

TRANSCRIPT OF  
STATE ALLIANCE FOR E-HEALTH  
QUARTERLY CONFERENCE  
AUGUST 15, 2007  
THE HILTON HOTEL  
BURLINGTON, VERMONT

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1 August 15, 2007, 10:19 a.m.  
2 GOVERNOR JIM DOUGLAS: Well, almost  
3 everyone is here, so why don't we get the meeting  
4 under way. We really appreciate everyone coming to

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5 Burlington for our State Alliance for e-Health  
6 meeting.

7 I think it was useful to take the time to  
8 go to GE Healthcare this morning to see a major  
9 player in the health IT field. It's located just a  
10 couple of miles from our meeting site.

11 It worked out very well, and we appreciate  
12 GE Healthcare's hospitality in sharing their  
13 experiences with us, and we ran out of time for  
14 questions, but as Norman indicated, if other issues  
15 or requests or questions come up, just funnel them  
16 through Kathleen, and she'll be happy to get the  
17 information back from GE.

18 I want to, on behalf of my cochair,  
19 Governor Bredesen, welcome you all to our quarterly  
20 meeting. We enjoyed a nice reception last evening  
21 on the shores of Lake Champlain.

22 I've taken a little grief for calling it a  
23 Great Lake, but I have to explain to you that it  
24 actually was a Great Lake at one point. About a  
25 decade or so ago, one of our Vermont senators snuck

1 a little amendment into a bill in Congress to  
2 designate Lake Champlain as the sixth Great Lake.  
3 Well, it was short lived, because the Congressional  
4 delegations in the Upper Midwest took some exception  
5 to that and persuaded their colleagues to rescind  
6 it, so it lasted for a very brief time, but it is a  
7 formerly Great Lake, and still a darn good one, so  
8 thank you all for coming to meet on its shores.

9 Well, last time at our meeting in  
10 Washington, we received an overview of state

11 activities related to electronic health information  
12 exchange, including some legislative approaches that  
13 are used by some of our states and also some  
14 emergent sustainability models.

15 We discussed challenges that are faced by  
16 publicly funded programs in engaging in electronic  
17 health information exchange with representatives  
18 from the state public health programs and with  
19 Medicaid.

20 As we've indicated in our deliberations,  
21 unless the public payers and players are at the  
22 table, it's going to be very difficult to realize  
23 our goal of a true universal exchange.

24 We heard reports from members of our task  
25 forces on information protection of health care

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1 practices, we revised their work products, and  
2 refined the charge for the health information  
3 communication and data exchange task force.

4 We asked our task forces to examine the  
5 issues and identify recommendations for states with  
6 regard to several initiatives -- first, the  
7 participation of publicly funded programs in an  
8 exchange; secondly, approaches for addressing  
9 privacy and security challenges in health  
10 information exchange.

11 We learned about some of the approaches  
12 that GE Healthcare is taking at our visit this  
13 morning. And then also to address provider  
14 licensure, something that's going to be very  
15 important as we cross jurisdictional boundaries in

16 Opening and Taskforce Presentations.txt  
the provision of care with electronic information.

17 So since we met last, these three task  
18 forces have met, they have done a great deal of  
19 work, and developed some reports that we'll be  
20 hearing in just a few minutes.

21 Two of the task forces will present their  
22 first set of recommends for our consideration that  
23 we would plan to advance as guidance to the states.  
24 First, before we get into the agenda, I want to take  
25 our roll, so you all get credit and paid for -- all  
5

1 right, credit -- for being here today, and I really  
2 do appreciate it.

3 Governor Bredesen appears to be here. I'll  
4 mark you as present, sir.

5 GOVERNOR PHIL BREDESEN: Present.

6 GOVERNOR JIM DOUGLAS: General Carter  
7 I know is here. Commissioner Cline isn't. Are we  
8 expecting -- oh, she is, okay. Oh, that's fine.  
9 Assemblyman Conaway is here. Ms. Contreras isn't, I  
10 guess. Mr. DeVore is here. Governor Geringer can't  
11 be with us this time, I guess. Representative  
12 Harrell is here. Senator Moore is here. General  
13 Myers here. Mr. Palmer is -- there he is -- here.  
14 Commissioner Praeger is here. Ms. Pritts is here.  
15 Dr. Ruffin is here. Mr. Sensor is here. Governor  
16 Shaheen is here. Dr. Sundwall is here.  
17 Representative Svedjan is here. And Dr. Tuckson  
18 isn't. Are we expecting him? Well, we'll hope that  
19 maybe he's stopped at a store to buy some Vermont  
20 products or something, and will be with us shortly.

21 Well, again, I really want to thank you all  
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22 for being here, for being a part of our Alliance,  
23 and welcome to Vermont.

24 GOVERNOR PHIL BREDESEN: Okay, thank  
25 you, Jim, I thank you very much. When we were at <sup>6</sup>

1 the last meeting, and this meeting was originally  
2 scheduled in July, I was having the day off because  
3 my son and I were going to go fishing, so I  
4 appreciate you moving our meeting, because we got  
5 lots of salmon and lots of trout, and really this is  
6 a wonderful thing to be doing here, but that was  
7 actually a lot more satisfying for that particular  
8 week.

9 This morning's meeting began, obviously,  
10 earlier with a site visit which Governor Douglas  
11 coordinated, and Jim, thank you once again for doing  
12 that. That was a very useful couple of hours to  
13 witness an exchange and some of the things that are  
14 going on with technology and medical records and  
15 information exchange in real time.

16 As we work to identify opportunities and  
17 advance recommendations, I think these real-world  
18 examples are very helpful to just kind of give us an  
19 a little dipstick to what private industry are doing  
20 and I'm sure what nonprofits are doing in this field  
21 and give us some things to hang onto as to both  
22 what's going on and also what are some of the  
23 challenges in health care information technology  
24 today.

25 We have an ambitious agenda today; you have <sup>7</sup>

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1 the information in your packets there. The task  
2 forces are going to share with us their progress to  
3 date. Two of them are prepared to present some  
4 initial recommendations. And we need to then review  
5 those recommendations and discuss outstanding issues  
6 and vote on accepting or give them additional work  
7 to do in relation to those.

8 After lunch, we're going to take a look at  
9 e-prescribing and its potential to help drive the  
10 adoption of health IT systems. Part of the reason  
11 here is I think the growing feeling in this group  
12 that promoting e-prescribing could be a feasible and  
13 incremental step toward advancing the development of  
14 health information exchange and the widespread use  
15 of records. It has potential to point the way in  
16 this regard.

17 I think we are -- what both of us are  
18 trying to do is reduce the size of the landscape  
19 here enough so we can actually tie a bow around one  
20 or two things and show some real accomplishments and  
21 begin implementing some things.

22 With that in mind, we've got time reserved  
23 this afternoon to discuss what specific actions we  
24 might take with regard to e-prescribing, so I'd ask  
25 you to be thinking about those ahead of time. And

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1 then we're going to just focus on our vision and our  
2 progress to date and plan the future course for the  
3 Alliance.

4 We know there's no clear path for how this  
5 is all going to evolve, because the challenges  
6 before states are certainly complex, and again, we

7 want to keep this focused, so that we can actually  
8 move ahead and overcome some complexities.

9 In my brief association with this field, it  
10 is infinitely clear to me that we need to stop  
11 talking and start doing some things and learning  
12 from those things, and I hope very much to have this  
13 group one of the groups that is pushing forward  
14 toward making that happen. Governor Douglas and I  
15 both look forward to hearing your thoughts about  
16 where you see this heading.

17 We have an opportunity, should members of  
18 the public have an interest in presenting, to hear  
19 from them later this afternoon, as we've done at  
20 some previous meetings.

21 Remind the Alliance that when we started  
22 out our discussions earlier this year, we agreed to  
23 a set of principles to help guide our work. I think  
24 they're going to put them up on the screen which  
25 they have there, which are basically pretty

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1 straightforward. That this is all about increasing  
2 effectiveness and efficiency in the delivery of  
3 health care.

4 Second of all, that we are going to protect  
5 consumers' health information, and that's an  
6 important key component of anything we're doing;  
7 that the networks provide portability and access, I  
8 guess is self-evident, and will allow timely  
9 exchange of the information to improve the health of  
10 the population.

11 Ultimately underlying all this is the

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12 feeling that we can do better in medical care if the  
13 various highly skilled practitioners we have in our  
14 country have access to the information they need to  
15 make decisions. So please help keep that in mind as  
16 we vote on recommendations and discuss these.

17 Certainly want to encourage active  
18 discussion, participation on the part of the members  
19 as we go forward, and with that, Jim, I turn it back  
20 to you.

21 GOVERNOR JIM DOUGLAS: Well, thank you  
22 Phil. Thanks for your leadership on this Alliance,  
23 and I'm delighted that we are able to accommodate  
24 both the fishing schedule and the work of the  
25 Alliance and get you here to the Green Mountain

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1 State.

2 It's a pleasure now to welcome leaders and  
3 members of our three task forces. We're going to  
4 hear an update from Dr. Rhonda Medows, who cochairs  
5 the Information Communication and Data Exchange  
6 Taskforce. We're going to hear from Sallie Hunt and  
7 Bill Hacker, who are cochairs of the Information  
8 Protection Taskforce, and then hear from Darlene  
9 Bartz, the cochair, and Rowen Zetterman, a member of  
10 our health care practice task force.

