't focus at all on merely increasing the use of EHRs or telemedicine. We were really looking at health information exchange between multiple entities. Also, on financial sustainability, that basically means having sufficient revenue to support ongoing operations. We did not consider startup costs for a number of reasons and also some of them, just as disclaimer, have a short track record. A couple have no track record, but enough financial commitment and enough evidence to support an argument for financial sustainability.

(Slide.)

MS. PRESCOTT: So the study revealed that although there are only a few examples so far there are some sustainable models for health information exchange. The recommendations that came out of the

study basically need to leverage any infrastructure

that's built and the data that's collected because the reuse of the data is what's going to be used to build other services upon it.

The key is just not to build another silo of data, but to reuse it for purposes that are acceptable to the community and the participants. Five particular services that were identified that I'll go through briefly, and I understand you've been provided some of the materials in advance. They're also available on the website at www.staterhio.org in case anyone wants to go there to see the full text.

The five are kind of broken into two different groups. One is some initial services that are a little bit less complex and easy to implement and the ones that are a little bit more complex. The first two are clinical messaging, which we found at HealthBridge, Inland Northwest and also in Indiana. Then Medication History Service in Indiana. The other three are the e-prescribing, sharing patient clinical data at the point of care and quality reporting. Two others were identified in the study,

but determined by the steering committee to have

limited applicability, so I won't go into those today.

(Slide.)

MS. PRESCOTT: The first one is clinical messaging. I only have a few minutes and I have to go over five business models, so I may be very brief. But you all can ask me any questions you want about specifics of them after we talk. So clinical messaging, just the basic premise, is to deliver the electronic clinical results such as a lab result from the lab system to the physician that ordered it, for instance. The return on investment is fairly easy to understand for the hospitals. They like the economies of scale and reducing the cost of not having to deliver the results themselves instead of having a central group to do that and the doctors like it because they only have to log onto one system to receive the results instead of having to log onto this hospital system and this hospital system. It also establishes connections between clinical data providers and physician offices. You don't need to

know who the patient is. Technically, you don't need

to know who that is. You just deliver the results.
It came out of the lab to the doctor.

The key is to know who the doctor is to deliver it to and also it's very highly relevant clinical data that can be used later on for other purposes and the physicians receive the test results faster and with less administrative time. There's also no privacy issues because you're delivering the result from the lab to a doctor. They're already doing that today.

Who pays for this? The hospitals have been found in the studies we saw and the labs to pay for this because it's a service. You're delivering it on their behalf. The doctors do not pay for the service.

(Slide.)

MS. PRESCOTT: The next one is medication history. It's basically sharing a patient's medication history from various sources obtained and sharing it with the clinician or institution that's treating the patient. This is attractive to

hospitals because there's a joint commission

requirement for them to do joint medication reconciliation. It could potentially reduce their costs in doing that. Usually, eligibility and formulary functions are included in the medication history and that can also reduce drug costs and increase efficiencies.

The clinical relevance of the data is very relevant to treatment. Patients frequently don't know what medications they're on. They could be unconscious, other medications could indicate other illnesses, which could impact the treatment regime. You could also reduce adverse drug events and duplication of drugs and actually, hopefully prevent some abuse of the system as well. It's also a little bit easier than some of the other functions because some of the sources for medication history have been pooled so you'd only have to do one or two interfaces, hopefully, to be able to get a good mass of data.

Who pays for this? The hospitals were paying for it based on the number of patients that

were matched.

(Slide.)

MS. PRESCOTT: The next one is e-prescribing, which is automating the process for the clinician to prescribe medications electronically to the pharmacy. A lot of this has been in the press as far as the benefits to lots of different stakeholders -- the payers, the employers, doctors, pharmacies and the patients themselves. This process could also include medication history, eligibility -- formulary things all combined into one. There are some implementation challenges to this, which is why it's not recommended as the No. 1 thing to start with, but you need a critical mass of pharmacies to be covered. There has to be software that the physicians are willing to use and some of those work flow changes are not insignificant when you try to implement it in a doctor's office.

Also, a critical mass of medication history and you need to be able to map the data to standard vocabulary for it to really be useful for physicians doing the e-prescribing.

Who pays for this? The study revealed

that the e-prescribing delivery network pays the health information exchange a portion of the fees that it receives from the pharmacies.