11 So let me first introduce Dr. Medows.  
12 She's Commissioner of the Department of Community  
13 Health in the State of Georgia. She leads the  
14 agency responsible there for the purchase, planning  
15 and regulation of health care programs, including  
16 Medicaid, Peach Care Health Insurance Program for  
17 Kids, and the State Health Benefit Plan for state

18 employees. So Dr. Medows, thank you very, very much  
19 for being with us.

20 DR. MEDOWS: Thank you very much,  
21 Governor Douglas, and hello to you, Governor  
22 Bredesen.

23 Good morning to the members of the State  
24 Alliance. I am honored to be here today. As  
25 Governor Douglas said, I am Dr. Rhonda Medows. I'm  
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1 honored to serve as the cochair of the Health  
2 Information Communication and Data Exchange  
3 Taskforce. If you say that three times fast, you  
4 get an extra reward.

5 In addition, I'd like you to also know that  
6 I am not in this work alone. I have a cochair whose  
7 name is Anthony Rogers, who is the director for the  
8 Arizona Health Care Cost Containment Program.

9 What I'd like to share with you is that  
10 although this task force has just begun meeting in  
11 May, we have come a very, very long way. We have  
12 had lots of discussions. Kathleen Nolan has been  
13 prodding us to move and move and move, and the NGA  
14 staff has been fantastic in helping us along with  
15 several consultants.

16 I am happy to share with you today some of  
17 the activities that we are currently undertaking and  
18 some of the plans going forward. I do want to  
19 reassure you that we do anticipate having before  
20 this Alliance recommends regarding Medicaid and  
21 SCHIP with respect to health information exchange  
22 activities in October, and we anticipate having the

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23 remainder of the information regarding the state  
24 health benefit plan and public health, combined with  
25 Medicaid for final report January 2008.

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1           There are four main topics that I'm going  
2 to be covering for this morning's preparation for  
3 you, and they include an overview of the task force  
4 charge, which many of you may remember, as well as  
5 an overview of who the membership is at the task  
6 force. I am going to discuss with you the goals,  
7 the guiding principles that the task force has used  
8 in analyzing the current issues and market within  
9 state governments, as well as the methodology for  
10 the work products being created.

11           I'm also going to discuss with you those  
12 key themes that we already see arising from these  
13 discussions within the task force and with the  
14 assistance of our consultants, and I'd finally like  
15 to talk to you about next steps for our work  
16 products which are due to you all.

17           In overview, I'd like to put before you the  
18 charge of the task force with a very minor word  
19 change, however, with very large significance, for  
20 the task force members.

21           Overall, the charge of the task force is to  
22 support this Alliance in analyzing those issues  
23 which present opportunities and challenges for  
24 publicly funded health programs in the world of  
25 information exchange, health information technology,

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1 et cetera.

2           In addition, we are to present to you our  
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3 recommendations and resolutions for states to be  
4 successful in this arena. However, we felt that one  
5 small piece was missing from the description of the  
6 charge, and we thought that it was very important  
7 that we include a key piece that said that any  
8 effort that we recommend to you include and  
9 integrate our work with private sector.

10 Publicly funded health care programs cannot  
11 stand alone successfully in the implementation of  
12 electronic health exchange and health information  
13 technology development.

14 An overview of our memberships: We are 18  
15 strong. We represent leaders in state government  
16 who lead Medicaid programs, SCHIP programs, employee  
17 health programs, health IT across the state. We  
18 represent also members from the private sector from  
19 individual provider groups such as hospitals and  
20 labs.

21 We have within our group representatives  
22 from existing and successful health information  
23 exchanges, so we have the wisdom of their expertise,  
24 and we also have an IT organization on board, as  
25 well.

14

1 When we met, we decided, after much  
2 discussion, that perhaps we would do best to come up  
3 with five basic principles that would help guide us  
4 as we analyzed what information was available about  
5 current state opportunities and challenges, and then  
6 also use that same framework to discuss  
7 recommendations that we would present before you,

8           Opening and Taskforce Presentations.txt  
and you'll see on the screen the five areas or five  
9 principles that we chose to focus on.

10           With respect to leadership and governance,  
11 we discussed amongst ourselves who should be the  
12 lead for statewide efforts in health information  
13 exchange. What role did the state itself actually  
14 have? Are we simply payers as Medicaid providers?  
15 Are we providers as public health care clinics?  
16 What exactly role will we need to provide? And then  
17 also, what level of leadership do we need for these  
18 programs to be successful?

19           And we have all voted and we have decided  
20 it is all at the governor level. In addition, with  
21 respect to interoperability, we have talked about  
22 the need for states and the Federal Government to  
23 come to terms and in agreement with national  
24 standards. We know that sometimes it takes a little  
25 bit of while for national standards to filter down  
15

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1 to the states, and that perhaps sometimes the states  
2 have ideas that could be shared up or across.

3           But we basically understand that in order  
4 for the key component, the thing which makes health  
5 information exchange actually work, interoperability  
6 standards have to be in place and have to be adhered  
7 to. They must also be improved as we learn.

8           Third, even though for the most part folks  
9 talk about electronic medical records and what a  
10 doctor can do with that and electronic records and  
11 what a health plan can do with it, at the end of the  
12 day, at the end of the day, the person who is at the  
13 center for electronic health exchange is the actual

14 consumer, or in my world, the patient.

15 That means that any initiative that the  
16 states put forward has to include consumer  
17 involvement, which means not only their education,  
18 but their engagement, and tools which they can  
19 actually use to access relationship information and  
20 health education as needed.

21 We have discussed what I'm sure most people  
22 in this room have been waiting for me to say, the  
23 financial and contributory responsibilities that  
24 states need to provide. I think there's an  
25 assumption that there is some information that we

16

1 would have to provide as partners with private  
2 sector. I do not think there is any consensus for  
3 the states needed or government needed to own the  
4 entire process. In fact, I can feel Kathleen nearly  
5 fall out of her chair at the mere mention of that as  
6 a topic as discussion. But it's really important that  
7 we feel that there be a financial there be a  
8 financial contribution, a commitment that is made,  
9 for a tool that we believe is critically important  
10 to health care delivery.

11 In addition, the fifth principle is with  
12 respect to the current structure of health  
13 information technology and health information  
14 exchange initiatives.

15 We as a group have to look at what the  
16 opportunities are for the existing exchanges that  
17 are out there that may or may not include publicly  
18 funded programs at this point in time. But we also

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19 have to look at some of the challenges and some of  
20 the challenges may be a matter of more resources,  
21 but some of those challenges are also with respect  
22 to the culture of public programs to some extent,  
23 and the culture within different states.

24 It is not simply enough to have the  
25 computer technology and the software. There is 17

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1 actually a culture or mentality that goes with it,  
2 as well as an understanding of the critical  
3 importance of it being effective and the issues and  
4 responsibility regarding privacy and security.

5 This is a listing for you of our two  
6 primary goals with respect to the recommendations  
7 that we wish to proceed with presenting you, and one  
8 for our job for you is to actually analyze the  
9 opportunities and challenges for publicly funded  
10 programs, which is not going to be a very small  
11 effort. This is massive.

12 By publicly funded health care we are  
13 describing within that realm Medicaid, SCHIP, public  
14 health, as well as the state health benefit program.  
15 We have to assist us two consultants. One is the  
16 University of Massachusetts Medical School Center  
17 for Health Policy, who are conducting interviews  
18 with stakeholders and key leadership in the states  
19 in an interview protocol.

20 In addition, they're doing literature  
21 searches, as well, and will be able to provide us  
22 additional information as we proceed. They've  
23 already been helpful in that regard.

24 In addition, Health Management Associates  
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♀ 25 is the second consultant who is assisting us, and 18

1 they are doing a nationwide, state-by-state, survey  
2 of current state health information technology and  
3 public e-exchange initiatives. It is always helpful  
4 to know what your baseline is before you can proceed  
5 to improve upon it.

6 The second goal is the analysis of the  
7 development of succinct national recommends. Sounds  
8 fancy, but what it basically means is that we have  
9 to come before you with recommendations that we know  
10 can actually be acted on and that will be successful  
11 in helping states have very successful health  
12 information exchanges.

13 This, for you, is a timeline of the  
14 meetings, as well as actions and milestones, for the  
15 task force. We have already had the first three  
16 meetings in May, July, and August, and as I promised  
17 you, in October, we will have the first set of  
18 recommendations regarding Medicaid and SCHIP in the  
19 world of e-health exchange.

20 In September, and going forward, we'll be  
21 focusing more on public health as well as the state  
22 health benefit plan and the challenges and  
23 opportunities with those programs. In addition, by  
24 January again, we will have the final report and  
25 recommendations for you.

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1 I wanted to share with you with these next  
2 six slides a couple of things that we can already  
3 share with you, and they are initial findings,

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4 recurring themes, successful practices that are  
5 already in place, some challenges that we've already  
6 identified, and some operational changes that we  
7 feel at the state and federal level are already  
8 becoming glaring items that will be included in our  
9 recommendations.

10 Some of the key items or themes that we've  
11 already noticed is, once again, with respect to  
12 leadership and governments, we have to actually  
13 assure our partners in the private sector and our  
14 partners across the public sector, that there is  
15 leadership within publicly funded health care  
16 programs with respect to health information  
17 technology.

18 If we do not do that, then we are seen as  
19 not really being at the table, and if we are not at  
20 the table, we will not be successful.

21 We also have to make an effort to make sure  
22 that the people who are put in charge in the states  
23 are actually persons of enough stature and knowledge  
24 that they can actually be effective in organizing  
25 statewide efforts, whether it's across the state

1 government as an enterprise, or the state as a  
2 whole.

3 And thirdly, we, as state officials, have  
4 to also address the need to harmonize our efforts  
5 with the federal government. It will not do us well  
6 if we cannot work with our federal partners.

7 We note once again that with respect to the  
8 consumer role, we cannot do this without them, nor  
9 should we. They have to be engaged and educated and

10 brought and included into the process.

11           With respect to financial and contributory  
12 responsibility, this goes far beyond the usual  
13 saying of "show me the money."

14           It also includes the idea that there has to  
15 be very flexible and innovative ways in which we use  
16 our financial and other contributory items to  
17 encourage the development of health information  
18 exchange. With respect to interoperability again,  
19 we know that there must be acceptance of standards,  
20 and they must be adhered to.

21           And then finally, with respect to the  
22 structure of current approaches, one of the most  
23 glaring things that became obvious during the first  
24 meeting was that there had to be a common language,  
25 that everyone had to understand the difference

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1 between an EMR and EHR, a PHR and PMR, and every  
2 other alphabet soup conglomeration that we could  
3 come up with. There there had to be a common  
4 understanding of what that meant. Otherwise, we  
5 were wasting time.

6           There were national organizations that had  
7 done some of that work for us, however, but we  
8 needed as a organization to be able to recommend to  
9 you, that before we could build, we had to at least  
10 be able to speak the same language.

11           In addition, we talked about addressing  
12 federal needs, which we'll go into in a few minutes,  
13 and then promoting workplace development. Again, it  
14 is not sufficient simply to have the equipment.

15           The actual people who operate the equipment  
16 had to be trained and educated on how this works and  
17 how it can be used again in the best interest of  
18 improving health care delivery.

19           Next steps: It's not always about the  
20 actual work product or piece of paper. It's  
21 sometimes more about the idea that this information  
22 is being pulled together for us, so that we can pull  
23 it together for you, and come to you again with  
24 strong actionable recommendations. The consultants  
25 at the University Massachusetts Center for Health

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1 Policy is creating a white paper that will  
2 incorporate what they have found through literature  
3 searches and through some interviews with state  
4 leaders.

5           In addition, they will be doing ten public  
6 health agency interviews and eight state employee  
7 health benefit planning interviews, as well. All of  
8 that information will then be integrated together  
9 and presented to first the task force for our use,  
10 and then also to be shared with you.

11           But probably at the end of the day, what  
12 will need to happen is the following: The task  
13 force will have to meet one final time, and they  
14 will have to decide what recommendations we need to  
15 send to you that are concise, actionable, realistic,  
16 and all within the purview of the authorities of  
17 each of the states. We also have to present to you  
18 what we believe to be the goals that need to be  
19 achieved.

20           There has not been one person who I have

21 met in the task force who has not understood the  
22 value of health information exchange and health  
23 information technology in the delivery of health  
24 care. There has not been one. Most are already  
25 leaders in implementing these programs in different

23

1 states.

2           However, what we need from you and what we  
3 need from ourselves is an understanding that it is  
4 not acceptable for the health care industry to be  
5 this far behind in the implementation of health  
6 information exchange and information technology,  
7 when the remainder of industries -- everything from  
8 Pizza Hut online delivery to car insurance to  
9 anything else -- it is not acceptable for this  
10 aspect of our life not to be at least up to speed  
11 and at least up to this century's standards. We  
12 would not accept this in any other aspect of our  
13 life.

14           We are going to do our best to help you  
15 with those recommendations, so that you, in turn,  
16 can provide the leadership to the states in their  
17 efforts to approve and to achieve what we think is  
18 absolutely necessary in the delivery of health care.  
19 Thank you.

20           GOVERNOR JIM DOUGLAS: Thank you very,  
21 very much indeed for your leadership on the task  
22 force and for your obvious passion for moving the  
23 health care system toward an interoperable stage,  
24 and we hope we can work with you and the task force  
25 members to accomplish that, so thank you very, very

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1 much, and we look forward to the details of your  
2 recommendations next time.

3 At this point, Rhonda would entertain  
4 questions about the work of the task force to date,  
5 any reactions to the themes or next steps that she  
6 has outlined. I should note that the slides that  
7 she's presented are available in hard copies so you  
8 can review them later. Any questions from Rhonda or  
9 reactions?

10 DR. SUNDWELL: Thank you. Just one  
11 comment, Dr. Medows. I am sure you are aware of how  
12 much activity that is going on in this area, but I  
13 sometimes wonder if there are so many cooks in the  
14 kitchen that we have to keep track who's doing what.

15 Myself, and I'm sure my fellow health  
16 officers who are here, just received a 15-page  
17 survey from the National Governors Association about  
18 what we're doing in health IT, and I hope you're  
19 aware of that and whatever you're doing is not going  
20 to be duplicative.

21 And the deadline's Friday, and we're good  
22 citizens and we got it done, but it wasn't easy.  
23 I'm sure Dr. Hacker had to do that, and maybe you  
24 did, as well, so I just hope that we're not  
25 reinventing the wheel when we do these surveys and  
25

1 surveys and surveys on who's doing what, where.

2 DR. MEDOWS: Okay, I think that's our  
3 survey.

4 DR. SUNDWELL: That makes me feel  
5 better. I thought, oh, my Heavens, here comes yet

6 another. So this is the one that is part of your  
7 thing that was done with Burn Smith.

8 DR. MEDOWS: That's correct.

9 DR. SUNDWELL: Thank you.

10 MR. SENSOR: Dr. Medows, thank you for  
11 your leadership and your presentation. I certainly  
12 would agree with all your underlying principles. I  
13 would just underscore two that I find particularly  
14 pleasing. One is the notion that at the end of the  
15 day the consumer or patient is at the center of this  
16 equation, and for us to develop solutions without  
17 them clearly providing input I think would be a  
18 misstep, so congrats on that.

19 And secondly, I have passion, coming from  
20 the private sector, that there is no solution the  
21 government can deploy without the private sector  
22 working hand in hand, and I would appreciate and  
23 applaud both of those notions. Thank you.

24 MR. MOORE: I was wondering why, and  
25 maybe it's in your charge, but the recommendations  
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1 that you list on slide 11 there, the key themes, are  
2 all relative to publicly funded programs. It seems  
3 to me that there's an issue in privately funded  
4 programs, too, to the degree there are any totally  
5 privately funded.

6 And the governors and legislators represent  
7 people who get privately funded health care, as  
8 well, and we want to make sure that they get the  
9 same quality, unless you're thinking that far ahead  
10 of the publicly funded programs.

11 DR. MEDOWS: I don't. I think our  
12 charge was actually to address the opportunities and  
13 challenges to publicly funded programs, and I think  
14 we actually added in the charge -- we actually  
15 edited a little bit -- the charge that was given to  
16 us to conclude the private sector, so all of the  
17 discussions actually do cross over. However, some  
18 of the operational items or changes are directed  
19 toward the public programs.

20 MR. MOORE: Generally we set  
21 regulations and laws for all programs, so I just --  
22 to me it sounds we're being narrow when we're  
23 setting up potentially two systems. And maybe the  
24 recommendation -- maybe it's the wording -- needs to  
25 be clarified of what we're recommending.

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1 GOVERNOR JIM DOUGLAS: Well, let me  
2 jump in and point out, as she indicated, that  
3 actually the charge of this task force is focused on  
4 integrating publicly funded programs into this  
5 change, and but with the helpful addition that she  
6 mentioned to ensure the cooperation with the private  
7 sector.

8 I'm sure we're all conscious as an Alliance  
9 of a need address both sides of the payer equation.  
10 You're absolutely right. I thought probably the  
11 toughest item that you listed here is proving  
12 leadership competency among governors. Except for  
13 my colleague.

14 GOVERNOR PHIL BREDESEN: Badly needed.

15 GOVERNOR JIM DOUGLAS: Joy?

16 MS. PRITTS: Dr. Medows, I really

17 enjoyed your presentation and I like the focus. You  
18 seem really headed in a very good direction. I  
19 noticed that one of your key themes is the consumer  
20 role, and again, I applaud you for focusing on that.  
21 I was wondering if you can explain to me a little  
22 bit how that ties into the work product that you've  
23 enumerated, please.

24 DR. MEDOWS: Okay, in both of the work  
25 products, one of the questions that come to the

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1 state, like in the 50-page survey that you're  
2 looking at, it's going to say what are the  
3 departments within the state government actually  
4 doing in terms of initiatives? I know that in my  
5 own state, one of the initiatives would actually be  
6 the inclusion of the consumer, or a patient  
7 web-available site to actually get in, to actually  
8 see their own health information, as well as health  
9 education information specific to the disease states  
10 or conditions, or wellness issues, that they are  
11 interested in.