(Slide.)

MS. PRESCOTT: The next one is sharing the patient clinical data at the time and point of care, which I think is kind of the ultimate goal of health information exchange. This is, of course, of very high value to treatment as far as avoiding errors and reducing duplication of tests and procedures and providing some continuity of care.

Also, the standardize repository of clinical data can be used to benefit other stakeholders and secondary users -- public health researchers, pharma, the addition of clinical decision support and reminders functionality will also help improve care and there are some implementation challenges, of course, to doing such a large scale project. You need some kind of ability to match the patient. You have to standardize the data to really be of any value.

Also, it's sort of a difficult project to

value across different stakeholders, hence there has been hesitancy to invest. The one that we did find as far as who's paying for it, it's really funded primarily by research grants to study the effects of electronic health information on care and also long-term funding from a philanthropic local foundation that's seeing it as a public good. Some of the HIEs that are out there are trying to pursue a subscription model, but we don't know of any that have been successful yet.

(Slide.)

MS. PRESCOTT: The final one is quality measurement reporting, which is basically taking the clinical and the claims data together from multiple sources and looking at outcome measures and trying to use those to support provider quality initiatives and also serve as a basis for determining incentives for the payers to the providers. The payers can recognize improvement in their efficiency, of course, in doing this. The providers are happy because they only have to comply with one set of requirements

instead of all the different ones now from a variety

of payers and as the quality increase the patients will have better outcomes. Of course, the significant challenge to that, a quality reporting type function is that you really need a critical mass of clinical and claims data to be of any relevance.

Who pays for this? In Indiana, where we found this project being initiated and it's getting ready to go live pretty soon, the payers pay the HIE a per member, per month fee for the reports. Reports are given to the payers as well as the providers directly to help them improve care. The payers then give incentives directly to the physicians based on their score, their performance.

(Slide.)

MS. PRESCOTT: Where can state government get involved? Any of these basic places is where we can get involved. Whenever the data is entered, getting it into electronic form, the data source sending the data you can try to support that. Mapping and standardizing the data, which is actually the biggest expense that we found in Indiana. Also,

the data being matched to the patient and being sent

to where it should go, accessing the data and having that incorporated into the work flow of the physician, incenting him to do that. Also, the decision support tools.

There are many different points in which the state can get involved. Just to throw out, of course, you know what the options are, in general, for state government. You have carrots and sticks, but I just want to emphasize a couple of examples. I think the two main things is basically the state can help participation, getting that critical mass of data. For instance, to allow the RHIO, for instance, to get access to state data or to get access to money, for instance, from a funding state's grant program. You could have them secure 50 percent of the hospital's participation in the region and actually get the hospitals to sign on the dotted line to say they're going to give data. They're going to subscribe, for instance, if they're trying to promote a clinical messaging service, that's just one way.

Also, you could increase reimbursement

through Medicaid or give tax credits for for-profits

corporations. To the doctors for using the patient look-up, even make it a reimbursable event to do a patient look-up for the history or you could increase the reimbursement to hospitals and labs who supply the data. Also, to be a vantage care organization for Medicaid you could require their participation in a local HIE. The state could also use its size to negotiate deals with national data sources and to secure more discounted deals with them.

The other biggest thing, I think, is the state could help with the mapping of the data. As I mentioned before, it's a very large and expensive task to map. Basically, mostly the lab data is the key. If there's anyway that you could encourage or require mapping, you could increase the reimbursement to labs. If the submit link maps lab results or you could require for the lab to actually be a lab for the state. You could require them to map their data.

Those are just a few ideas to throw out for discussion. I'm happy to take your questions.

GOVERNOR BREDESEN: Thank you. I remind

you again, Ann is from Intel and is going to speak

about the private sector initiatives.

MS. CHAPMAN: Thank you very much for inviting us.

(Slide.)

MS. CHAPMAN: I'm here representing both Intel and Dossia Employer Coalition. The Dossia Employer Coalition is building a secure infrastructure that will aggregate health information for our employees to be able to provide them with a portable, personal health record. That is our goal. Intel has lead the effort to recruit the other founders to the Dossier Coalition.

(Slide.)

MS. CHAPMAN: I've given you a little background and rationale and I won't go into all of that with you, but just a little bit about why employers are engaged because we pay almost half of the U.S. health care bill. So at a high level what we're intending to do is recruit other employers to fund a not-for-profit organization. So arm-length from the employers because employers are not viewed

as trusted stewards of their employees health care

data to build a secure infrastructure of information that then would be provided to our employees as a benefit in their health and wellness programs.

We believe once this is built the infrastructure will automatically populate information into an electronic format for our employees to view. And once they're members of the Dossia infrastructure, they can take that data with them regardless of which health plan they belong to. A doctor or a health system may see they are employed. It makes it personal, private and portable, which are the three Ps we tried to integrate into the system.

(Slide.)

MS. CHAPMAN: What is Dossia? Dossia is frequently confused with a personal health record. What we are really trying to do is build the infrastructure that would populate personal health records. So it is an infrastructure, not the personal health record. We expect that Dossia will work with all personal health products and services

to provide that information to them. It's a multiple

employer initiative. As I said, there are currently six large employers involved. We're about to announce two additional employers, so we will have eight employers participating. They represent, I think, about 3 to 4 million potential users in the system and our employees dependence and retirees. We are intending to run Dossia as a public utility, so the infrastructure part would be a public utility. At the utility level, we would then integrate the privacy and security safeguards. It is an effort by large employers to improve quality and accelerate health information exchange. It is directed to consumers.

(Slide.)

MS. CHAPMAN: What Dossier is not? It is not a personal health record, but it would work with all other personal health records or personal health services. It is not a commercial activity for the founding companies. We have our large employer hats on when we are talking about Dossia. We are interested in providing this as a benefit for our

employees rather than as any kind of commercial

activity. It isn't teetered just to one particular current player in the health care system. In other words, we would work with plans. We would work with PHR vendors, integrated delivery networks -- all different players in the health care system today.

(Slide.)

MS. CHAPMAN: This is a high-level summary of our business plan. Again, the goal is to accelerate the computerization of the U.S. health care industry by funding a public utility that provides for an infrastructure that will enable the widespread uptake of personal health records for consumers. We're funding a separate not-for-profit organization to do that. The Dossia board will guide in the development of that infrastructure.

I'm trying to think of anything else I missed, but you can read this. Funding for this comes from the 10 employers. The board has authorized up to 13 member companies to participate.

(Slide.)

MS. CHAPMAN: This is kind of hard to read

on this, but what that blue area up there is -- it

says it's the Dossia infrastructure. This is kind of a visual of the Dossia scope. The .org portion of the scope is what we envision Dossia will build, the not-for-profit will build.

We would aggregate data from the various data sources, which are depicted at the bottom of the screen -- electronic data aggregated in various places. Then we would provide authentication to make sure that individuals are who they say they are. We would gather their data with a record locator service, bring that data into the Dossia infrastructure in a secure way in a standard format. We would also build the API, the Applications Programming Interface. That would be open-source so that all vendors that we say are on top of the system and building on top of the system could use the Dossia infrastructure to populate their applications. This is essentially what we're building, what employers are funding to be built by Omnimedix.

(Slide.)

MS. CHAPMAN: Our commitment as employers

that we will provide \$1.5 million to Omnimedix to

develop Dossia. We will guide in the development of that infrastructure, but we will keep arms length from Omnimedix because, as I've said, employers are not viewed as trusted stewards of their employees' data.

The founding companies for this can use the infrastructure once it's developed for the five years of the project's development. During that time we would also work with Omnimedix to begin to develop the longer term business model to sustain Dossia as a public utility and to scale the project to achieve widespread uptake of PHR usage amongst consumers.

Those are our goals.

(Slide.)

MS. CHAPMAN: A little bit about the underlying considerations that we used in developing Dossia. We built much of our business plan upon the work that the Marcol Foundation and the Robert Woods Johnson had done -- the research and the public/private collaborative Connecting for Health project. We continued to work closely with

Connecting for Health to be able to update any of the

things that they are discovering in their research so we are not reinventing the wheel.

We are also working with numerous organizations that were pilots for the Marcol project as well. We are developing this not-for-profit public utility model because we want to remove the incentive for data ownership by the data silos. Many of the PHR vendors are beginning to build linkages to data sources, but those will all be proprietary. So from an employer perspective, if we have a linkage to a PHR vendor and they build linkages to data sources, if we decided to change vendors, we reinvent that wheel again and again. So what we're trying to avoid is the ownership at that data infrastructure level.