12 So there are other states who are already  
13 much further out than we are in Georgia, but that's  
14 actually included in what would be picked up on the  
15 survey with Health Management Associates.

16 In addition, the University of  
17 Massachusetts, when they're doing their interviews  
18 with state leaders about what the states were  
19 already doing, they will also be asking the same  
20 questions -- how would this impact the providers in  
21 your community, but also how would it impact the

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22 actual public in terms of the public health, how  
23 would it impact the actual consumers in their day to  
24 day.

25 GOVERNOR JIM DOUGLAS: Questions at  
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1 this point? We can -- oh, Ken, go ahead. I was  
2 just going to say parenthetically that after the  
3 presentations of the other task forces as time  
4 allows, we can come back to any of the three. But  
5 Ken?

6 MR. SVEDJAN: Thank you, Governor, and  
7 thank you for your preparation.

8 Maybe I'm way premature in even thinking  
9 about this question, but does anyone have any idea  
10 yet as to the magnitude of investment that's going  
11 to be required in order to achieve what's being laid  
12 out here? What I think of, and maybe this isn't a  
13 good analogy, but as states look to rewrite their  
14 Medicaid management information systems, under a 90  
15 percent/10 percent federal/state ratio match,  
16 millions and millions and millions of dollars are  
17 being spent in federal money. Because if you've  
18 seen one Medicaid program, you've seen one Medicaid  
19 program.

20 Here we're talking of something of  
21 significant magnitude, and I'm just curious to know  
22 if anyone has made any projections as to what the  
23 total cost might be or the total investment might be  
24 to achieve what we're setting out to do.

25 DR. MEDOWS: I don't know if anybody  
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1 has done a nationwide tally or can actually provide  
Page 24

2 each state with a range in terms of cost. I know  
3 what is occurring right now are two things.

4 One is that CMS has been actually  
5 collecting information and doing a comparison  
6 regarding the health information exchange components  
7 that are being being added to NMIS in procurements  
8 going forward.

9 I know again the State of Georgia has a  
10 procurement going forward now, and we have chosen to  
11 include in our fiscal agent NMIS system the ability  
12 to be interoperable with health information  
13 exchanges.

14 So we know that there's a price attached to  
15 that, and then when we were creating our proposal,  
16 we went to our states and said what have you guys  
17 already paid for, what have you created and what has  
18 worked? So there's kind of an informal networking  
19 that's also going on, because other states have then  
20 come and asked us, how did we arrive at what we got.

21 I also know that when folks talk about how  
22 much money is being put into this, there are some  
23 economies of scale by being able to share  
24 information across, but no matter which way we cut  
25 this, there has to be an investment up front. And I

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1 think a lot of the questions around, you know, what  
2 is the value of that investment, well, if you look  
3 at it for one year to one year, you may not see that  
4 that easily sellable return on investment that you  
5 want.

6 But I can tell you that the impact of being

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7 actually within the -- what with century are we in  
8 now? Within the century with technology that can  
9 actually increase the efficiency and effectiveness  
10 of delivery over time is where I believe we would  
11 see more of that return on investment.

12 GOVERNOR JIM DOUGLAS: Gayle?

13 MS. HARRELL: I'd like to pursue that  
14 a little bit more, since we've opened the big  
15 Pandora's box of how we're going to finance  
16 something like this and actually where we're going  
17 to get dollars. When we're talking about public  
18 programs, especially in Medicaid, right now, as you  
19 know, having, of course, come from Florida, that we  
20 barely pay our providers enough to keep them in the  
21 system. In fact, we're losing providers on a daily  
22 basis in our Medicaid system.

23 And if we are going to build -- make those  
24 recommendations, and if you can give us a direction,  
25 perhaps, where you're going, into perhaps

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1 incentivizing providers, who really are down in the  
2 grassroots level, and that's where the system has to  
3 work.

4 Do you have any view of how you're looking  
5 to perhaps help fund that segment of it, not just  
6 the state MIS systems, but let's talk about down to  
7 the provider level?

8 DR. MEDOWS: Actually, the task force  
9 is engaging in discussions -- I won't say debates --  
10 about where the additional funding should come from.  
11 I can use several examples.

12 I know that when I'm able to choose -- when

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13 I'm able to achieve savings within my own state's  
14 Medicaid program, then I am actually able to use  
15 that designated money to provide separate funding  
16 for the health information technology.

17 I think what the group has discussed  
18 amongst ourselves, that it simply would not be  
19 enough to even marginally increase a provider rate  
20 thinking that they're going to use that will little  
21 tiny increase toward health information technology.  
22 We don't think that that is going to be a successful  
23 way of doing this.

24 We think that it's actually going to take  
25 dedicated funding to do this. We also think that

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1 the idea of giving something equivalent to a pay for  
2 performance, or some kind of incentive that way, is  
3 going to be much more effective in getting the  
4 different providers to actually come to the table  
5 with us and at least try, and at least start to  
6 adopt some of these changes.

7 We have also some proposals that we have  
8 discussed about whether or not we're able to achieve  
9 savings because we are noticing that prescriptions  
10 are going down, hospitalizations or emergency room  
11 visits are decreasing, or et cetera, et cetera, et  
12 cetera, but we're able to relate that back to the  
13 implementation of health information exchange. Is  
14 there a way for us to share that savings with  
15 providers?

16 So there are different mechanisms that are  
17 being discussed, and I think we'll have a

18 Opening and Taskforce Presentations.txt  
19 separate -- a menu of them that we can actually  
20 share with you at the end of the recommendation  
21 period.

21 GOVERNOR JIM DOUGLAS: I wonder if at  
22 this point if we should move on to the presentations  
23 of our other two task forces, and whether we have  
24 some recommendations from the other two that we need  
25 to act on today, but we can return and invite

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1 questions for all three before the end of our time.

2 So Commissioner, thanks very much for your  
3 great work, and we look forward to the  
4 recommendations next time. I want to introduce now  
5 Sallie Hunt, what is cochair of the Health  
6 Information Protection Taskforce, and her colleague,  
7 Dr. Bill Hacker.

8 Sallie is the Chief Privacy Officer of the  
9 Health Care Authority in West Virginia. She leads  
10 the privacy program for the state. She's  
11 responsible for facilitating the Executive Branch's  
12 implementation and compliance with privacy  
13 principles and 20, yes 20, different federal and  
14 state privacy laws.

15 Bill Hacker, as I'm sure the Alliance  
16 members recall, was with us at our last meeting, and  
17 we appreciate you coming again, Bill. And he's the  
18 Commissioner of the Department of Public Health in  
19 Kentucky. He coordinates a diverse group of  
20 programs that impact the health of all the people of  
21 that state, including emergency preparedness,  
22 maternal and child health, chronic disease,  
23 nutrition and wellness, environmental health,

24 epidemiology, the public health lab, and working  
25 with the local health departments around the

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1 Commonwealth, as well.

2 So Sallie and Bill, thanks for your  
3 leadership on the Information Protection Task Force.

4 DR. HACKER: Thank you, Governor  
5 Douglas and Governor Bredesen and the Alliance  
6 members. Sallie and I are really pleased to be here  
7 today with the opportunity to talk about the progress  
8 we've made with our task force since we began  
9 meeting in February.

10 We meet on a monthly basis, every other  
11 month by telephone, and every other month in person,  
12 and we feel like we have made some progress. The  
13 Alliance, I want to compliment you on the people you  
14 put on our task force.

15 As a physician and as a public health  
16 official, I'm not an IT expert, but I have people  
17 like Sallie Hunt, and others on our task force, who  
18 really do know the details of what we're talking  
19 about in protecting health information technology or  
20 protecting health information.

21 Our task force, of the many years that I've  
22 been task forces, has been the most engaged that  
23 I've ever had the opportunity to work with. We  
24 really do have a talented group of folks, so when  
25 you send out a draft document, rather than one or

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1 two people suggesting edits, there's a lot of edits  
2 coming in.

3 We're also blessed with the NGA staff. I  
4 just need to compliment Michelle Warner for her  
5 excellent facilitation of the work in our group.  
6 Kathleen and the rest of the group, that it really  
7 has done a wonderful job for us.

8 I think you'll find the remarks that we'll  
9 be making -- Sallie and I will be making -- will  
10 really reflect a lot that you heard this morning at  
11 GE. There really is an awful lot of overlap.

12 But before I do my remarks, I want to  
13 compliment and to say I'm pleased to have my  
14 colleagues from public health with me: David  
15 Sundwall of Utah; Sharon Cooper, Commissioner of  
16 Tennessee, and I'm sorry -- Susan Cooper, and Sharon  
17 Moffitt's here in Vermont. So it's nice to have  
18 public health officials participating in these kinds  
19 of meetings.

20 Our charge, and I believe we have the  
21 slides, so I am going to -- rather than read the  
22 slides, I'm going to talk about key points I'd like  
23 to make, and then we'll move forward. We've been  
24 working on our charge, trying to identify findings,  
25 policy statements and recommendations that we would  
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1 present to the Alliance to help you with your  
2 deliberations and choose and modify as you -- wisdom  
3 dictates.

4 We've been receiving expert testimony from  
5 a wide range of individuals, from stakeholders,  
6 providers, vendors, public officials, people  
7 representing the consumer market area.