We want the PHR industry to thrive and to go forward. So we're hoping that if we build this infrastructure the public, the PHR industry then will expand. We're essentially using large self-funded employers to finance the Marcol Connecting for Health model and we are going to test with our own workforces, so that's why we need to be very involved

in what the product looks like. But we're going to

test with our own workforces and we really would like the consumer, at least initially, to become the point of interoperability within the health care system. So as they travel across the system, they're engaged with their own information, sharing that information as the Marcol research says with providers of care or others. But it's a completely voluntary system and consumers opt into that system.

(Slide.)

MS. CHAPMAN: Where we are in the project at this time, the Dossia's founders board has been convened. We have officers. We're finalizing a development agreement with Omnimedix at this time, which will really be our work plan going forward with timelines, milestones, et cetera.

The founder's board has developed work groups that are staffed and actively working with Omnimedix. I've given you those work groups there as well. We're also planning to have at least three advisory groups, which would be external bodies that would advise our effort as well. We will have an

external privacy and security group. We will have an

external group of clinical group providers, et cetera. We're also developing a kind of public entity group for want of a better way to describe it that would be comprised of state and federal representatives that would help influence us about what is going on in terms of states and the federal government about PHRs.

Brian DeVore, who sits on this committee, will be heading up that effort for us. Our next steps are really to begin to build the infrastructure and plan deployment to our workforces, based on project milestones.

(Slide.)

MS. CHAPMAN: I think that applicability to states efforts -- it's been very interesting to listen to a lot of the presenters here today. I think we will have a much better idea once we begin building exactly how we will work with states, but we're talking about testing our initial plan with private employers. We think that's a less restrictive environment for testing something that

has never been built before. Then at the same time,

we want to begin to engage public entities as sort of Phase 2 participants in Dossia.

We've begun to reach out to state and federal agencies to do that. As I said, we're going to develop this public sector advisory group that will create dialogue with states and interested public agencies about how Dossia can be applicable to the states' efforts. Ultimately, we would engage with three to four receptive public groups to identify state/federal requirements that would be necessary for engaging the populations and using Dossia, then identify state and federal business problems that Dossia might be able to solve as well.

That's what we're working on.

GOVERNOR BREDESEN: Thank you very much.

We now have some time, 25 minutes perhaps, for some discussion of this. For those of you who weren't here right at the outset, I just remind you that this was a subject which was, I think it was fair to say, was in the original charge for this group. We did not assign it to a taskforce and I

think really the taskforce that we're going to talk

about more this afternoon on the use of e-health in state health initiatives plans, the delivery of health care, Medicare and the like sort of bumped it one notch down. We thought that was important.

What we need to do today -- what I'd like to come out of this session with today is some decision from this group about how we handle this subject. We can try to take it on ourselves as a group. We can make a fourth taskforce I'm told. And if we want to do that, there's no reason not to do that. We can do some sort of study. I believe there's at least a little money available to do something like that. We even have someone report in the study group back to us. We can say this is none of the government's business. There's other things we should be concentrating on. We could say this is a second-year issue. This is a three-year commission. I think they'll fire Jim and I after one, but you all will be here and this could be an issue we take up in the second year.

I'd like to come out of this next 20 or 25

minutes or so with some ideas about how we should

proceed on this particular issue. It may well help to question these people about some of those things to come to a decision about that.

Any questions for these people? Then I'd like to tackle that issue? Yes, Gayle?

REPRESENTATIVE HARRELL: Thank you very much.

I do have a question. Listening to both the public and private sector and how we can integrate the two. What concerns me if we have two silos developing, we have a public sector that's PHIN in Florida. Then we have a private sector, Dossia, going on at the same time. There needs to be integration between them. Is there a way that that can happen? Certainly, the personal health information record is important, but you need to be able to populate that with information that may be in the Florida Health Information network. Is there a way to bridge that gap and pull these two things together so that we have the individual person who is keeping the record for themselves could also have

access to the information that's already existing as

we get our public entities infrastructure in place?

MS. CHAPMAN: We envision that Dossia will be complementary to all the HIE efforts that are out there. We had envisioned that information could flow from those data sources into Dossia or vice versa. We view Dossia as kind of a national platform that could link to regional HIE efforts as well. We think of those as being complementary.