8 We've been working very closely with the  
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9 HISPC states. As a matter of fact, at the last  
10 meeting, we had 26 of the 34 HISPC states meet with  
11 us as a group as they identified barriers to health  
12 information exchange through their activity over the  
13 past year, and we were able to engage in a very  
14 productive dialogue, I believe which led to some of  
15 the recommendations I'll be presenting.

16 We've conducted our meetings in a  
17 transparent manner with public forums, and we've  
18 always allowed public comment. And I'll -- Sallie  
19 and I are going to do a tag-team, and I'll try to  
20 follow with you.

21 MS. HUNT: Governor Douglas, since  
22 we've last met, I've taken on an additional  
23 responsibility. I'm the Acting Executive Director  
24 of West Virginia's Health Information Network. So  
25 I learning a lot there.

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1 GOVERNOR JIM DOUGLAS: Congratulations.

2 MS. HUNT: Thank you. It's been  
3 exciting so far. So we have findings for you, we  
4 have policy recommendations. The findings, as Bill  
5 said, came about from hearing a lot of testimony  
6 from different states, from consumers, from people  
7 across the country, and what we heard, really from  
8 everybody, is that consent is very different  
9 everywhere. It's different from state to state.  
10 It's different within states. It's different from  
11 entity to entity, from people across the street.

12 That is not to minimize the value that  
13 privacy brings. Privacy is important to our

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14 consumers. It's integral to the relationship  
15 between the patient and the physician, the hospital,  
16 the payor. Patient is essential to -- I'm sorry,  
17 privacy is essential will everything that we do.

18 However, privacy has been built in the  
19 United States in a very fractured way. It -- When  
20 you look at how privacy laws come about, you have  
21 different types of health privacy laws for different  
22 kinds of information. You have a whole structure  
23 around mental health information. You have a  
24 different law around substance abuse information.

25 If your information is being sent for 39

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1 treatment, you have one set of rules. If you have a  
2 different use, you have another set of rules.

3 What you end up with is that not one  
4 provider has one clear idea of how to proceed. And  
5 even when you get through all of the quagmire and  
6 all of the intricacies of all of the laws, you still  
7 have different interpretations; people are doing  
8 things differently.

9 We have accepted that in a paper world,  
10 because we haven't been as big on sharing  
11 information. Now, if you switch doctors, you'll  
12 sign an authorization form, a HIPAA authorization  
13 form, and you'll take your whole hard-copy file with  
14 you, but we are just really getting into needing to  
15 have information real time.

16 And when you talk about real time, you  
17 really can't have all of these different rules with  
18 everybody playing by a different game plan, and when  
19 you sit in Vermont, you may not know what the game

20 plan is in Arizona, and you may get a call from  
21 Arizona. What are you going to do? Are you going  
22 to follow your rules, or are you going to follow  
23 their rules? It's really very, very confusing.

24 We add a new layer to that whole discussion  
25 of health information exchange. States are looking  
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1 at what sort of consent do we need to actually get  
2 from the patient before we can put their information  
3 in, or do we need consent at all? And then behind  
4 the scenes, totally unrelated, but part of this  
5 whole discussion, is the whole consent for treatment  
6 piece.

7 So health care providers are dealing with  
8 all of these different layers of consent, all of  
9 these different rules, and all of these different  
10 policies, and it's yielding a variety of results.

11 Nobody understands what they're supposed to  
12 do, we have misaligned policies, and we don't have  
13 consistent laws. So this is sort of our background  
14 piece to tee it up for later discussions on policy,  
15 and I'll turn to Bill for the next one.

16 DR. HACKER: And in addition to the  
17 laws, we deal with inconsistency of security  
18 protocols that are being built and are being used in  
19 different systems. We have large networks, we have  
20 very small in-office networks, so there's a scale  
21 size that is challenging.

22 We also, you know, the complexity of how  
23 you deal with different, either vendors or the  
24 people who have the same product may apply it

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25 differently, so there are lots of inconsistencies 41

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1 that do contribute to challenges in moving forward  
2 with electronic health exchange.

3 Our committee, or our task force, really  
4 focused on information in transit, meaning it's  
5 being moved from one person or one provider to  
6 another. How are those different issues addressed  
7 and what are the potential barriers we need to talk  
8 about?

9 Some of those, again, were discussed this  
10 morning at GE, in linking the correct individual to  
11 the correct piece of health information; the correct  
12 provider to the correct person, patient you're  
13 actually looking at; being able to control access to  
14 the information by a provider to just that  
15 information you really need to, so the patient or  
16 the consumer has the ability to influence the  
17 sharing of that person's information. And then  
18 auditing, and all those are critically important  
19 pieces of any sort of stable, secure network.

20 In the absence of security benchmarks,  
21 health information exchanges are just not going to  
22 go forward. Providers are not trustworthy, because  
23 they're don't know whether they have unusual exposed  
24 liability. And patients or consumers are concerned  
25 about who's really going to have access to this 42

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1 information.

2 Now, there are two national activities  
3 going on that do help us in this arena. The first  
4 is the Health Information Technology Standards

5 Panel, HITSP, which is identifying technical  
6 standards, interoperability standards, that will  
7 help the industry move forward.

8 And the second is the Certifying Commission  
9 for Health Information Technology, CCHIT, which is  
10 then certifying electronic medical records for  
11 inventory and in-patient use, and they will be  
12 looking forward in the near future to be moving  
13 toward network certification.

14 There are about 90 electronic health  
15 records now certified in the CCHIT, of meeting the  
16 standards that have been nationally being evolved  
17 and being generally agreed to in wide participation  
18 by all the stakeholders, the vendors and the  
19 providers and so forth in this discussion.

20 MS. HUNT: Okay, we'll turn to the  
21 third finding. As we heard from states about the  
22 variability in different state laws, we also heard  
23 from folks about the variability in federal laws.  
24 We have multiple federal laws that all deal with  
25 protecting health information, and I'll just very  
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1 quickly walk you through a few of them, just so that  
2 you can get a feel for what we're talking about.

3 You have HIPAA, and we've all signed  
4 acknowledgements of receipt of a HIPAA notice when  
5 we go to the doctor or the hospital, but HIPAA does  
6 not require consent for any disclosure of protected  
7 health information for treatment, pain, or health  
8 care operations.

9 But then we have other federal laws that do

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10 require consent, and it may -- those federal laws  
11 may apply at the same time to the same patient to  
12 the same encounter to the same information. Say you  
13 have a patient coming to your facility and they have  
14 a substance abuse problem, and they bring with them  
15 substance abuse information.

16 That information carries its protection  
17 with them, and that information is governed by Part  
18 2. It's called 42C of our Part 2, and everybody  
19 refers to it as Part 2. So when you receive  
20 information that has -- that is governed by Part 2,  
21 you have to protect it to the same standards, so you  
22 layer that on.

23 Now, if you're dealing with information in  
24 a school based setting it may be that a law called  
25 FERPA applies, and that deals with educational

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1 records. And if your patient is a Medicaid patient,  
2 you have federal Medicaid confidentiality rules.

3 So when you start looking at these  
4 different scenarios and you start picking apart the  
5 different kinds of information you're dealing with,  
6 if it's specially protected, such as mental health  
7 or substance abuse or HIV, or is it general physical  
8 health information, you can have a variety of laws  
9 applying to your situation.

10 We heard testimony from the HISPC states  
11 that this process has just been tremendous in  
12 looking and identifying first the variability across  
13 states, and helping states to get a handle on what  
14 they need to do to still maintain the appropriate  
15 levels of privacy, but to reduce the variability.

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16           We need the Federal Government to really do  
17 the same thing. We have all of these different  
18 federal laws, and we really need to have clarity and  
19 a clear way to go when a patient appears.

20           Right now we have sort of a tossed salad of  
21 federal laws, just like we do with state laws. So  
22 that's the information behind this third finding.

23           From our findings, we've developed a number  
24 of policy statements, and the way we would ask you  
25 to use these policy statements is, as you're

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1    developing executive orders or legislation, or  
2    taking action within your respective states, that  
3    you would incorporate some of the policy statements  
4    and information that we're providing to you.

5           So the first policy statement has to do  
6    with giving states a framework upon which to develop  
7    their privacy laws, upon which -- or a lens to look  
8    at all of their privacy laws to reduce the  
9    variability.

10           We heard testimony from a number of groups  
11 about different frameworks that are out there that  
12 states can use, that really anybody can use, that  
13 entities can use. One is the Markle framework, one  
14 comes from ISTPA -- and when you look in your  
15 Appendix A, there's all this information.

16           Our task force sorted through it and tried  
17 to pick elements that we thought were really good  
18 from the different frameworks in terms of the  
19 electronic world, but frameworks are out there.  
20 Utilize them, so as you respond to consumer

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21 problems, as you hear problems that occur because  
22 you don't have enough privacy, think about it in  
23 terms of a framework, instead of just responding to  
24 the individual problem.

25 That may be what has happened over the 46

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1 years as we tried to be responsive. We have this  
2 crazy patchwork quilt. Nobody in this quilt -- if  
3 every state is a different square, nobody's using  
4 the same pattern.

5 We could have a log cabin as one square; we  
6 could have fan in another square; we could have a  
7 wedding ring in another. Everybody is using an  
8 entirely different pattern, and with all different  
9 colors, and it's just not working. So if we could  
10 point people to a framework, and if you all can push  
11 this framework, we could reduce a lot of the  
12 variability.

13 Okay. Bill?

14 DR. HACKER: And the second bullet is  
15 self-evident, but it's at least worth saying out  
16 loud. Policy has to be in place in order for  
17 technology to advance consistent with the policy  
18 rules that are being developed. The technology has  
19 to be in place in order for policy goals to be  
20 really developed to meet the technology.

21 The concern we have is that if they don't  
22 work in tandem and develop in tandem, we could end  
23 up with overly restrictive policies that really  
24 prevent technology from solving problems that it  
25 could solve, or we could have situations in which

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1 technology is limiting the development of potential  
2 policies that would be advisable and advantageous.  
3 So what we strongly encourage is a concerted effort  
4 to move together in tandem, policy and technology.

5 MS. HUNT: Our last policy statement  
6 really focuses on the consumer. The whole reason  
7 we're doing this is to improve the quality of health  
8 care delivered to the consumer, and the consumer has  
9 to want to have their information in the health  
10 information exchange. It needs to be their benefit.  
11 It needs to provide them with a value-added service.

12 It will provide a lot of other things, but  
13 really the crux of this is for the consumer. We  
14 heard it is very difficult to get consumers to the  
15 table, it's difficult to engage them. We heard  
16 states are having success with engaging consumers  
17 directly through focus groups.

18 So we need to continue to think about  
19 getting consumers to the table, keeping them  
20 involved in the discussion, and then building upon  
21 what the consumer wants and deliver it in an  
22 appropriate way within our own states.

23 DR. HACKER: We do have  
24 recommendations for the Alliance to consider in your  
25 deliberations.

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1 Recommendation 1.0, a lot of words, but let  
2 me see if I can summarize. What we're calling for  
3 is certification of electronic health records  
4 applications. The certification process really will  
5 help to standardize the security standards, so that

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6 we do protect information, that it will be a  
7 well-vetted process, and it will be one that both  
8 the vendor community requests, as well as the  
9 consumer community requests. This is a situation  
10 where I think we have alignment, that we need to  
11 have standards that people can really build toward  
12 and move into.

13 Certification ensures that those providers  
14 out there who may not have electronic health record  
15 know that if they purchase one today, it will be  
16 applicable tomorrow. That, you know, they're not  
17 buying a Betamax when in fact the world is going to  
18 go to VHS.

19 So there's value to having standards that  
20 are there. So we're moving and we're requesting  
21 moving toward requiring certification as an  
22 assertive effort, rather than a more passive way of  
23 encouraging it. So we do recommend that.

24 Our task force deliberated on several key  
25 topics. I can briefly mention three of them. The  
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1 first is the complexity of health care organizations  
2 is so varied, how do you hold those to the same  
3 standards? You know, small practices versus large  
4 medical centers. We believe that the certification  
5 process can accommodate that.

6 Secondly is legacy systems. Those folks  
7 who are early adopters, they've got one today that  
8 they purchased maybe two years ago that wasn't  
9 CCHI -- or that is not CCHITS certified today.  
10 What do we do with those folks? We don't want to  
11 penalize them.

12           So we had a lot of discussion, including  
13 individuals who have electronic medical records in  
14 their offices, clinicians, saying gee, I've had this  
15 for ten years. Will I have to get rid of it and  
16 then reinvest?

17           We feel like we should not penalize people  
18 people who have had those in place, but try to find  
19 ways that will help motivate or move them toward  
20 newer certified products, and again, as policy and  
21 certification processes become more stabilized, I  
22 think both the industry, as well as the clinical use  
23 providers will move, migrate in that direction.

24           Lastly, there is a product cycle, and IT  
25 does change rapidly. I'm carrying a Blackberry 50

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1           today that I didn't have last year. I mean, it's  
2 just evolving, and so the physicians and private  
3 health care providers, as well as public providers,  
4 will have to migrate through the public health care  
5 system, and as they migrate, they move into the  
6 certification, of selecting certified products is  
7 the way we're trying to move the country.

8           Recommendation 1.1: Although the Secretary  
9 of Health and Human Services certainly supports the  
10 efforts of CCHIT, HHS has not formally designated it  
11 as the single certifying body. We recommend that  
12 the HHS do select a certifying body. We would think  
13 the CCHIT is a good candidate. It has  
14 provider/vendor input. It has a lot of --  
15 developing national, I think, acceptance of  
16 recognition.

17 But if not CCHIT, then at least some some  
18 entity should be designated that will be the entity  
19 that can certify, so that we can reach those goals  
20 I've been addressing. You know, processes  
21 delivered, transparent, and all the other  
22 common-sense things.

23 States need to really, I think, move  
24 forward, and not just encourage the Federal  
25 Government, but really insist that the Federal

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1 Government do the same thing with their program, so  
2 if we have states saying, We want CCHIT  
3 certification, as an example, or whatever is chosen,  
4 we want the Federal Government to do the same  
5 because again, that helps promote the exchange of  
6 health information through the different networks,  
7 as you can imagine.

8 We feel like simply supporting the efforts  
9 is not enough. We really do want to have a more  
10 assertive stand on moving forward with the  
11 certification process.

12 Recommendation 1.2 is really to note the  
13 participation in states. It's critical that states  
14 be engaged. State governments, state governors,  
15 state legislators, state policymakers need to be  
16 aware of what's going on with health information  
17 exchange and be engaged, or CIOs.

18 This is not one that you should leave to  
19 the private sector or other entities, because states  
20 do have unique environments with which states  
21 operate, whether your public systems or Medicaid or  
22 be public health.

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23 Both CCHIT and the HISPC efforts are  
24 public-private partnerships and do encourage  
25 participation of state representatives, and so we  
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1 call on the governors to support and encourage, with  
2 their leadership, and the state general assemblies,  
3 to be engaged with health information exchange as we  
4 develop and move forward.

5 MS. HUNT: Okay, with regard to  
6 recommendation 2.0, we're asking you to talk to your  
7 peers and highlight to them the importance of these  
8 initiatives. Talk to them about the impact of  
9 supporting CCHIT certification; reducing  
10 variability, in terms of all of their different  
11 privacy laws; keep this issue alive; make it your  
12 top agenda item; talk to them about making it be an  
13 agenda item within their states; support this  
14 politically and financially.

15 It's important to keep this on everybody's  
16 radar screen as laws are developed, as regulations  
17 are promulgated, as we have opportunities to make  
18 changes within our states, other states who are not  
19 directly involved in this process need to understand  
20 what their real can be and need to receive guidance.

21 Now, with regard to recommendation 2.1, as  
22 I mentioned before, we heard a lot of testimony with  
23 regard to the variations in federal law, as well as  
24 regulation. And the success of state efforts will  
25 be hampered in this area if the Federal Government  
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1 does not take action to reduce the variability in

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2 their own privacy laws. We need the Federal  
3 Government to go through the same process that the  
4 states have gone through.

5 So with this recommendation, we are asking  
6 you to call on the Federal Government to do just  
7 that -- to go through the process of looking at the  
8 impact of their federal laws and the regulations  
9 upon each other and on different scenarios. How do,  
10 if their laws were written for a paper world, what  
11 do they look like in an electronic world? What are  
12 the implications? Will people readily participate  
13 in health information exchange with their laws as  
14 they are today? So those are our recommendations to  
15 you.

16 DR. HACKER: Well, our work is not  
17 done. We have identified three topics I'll briefly  
18 discuss for you that we see as next steps.

19 We want to look at the issue of consent.  
20 As we've already described, there are different  
21 levels of consent across the states and the systems.  
22 We want to try to develop through our task force,  
23 develop essential definitions pertaining to patient  
24 consent for the electronic health information  
25 exchange environment. Big challenge. We realize

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1 it's a big challenge. We're willing to take it on.

2 We want to help develop consent options and  
3 process options, so that this doesn't have to be the  
4 same identical thing across states. My model is  
5 each state has their own banking laws, but then  
6 still, we have banks with ATMs who exchange dollars  
7 across state lines, so there has to be a way to

8 reach an accommodation so it will allow state  
9 uniqueness, but still have a standard, workable  
10 consent process.

11 Secondly, a safe harbor. Professional  
12 liability is a big issue for physicians and other  
13 clinicians. There are some issues that have arisen  
14 with electronic health information that are not  
15 resolved to this time.

16 If there is a patient record on electronic  
17 availability, and the patient calls at 2:00 in the  
18 morning to the physician, is the physician required  
19 to go to the electronic health record at that point  
20 to see has there been a new addition to the  
21 electronic record that the physician may or may not  
22 know. So they're saying, geez, what's my exposure  
23 here if I do this?

24 We feel like we should have a safe harbor  
25 that says, if you're using good faith, your

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1 authentication process is valid, you're using  
2 reasonable security measures, and if the system with  
3 all the other policies, that there should be a safe  
4 harbor if for some reason, some error is made.

5 So we recommend that the states look for  
6 legislation. We'll try to develop some safe harbor  
7 language for you, for states to look at, and  
8 possibly incorporate when you consider legislative  
9 action at the individual state level.