GOVERNOR BREDESEN: Would you like to follow up?

REPRESENTATIVE HARRELL: I'd like to follow up on that. Say, I'm a physician accessing electronic health records for a patient through the PHIN in Florida. Would that PHIN then collect into Dossia and pull down everything that was in Dossia? Would a patient on the other end be able to come back through the PHIN and come back through everything that was -- all the hospital records and everything through the PHIN?

MS. CHAPMAN: Remember Dossia is consumer-centric. Everything goes to the consumer and the

consumer gives permission to providers to look at

that data, for instance. For instance, if a consumer has given information in their Dossier records to share with others, that information would be shared.

GOVERNOR BREDESEN: Dr. Tuckson?

DR. TUCKSON: I had the same sort of interest that was just expressed. One of the beauties about this historical moment is there's so much going on. There's so much initiative being developed. One of the challenges of this historical moment is how do you align it all up so that without creating enormous bureaucracies and sluggish activities that you can move and be innovative. Are you comfortable, as you are pushing through on this very exciting initiative, that the alignment -- that there's enough leadership at the federal level in terms of these national things that you heard about earlier today giving you enough guidance such that as you are building these things out that states like Florida and many other states that are trying to do these sorts of things that these things will sort of come together or are we going to wind up with a bunch

of trains all running down the road and then have to

some how or other have some massive effort to
reconfigure them so they can actually talk to each
other and be consistent?

DR. TUCKSON: Is there something lacking at this point in terms of a more national leadership, that would allow you to plan your thing in a more coherent way with other activities?

MS. CHAPMAN: I think that as we begin to build, we are reaching out to entities that are already there. We are reaching out. We have legislative subcommittees. We have committees that gather information about where the other significant data aggregation, health information exchanges are.

But you're right. It's a huge issue, as the sort of major trains are leaving the station all at the same time. I think our goal is to align with what's out there.

Information will be in our system, in a standardized way, so it can be shared. It's designed to be a publicly-accessible system. It's not proprietary in any way, shape or form.

Obviously, we would build as best we can to anticipate that we would align with the other exchanges that are out there today.

GOVERNOR BREDESEN: Representative

Conaway.

REPRESENTATIVE CONAWAY : I'm very excited to hear your proposal today, because I believe it is important for this information to be managed as a public utility. I did have concerns about governance. You mentioned that you've picked a board already.

I presume these board members have been drawn from the corporate community that's financing this effort?

MS. CHAPMAN: Yes.

REPRESENTATIVE CONAWAY : I have to say I have a concern regarding that. I share a concern that's been mentioned by Representative Harrell and Dr. Tuckson about how this is going to be knitted together.

I'm very excited, speaking to the governor's point about the way the states are going to finance this thing. States are not going to be able to move forward with the financial limitations we have unless we make some decisions about how we

fund this.

Often we fund by assessing, for want of a better word, folks who are going to derive benefit from it. I'm most excited about the fact that business sees this as an important initiative, that they're willing to put their financial resources behind.

I hadn't had them involved -- well, I did, but I feel better about the fact that folks are willing to come forward and help fund this. You mentioned four million people that you expect to be involved with these personal health records. Was that the number you used?

MS. CHAPMAN: I'm struggling. We have these two new companies coming on. I'm struggling to give you an actual number. That would be employees' dependence and retirees of the companies, the founding companies. So those would be potential users of this system.

REPRESENTATIVE CONAWAY : That's a fair-sized state. We've got eight million plus people in New Jersey. Right now you've got \$15 million that

you believe you need to put together to manage

information for approximately four million plus people, is that right?

I'm just thinking of numbers really.

Ratcheting this thing up and figuring out how much it's going to cost is a big part of moving forward.

MS. CHAPMAN: From my own perspective, once the infrastructure is built, it could be scaled to other populations. I guess we were thinking it wouldn't necessarily have to be rebuilt, but instead we were thinking about scaling that existing model. But one could rebuild.

REPRESENTATIVE CONAWAY : I'm not asking about rebuilding. I'm really asking about how much, and you've got infrastructure questions. That was my next question.

But we're talking about buying service, buying hardware, housing that some place, protecting that and securing that hardware. Do you have some sense of just how large that is, how large a building that is? Is it going to be one place? Is it going to be dispersed? How do you see that infrastructure?