10 Then lastly, I'll briefly talk about  
11 consumer awareness and communication tools. We had  
12 nice testimony about the value of focus groups with

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13 consumers, because consumers today may not have  
14 really even a fair idea of what is electronic health  
15 information, what is electronic health information  
16 exchange, what's the benefits to me?

17 They can usually jump out, gee, I'm not  
18 sure I can control who has access. The truth is,  
19 electronic information is probably more secure than  
20 a paper chart, but the public may not believe that.  
21 So how we inform consumers of both the benefits, as  
22 well as their privacy rights, as well as their  
23 involvement, since there's not a single entity that  
24 represents consumers -- you know, all the different  
25 health professional organizations have their

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1 advocacy groups and the leadership and hospital  
2 associations and so forth -- there are different  
3 advocacy groups out there. Many of them really  
4 focus on the disease -- on the diabetes person, on  
5 the cancer person, or whatever.

6 So this is just some challenges of how we  
7 get there. We're going to work on that over the  
8 next several months. We certainly are committed to  
9 continuing to meet on a monthly basis through the  
10 end of the year and beyond if necessary to try to  
11 accomplish what the Alliance would like for us to  
12 achieve. Thank you all very much.

13 GOVERNOR JIM DOUGLAS: Well, thank you  
14 both for your hard work in developing these  
15 recommendations. Our plan was to hear a report from  
16 the third task force before acting on the  
17 recommendations, just so we have the benefit of  
18 everybody's thoughts, in case there's some overlap

19 or influence on our decisions on each one of them,  
20 but it would be a good time to ask questions of Bill  
21 and Sallie, if you have them at this point. Steve?

22 MR. PALMER: Thanks very much, and  
23 it's a very good presentation. Sounds like you all  
24 are doing some really good work. With respect to  
25 your dialogue around privacy frameworks and so on,

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1 it looked like you all identified several of the  
2 existing privacy frameworks, but one that's gotten  
3 some attention historically, but it hasn't really  
4 been embraced at the federal level thus far has been  
5 the privacy recommendations put out by the NCVHS,  
6 Committee on Vital and Health Statistics. Was there  
7 a specific reason why those were not included among  
8 the frameworks that you all considered?

9 MS. HUNT: I don't think that there  
10 was a specific reason. I think they just chose a  
11 variety to let us know that they're out there, but I  
12 think we can take a look at that and make sure we  
13 include that.

14 MR. PALMER: And then also just as a  
15 quick follow-up, when you all talk about using a  
16 privacy framework or harmonizing privacy laws or  
17 reducing the variability, I have some concerns that  
18 that would -- that sounds like it's going in a  
19 direction that will potentially restrict states'  
20 flexibility in setting their own stronger privacy  
21 laws or having their own thresholds.

22 Can you kind of speak to that, and I may be  
23 misunderstanding what you mean when you say reducing

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24 variability or harmonizing and things like that.

25 MS. HUNT: Sure, I don't think it's  
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1 our intent at all to dictate to states that they  
2 should have a certain level of privacy. We believe  
3 that privacy needs to be reflected at the state  
4 level based on the culture and the needs of their  
5 citizens.

6 And it's important, even with the need for  
7 health information exchange, to take the temperature  
8 of their consumers and have their consumers drive a  
9 lot of their privacy policies, so we wouldn't  
10 advocate that at all.

11 What we would advocate is to look to see if  
12 there's any way to standardize the process. For  
13 example, we have some states that have laws that say  
14 the consumer must sign in black ink, or we have a  
15 state that requires a verbal consent and another  
16 state might require a written consent or an email.

17 So we're not talking about trying to get to  
18 any conformity on the kinds of information; just on  
19 the way that we would collect the consent process.

20 MR. PALMER: Thank you.

21 MS. HUNT: You're welcome.

22 GOVERNOR JIM DOUGLAS: Gayle?

23 MS. HARRELL: Thank you very much.

24 These are fairly broad general regulations. Is it  
25 your intent at the end of the day to come forward  
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1 with some model legislation, as we do in other  
2 organizations? Or, you know, pretty broad model  
3 legislation that of course can be adapted to the

4 individual states, but including specific bullet  
5 points?

6 MS. HUNT: We heard from someone from  
7 the Commission on Uniform Laws, and we really  
8 wrestled with that. The issue you get to, I think,  
9 with consent, particularly, is the issue raised by  
10 this gentleman.

11 It's difficult to do a model law when every  
12 state really needs to be individual. That's why I  
13 think we looked at the frameworks and are advancing  
14 the frameworks, but certainly at the end of the day,  
15 if we can find elements or other frameworks that  
16 really should be everywhere -- for example, if we do  
17 find that through looking at the consent form  
18 process, that there are things that should be in  
19 place everywhere, we could certainly look at what a  
20 model law could be, what that process would be.

21 When we heard testimony from the Uniform  
22 Commissioners, it's quite a while, it's like a  
23 three-year process, and so it's not overnight. It's  
24 not as fast as I would like. But we can keep that  
25 in our arsenal or in our toolkit, and if it's the  
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1 best thing to advance, we will.

2 GOVERNOR JIM DOUGLAS: Herb?

3 DR. CONAWAY: I guess at the start of  
4 your comments, you talked about the consent  
5 requirements vary states, across states, and I'm one  
6 of these folks that believe that states are going to  
7 have to get their act in order before we can talk  
8 about dealing with neighboring states, and I was

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9 wondering, in the testimony that you got, were there  
10 themes that you could point to that states had with  
11 regard to their privacy laws?

12 Was there a lot of internal conflict within  
13 states that you could identify as a theme that we  
14 should go back and say, Generally these are the  
15 problems you should address these issues to get your  
16 state house in order?

17 MS. HUNT: I think the easiest place  
18 for states looking getting their houses in order has  
19 to do with the process piece. When you look at the  
20 substance, we had some states say we don't require  
21 consent for disclosure for treatment, and we don't  
22 believe consent is necessary and our consumers don't  
23 need it. We believe HIPAA is enough. Then you have  
24 other states who are at the table when the HISP  
25 states came, and they said, We absolutely have to  
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1 have consent.

2 It's integral to the way we do business;  
3 our consumers demand it; and in fact, when our  
4 consumers go to your state, we want you to operate  
5 under our laws. That's the difference that we're  
6 seeing, so I would really think that we could get a  
7 uniform approach, or I would hope to get a uniform  
8 approach with process, but at least at this point,  
9 it will be difficult, and I'm not sure appropriate,  
10 to try to get all states on the same page with  
11 regard to substance.

12 DR. HACKER: And I would add, sir,  
13 that within the states -- in Kentucky, we have an  
14 e-health board, and we have subcommittees, and one

15 of those subcommittees is actually looking at  
16 privacy and security within the state law in  
17 Kentucky, so we have a group of Kentuckians working  
18 on identifying inconsistencies between organizations  
19 or between departments.

20 MHMR may have some requirement that public  
21 health doesn't have, or Medicaid, so that we have  
22 folks within our state who live within these laws to  
23 bring to the table, hey, this is an inconsistency or  
24 a potential barrier, so then that elevates up  
25 through our board to the executive branch.

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1 DR. CONAWAY: So following along with  
2 that, would you recommend, then, that there is one  
3 thing we can do in law is to require this process to  
4 be done somewhere within the government to require  
5 this review and harmonization, and perhaps  
6 recommendations back to the legislature, to go ahead  
7 and have us pass the appropriate legislation.

8 And I guess as a follow-along, you've got  
9 HIPAA, and we've mentioned HIPAA doesn't include  
10 consent to treatment and some of these other things.  
11 Do you anticipate that states will do something with  
12 HIPAA, or in addition to HIPAA, to bring these  
13 various things into one body of law?

14 I think it will probably be easier to do  
15 that, to bring in your treatment arm, to bring in  
16 some of the other information going to insurance  
17 companies and payers and the like. I mean, how do  
18 you see that going forward?

19 DR. HACKER: Well, the testimony that

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20 we've received is HIPAA is being -- HIPAA is not  
21 well understood by providers. Providers are  
22 focusing on the consequences of being found in  
23 violation, and therefore many folks, many providers,  
24 especially physicians, are actually interpreting  
25 HIPAA in a more restrictive way than HIPAA is

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1 intended.

2 So that we had a lot of information about  
3 how we need to go out and help find some process to  
4 be able to inform providers of what does HIPAA  
5 really allow and not allow, as a process. The  
6 HIPAA requirements did not seem to be the barrier  
7 when interpreted as intended, but there's a lot of  
8 over-interpretation.

9 GOVERNOR JIM DOUGLAS: Sandy?

10 MS. PRAEGER: I'm wondering, back to  
11 Representative Harrell's point about model laws,  
12 if -- and I think that would be difficult, but  
13 perhaps in the final report some guiding principles  
14 or some guidelines, if you're anticipating doing  
15 this, these are the things you ought to consider,  
16 things you ought to look out for. To have  
17 something, I think, would really help.