What's the infrastructure going to look like, I

guess, is the question?

MS. CHAPMAN: Omnimedix is actually building that infrastructure. We've seen some preliminary plans. Once it's built, we can certainly share that. It can be some kind of a federated model of data storage.

REPRESENTATIVE CONAWAY : Thank you.

GOVERNOR BREDESEN: Governor?

MR. GERINGER: Here's a thought. Maybe I'm getting into the second part of what you talked about. It pertains to both of these presentations. Victoria, you didn't get too much into this full report, but I thought it was an excellent report.

One of the things -- well, first of all, your incremental approach in targeting those areas that have some potential early on I think is a very solid approach.

One of the things the report says more or less to do is stay away from Medicaid. In other words, it's going to be too complex. Medicaid has its Medicaid IT architecture coming along, which is

too far off to anticipate.

I would think just the opposite. We ought to be accommodating that moving into it. But to Herb's comment about this is a fair-sized state, it's pretty fair-sized compared to the population of Wyoming.

The idea would be that we aren't going to design what Massachusetts does, nor are you going to design what Wyoming does. So I wouldn't necessarily say we need to design what the private sector is going to be, except to say why don't we have the same standards?

Whether it's PHIN or Dossia or what's mentioned, the four reports or whatever other acronym is out there. As long as we work with the same standards and protocols, I don't care who does what.

I'm very excited by what the private sector has put together as an initiative here, because I think it will move a lot more quickly. It's a opt-in choice, where we develop the health passport model of our western states. We had a selected population. These were state recipients of

benefits in five different categories.

Then you put it under control of the patient, and the patient chooses who has health identification capabilities to access their records. So the patient is in control or the family, as was our case.

What I'd like to see is the private initiative move forward, with some coordination in what's going on in the public sector. What I put on the table is that the architectures that you've mentioned, and now I've lost the report, the one that had the purple blot on it, the PHR industry architecture, the Medicaid architecture that's being proposed for their IT.

As long as there is standardization of what can be interchangeable on records, since nearly 50 percent of all live births in America are paid under Medicaid and you move on from there, there needs to be some potential for interaction, as long as there's some acknowledgment of what's going on there. That would help.

The third point I'd make is the State

Association of CIOs and when it comes down to our

states implementing all the IT, we're talking about our CIOs would have to get involved, should be involved right away.

I know that they are interested. They have their own E-Health initiative going on. Mr. Chairman, to answer your question as to the second part, how do we move forward on this, I say let's engage the CIOs through NACIO. They could help head up whatever alternative or study committee we decide to pursue.

I think that would leverage our capability of the states to implement whatever comes along in the long run. I'd like to hear some discussion about how we can allow individual efforts to move along, how we can allow states to take their own initiatives as long as we abide by certain standards and protocols similar to the private sector, which I think can lead us rather than follow us.

GOVERNOR BREDESEN: Ricky, did you have something?

MS. PRESCOTT: I'd just like to respond on

the Medicaid point. I'm not sure exactly. It sounds

like they gave you the full report. I'm only presenting on Task No. 2, which was the sustainability piece.

There is a separate Task 3, I think it was, that was on Medicaid, and it was more like they interviewed several different people in the government and in the states, to try to kind of do a little survey on how Medicaid was involved currently in HIE.

I think that's what that was about. I just want to say from my standpoint, Medicaid is a great resource, and in Indiana they're a partner with us. They have given us all their claims data to be able to use in the exchange.

We're also working with them on their chronic disease management program, and several other different ways. So I highly recommend Medicaid being involved and really we don't have to wait for NIDA to be implemented to be able to use that data.

GOVERNOR BREDESEN: We've got ten minutes. What do you want to do with this issue? Joy?

MS. PRITTS: I had a brief funding

question for Anne. As I understand it, the initial outlay by the employers is to build a system. What is the long term funding proposition here? Even if it's a not-for-profit, you have to have some revenue stream coming in.

MS. CHAPMAN: Yes.

MS. PRITTS: Where is that coming from?

MS. CHAPMAN: We don't know at this point.

We're willing to fund the building of the infrastructure. We're willing to use volunteer labor from the companies to guide that.

But we don't exactly know what a sustainable business model would look like. We had ideas for what it might look like, but one of the tasks of this project is that by the end of Year 2 or the beginning of Year 3, we actually begin to put together sustainable business models and then pursue those.

The goal is that after the end of five years, the Dossia founders kind of recede from the whole picture, and the public utility is sustainable

and can move forward without us. That's the plan.

GOVERNOR BREDESEN: Wayne?

MR. SENSOR: Thank you, Chairman Bredesen.

It seems to me that every topic we have globally around E-Health at some time or another, the question of funding comes back to the surface.

At least from my seat, I can't imagine how we could see in the states a solution but not having figured out how we are going to pay for it. It seems the two topics here are functionality followed by funding.

Until we have a sense of the features and Victoria's presentation amply pointed out, there's a huge variety of what the model looks like, and therefore what it would cost.

So I throw it on the floor for consideration. I do think it's an important part of the work. It would seem to me it's something we can't ignore. If we're charged as governors for bringing forward something meaningful for the states, my two cents' worth, I don't know that it needs a task force.

But it does seem to me that we ought to

assign resources and ask for some study analysis and some options for business plans, transaction fees, whatever those may be, as part of this work.

GOVERNOR BREDESEN: Other thoughts on that?

REPRESENTATIVE CONAWAY : I would agree. Task force or not, they really would come back and present to us in as much detail as possible, all of their stakeholders and what their contribution and benefit from the system is.

Statistics, I guess it's the wrong word. But it's been asserted that the payors derive three to seven dollars in benefit from each electronic transaction. Well, from the extent of someone concerned about public health, how do I capture that to use to drive the system.

I hear now that business has an interest in this, and is willing to put their dollars behind. That sounds like commitment to me. I'm very happy to hear that, because that could be used to help fund the system that will help us develop the system that

will serve the Medicaid population.

We really need to save money in advance, coordination and reducing redundancy of care in that sector that's government-paid and supported in the field.

Each one of those players, it would be nice to have someone come back and report to us here are the benefits, here are the costs, this is what can be captured for the public good. I think that would be very valuable information to the states.

GOVERNOR BREDESEN: Governor?

MS. SHAHEEN: Since I missed the last meeting, I'm curious about why a task force wasn't appointed to address this issue, and I'm going to have another question.

GOVERNOR BREDESEN: I think it was. We were trying, and I certainly buy into the notion wholeheartedly. This is a three-year commission with initially a one-year time horizon to find two or three things we actually could do, rather than open up the entire world of E-Health for consideration. So we were just economical with the things we were

doing.

MS. SHAHEEN: My second question. I certainly agree with both Wayne, both of the earlier points about this is a topic that is important for us to know more about.

The question I've got, based on the presentations is, whether we would benefit by being a little further along before we do the kind of analysis that's being recommended, given that we're at the early stages of these business models.

It might be more beneficial to jump in at the end of the year and use this as a second year focus, when we've got a little more information from what's already been done.

I would ask you all if you have any opinion on that.

MS. PRESCOTT: Actually, Kathleen might already be aware of this. There's another organization. AHIMA has a grant from ONC, and it's been extended for another two years. There's a couple of things they're going to do in that process.

One of them is look at different HIE

services across the country, and describe those and

what's involved in it, the costs, if we know them, etcetera.

In addition to that, I believe they're going to take another look at sustainable business models a little bit later in this year. I just want to make you aware of that.

GOVERNOR BREDESEN: Go ahead.

MR. SUNDWALL: One quick comment. I don't want us to skip over those models you've already shown us that seem to be self-sustaining. There were some examples. I don't mean it to sound like I'm only talking about Utah, but we do have one example.

It's a not-for-profit public utility. It's the same kind of model that's been in existence for ten years. Why they were successful, I think, is that they started not with clinical exchange by providing a service that both hospitals, doctors and payors wanted. That is claims processing.

Ninety plus percent of all claims in this whole state are done through UM. It's not a data repository; it's a conduit through which this is

done. Everyone liked that and bought into it.

Now we have the specter of people that are interested, whether it be hospitals, doctors, dentists, payors. They are participants when we got our RHIO grant.

Now we're moving on to clinical exchange, and it's cheap. It is not expensive. I would recommend your consideration of getting this type of participants to pay a modest fee. Then they reap the benefit.

GOVERNOR BREDESEN: I don't know if any of the rest of you had the same reaction. When I listened to the presentations, it underlined for me the enormous gap between what was.

This may be overstating it, a fairly bleak picture of what is actually sustainable and working out there right now, and the very high-minded things we're all talking about.

There's a pretty big gap in there to fill in. Governor Shaheen mentioned this issue of perhaps the thing to do might be to start something in the way of studying something underway now and understand

that this might be more usefully picked up next year

or even in the third year, when some of these other issues have been resolved, and the whole thing had just cooked a little more. How do you all feel about that?

REPRESENTATIVE CONAWAY : Personally, I think it's going to be difficult to get decision-makers in the front office and in the appropriate chairs to make decisions about putting something together, unless they know what the financial outlay is going to be.

It's hard to move forward unless you know what it's going to cost. Maybe the governors do too much of that. I'm sure they have. We're going to try to figure out the paradigms of what the costs are, but we have to try to get something going, and I think the costs really are an early part of it, not coming in on the back end.

GOVERNOR BREDESEN: Other thoughts?
Commissioner?

COMMISSIONER PRAEGER: Maybe we don't have to figure out the cost per se, because we don't know

enough. What is the mechanism for bringing revenue

in? How do you bring it in? How do you pay for it? Then you can play with the numbers, but that has to be a key element.

GOVERNOR BREDESEN: I'm just trying to pull together how this one proposal -- to put it on the table here might be to say let's begin doing some work on at least models for how the costs, how money might be collected in regard to these transactions, put some work underway either in the form of a task force. That sounds more like a study group to me.

Then again, do we have the capability of doing that? Okay. Some sort of a study group put together to do that, with the idea of that information will feed back in over the course of this year.

We'll have maybe some successful defined work product in these other three task forces for next January, and this can be a subject which is then taken up with a little more information. Yes, Joy?

MS. PRITTS: I think one of the first things we can do, and this ties into what Victoria,

mentioned, is to make sure that we've been able to

identify and tap into all the resources that are currently underway, because there's no sense --

GOVERNOR BREDESEN: Somebody needs to enumerate those in the study. Well, since we need to bring this to a close, there's a proposal on the table, I guess.

I don't know how to formalize it, but to say let's put a study group together to look at how you collect money for the transactions, or something along those lines, with the idea being in mind that it works over the course of the next year.

But this is a second year issue in terms of putting more spectrum on that.

MR. PALMER: One quick point. It's important as we look into the study group to really bring it to the state level, whatever conclusions are drawn. These are things that the states can act on at the state level.

GOVERNOR BREDESEN: I as a governor would like to know is if there is transaction cost out there that somebody would pay, that could help it

work in my state. That's what I hope might come out

of some of these kinds of things.

COMMISSIONER PRAEGER: I'm sure it's inherent. But just to make sure we're clear that somebody's going to pay, and the potential payors.

GOVERNOR BREDESEN: I guess I'm trying to say rather than trying to budget this thing out and say "Well, maybe it's like mass transit. People are charged something, but it's also a public subsidy to make it work."

I'm just looking at those various kinds of alternatives. Dr. Tuckson?

DR. TUCKSON: I don't know whether to be part of a study group or not, because I think it's fairly specific. But as to the point that Representative Harrell made a moment ago, and I tried to make, as well as Dr. Conaway, could we get at least --

But I see we still have with us the American Health Information Community Office of Health Technology people. Jodi is still here.

If they could at least provide some

updates to us around the opportunities for synergy

around some of these standards that Governor Geringer sort of got out a moment ago, so we could start to get some idea of how these things are tracking together, and more of information updates, so we don't leave this issue hanging.

GOVERNOR BREDESEN: Okay. I would then ask for guidance here. We are already seven minutes over my assigned time here. I'm trying to get this done. Could we perhaps suggest that be done at the next meeting?

DR. TUCKSON: I mean an update next meeting, not now.

GOVERNOR BREDESEN: I thought you were going to have to extemporize here.

(Laughter.)

GOVERNOR BREDESEN: This idea of putting a study group out there, let's put a list together to gather information. Could someone make that into the form of a motion?

VOICES: So moved.

VOICES: Second.

GOVERNOR BREDESEN: Any further

discussion?

(No response.)

GOVERNOR BREDESEN: All in favor?

(Chorus of ayes.)

GOVERNOR BREDESEN: Opposed?

(No response.)

GOVERNOR BREDESEN: Jim, it's yours.