18 DR. HACKER: And I believe that's so,  
19 and I would certainly concur with that. That would  
20 be our intent.

21 GOVERNOR JIM DOUGLAS: Joy?

22 MS. PRITTS: There's so much I want  
23 to say here, it's hard for me to know where to  
24 start, but I think I will start with Assemblyman  
25 Conaway's questions about interstate variability. I

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1 wrote a report where I've actually looked at state  
2 health privacy laws across the states, and I also  
3 sit on the HISPC Technical Advisory Panel. And what  
4 came out from both of those -- wearing both of those  
5 hats -- is that even within a state there is a large  
6 degree of variability, because of the way states  
7 regulate.

8           You have one board that regulates doctors,  
9 for example, another one that regulates dentists.  
10 You'll have a state agency that regulates hospitals.  
11 So that even within the state, the requirements for  
12 whether a consent has to be obtained for certain --  
13 sharing certain types of information and what the  
14 elements of that consent form are can exchange.

15           So when you're looking at a state level,  
16 someplace where the governors here could really act,  
17 that there is a lot of -- there's a lot of work just  
18 to do at that level, which is something that the  
19 HISPC states raised.

20           Some of the states are participating in  
21 that project are conducting intrastate evaluations  
22 to try to gather some of their laws which are in  
23 various parts of their codes into one section so  
24 people can find them easier. Another approach some  
25 states are doing is they're trying to just within

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1 the state make things more uniform, because there is  
2 just, even within a state, a lot of variability.

3           I have a question about -- again about the  
4 different harmonizing, the consent. I understand

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5 that you have a work product that is addressing --  
6 that's supposed to come out, I guess in January,  
7 where the National Association of Attorney Generals  
8 is looking at state laws for you; is that right?

9 MS. HUNT: That's correct, on  
10 specially protected information, so that we'll have  
11 a feel. You all directed us before to get a  
12 representative sampling of how states are treating  
13 mental health, and you'll recall you asked us to  
14 look at the pros and cons of the different  
15 approaches, and that work product is still underway,  
16 and we should see some of it in August, in later  
17 August.

18 MS. PRITTS: Can I ask you how many  
19 states you're looking at?

20 MS. HUNT: You know, I don't recall.  
21 I know we have someone from the National  
22 Association --

23 DR. HACKER: 25.

24 MS. HUNT: 25 states.

25 MS. PRITTS: And are you looking at  
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1 just mental health laws, or other laws?

2 MS. HUNT: All of the specially  
3 protected laws. I know HIV and disability and  
4 genetics. Was there --

5 MR. HACKER: Substance abuse.

6 MS. HUNT: And substance abuse.

7 MS. PRITTS: So, now, the typical --

8 MS. HUNT: As many as we're aware of.  
9 The typical ones.

10 MS. PRITTS: And when you have that  
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11 information, are you trying to -- are you going to  
12 try to categorize it?

13 MS. HUNT: We are. We want to see  
14 what the differences are. You know, as we've  
15 mentioned, we understand some states require a  
16 written consent or a verbal consent.

17 We want to develop the continuum of options  
18 so that we can, as Assemblyman Conaway said, we want  
19 to give you an actionable item, so that you can say  
20 this seems to be the best approach for getting  
21 consent, and states could use this as a model law,  
22 or at least have some action to take within their  
23 own states.

24 MS. PRITTS: Are you also working with  
25 people who have expertise in technology? Because I  
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1 read -- I read the report, and it seemed to indicate  
2 that there weren't very many good technological  
3 solutions to this, and then we went over to GE this  
4 morning, and they seemed to think that they had the  
5 answer, so I'm just curious as to whether, as part  
6 of this process, you're dealing with people who have  
7 the technology and expertise.

8 MS. HUNT: We are, but you know, I  
9 think if you were to ask GE: So, we're sitting here  
10 in Vermont. Will your system know what to do if a  
11 patient presents in California? Will GE know if  
12 California law applies or Vermont law applies? And  
13 the answer is probably no, because we haven't  
14 figured that out at a policy level.

15 I think, as everybody says, the

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16 technological solutions are there. Technology is the  
17 easy piece. It's this policy and legal piece that  
18 we have got to sort out.

19 And as I'm thinking back to Assemblyman  
20 Conaway's question, what can we do now? Each state  
21 can decide on what privacy framework it should  
22 adopt, and it could be done by statute, or it could  
23 be done by executive order, and make that be the  
24 core of your activities around privacy. That will  
25 get your state on the same page.

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1 Then as we receive the Attorney General's  
2 work product on consent and what other states are  
3 doing, as we work through a form, then we can look  
4 at model laws or how we can get every state moving  
5 in the same way with consent, but there are things  
6 you can do today within your own state around  
7 developing a privacy program and having a framework  
8 that everybody works from.

9 MS. PRITTS: Just -- I'm sorry, just  
10 one more thing here. I wanted to let you know that  
11 the World Wide Web Consortium, W3C, is my  
12 understanding that they are actually working on  
13 definitions for -- standardized definitions for  
14 consent, along with some of the other standard  
15 organizations.

16 So I think it's a huge project, and not  
17 necessarily one that you need -- you may need to  
18 devote your time to, that there may be somebody out  
19 there who's actually doing it.

20 MS. HUNT: Yeah, it sounds like we  
21 need to hear from them.

22 MS. PRITTS: Yeah. They go by W3C  
23 often, so if you're doing -- looking for contact  
24 information.

25 MS. HUNT: Thank you.

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1 MS. PRITTS: And I think it's actually  
2 is looking at standardizing consent. You know, does  
3 it -- what does it mean when you say I'm giving  
4 consent, what does it mean, opt out, opt in, all  
5 that sort of thing.

6 MS. HUNT: Thank you.

7 GOVERNOR JIM DOUGLAS: Thanks, Joy.  
8 Brian?

9 MR. DaVORE: Just real quick, since we  
10 have time for further discussion, I think it may be  
11 helpful, and I think we're missing a step in there,  
12 which was, I was kind of struck by Dr. Medow's  
13 comment, one of her -- the thing that I've been  
14 thinking about, she raised the idea about standard  
15 definitions for health exchange.

16 I think we're missing the standard  
17 definitions for what security and privacy is. I  
18 think that's the biggest hurdle. We can't get past  
19 step three and four, because we've skipped step one,  
20 and I think the states could potentially be a  
21 driving force in defining what secure means and what  
22 private means, because even in a corporate setting  
23 amongst two or three corporations, there's never an  
24 agreement.

25 You have to get to that point, and I think

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1 that's one of the hangups that we're having at this  
2 point that might be helpful, if you, as one of your  
3 next steps, can work on potentially figuring out  
4 what that means and coming to a consensus of what  
5 those two terms are.

6 Maybe somebody else is already working on  
7 it, but I think it's problematic. It's something  
8 that needs to be taken care of from the get go, and  
9 then I think you'll see other things progress once  
10 that's kind of agreed upon, whether it's intrastate,  
11 or whether it's across state lines.

12 MS. HUNT: Thank you.

13 GOVERNOR JIM DOUGLAS: Anything else  
14 right now? Again, we can come back to this task  
15 force's recommendations -- well, we will, because  
16 we're going to act on them in just a little bit.  
17 Steve?

18 MR. PALMER: Yeah, just one quick  
19 question. In terms of your follow-up steps, it  
20 looks like you all are going to be looking at  
21 definitions of consent and things in that space.

22 I would encourage you all to also look at  
23 definitions of informed consent and what sort of  
24 content there should be around about what  
25 information consumers should be getting about the

1 benefits and consequences of their agreeing to  
2 participate in a health information exchange.

3 MS. HUNT: And we hope to give a  
4 toolkit back to the states with messaging and  
5 information that they can use to have that  
6 conversation with their consumers.

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7 GOVERNOR JIM DOUGLAS: Shall we move  
8 to the Health Care Practice Task Force report now?  
9 I'm really privileged to introduce Darlene and  
10 Rowen, who are the cochair and member of this task  
11 force.

12 Darlene Bartz is the Chief of Human  
13 Resources section for the North Dakota Department of  
14 Health. Dr. Bartz is responsible for the overall  
15 management of the Health Resources Sections,  
16 including the Divisions of Health Facilities,  
17 Emergency Health Services, Food and Lodging, and the  
18 Office of Community Assistance. She's the  
19 coordinator of the policy officer for HIPAA in North  
20 Dakota.

21 Rowen Zetterman is the Executive Director  
22 of the Nebraska Medical Association and Chief of  
23 Staff at the VA Nebraska, Western Health Care  
24 System. He's the professor of internal medicine at  
25 the University of Nebraska Medical Center, and

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1 Clinical Professor at Creighton University School of  
2 Medicine, so thank you again for your hard work on  
3 this task force, and we look forward to your report  
4 and recommendations.

5 DR. BARTZ: Thank you, Governor  
6 Douglas and Governor Bredesen and members of the  
7 Alliance. We're really pleased to be here with you  
8 today and have an opportunity to share what our work  
9 group is doing. It also has been a tremendous  
10 pleasure to hear from the other work groups and see  
11 how we touch on similar issues from a different

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12 perspective, and so that has been very enlightening  
13 for us today.

14 Since our task force last presented to you  
15 in late March, we've come a long way, and we want to  
16 share what we've been doing, where we are now and  
17 where we're going as far as a group. We've grown as  
18 far as the members of our group, and we've added to  
19 our group a consumer representative, a  
20 representative from a health plan, and we have added  
21 a representative for pharmacy. So those, we felt,  
22 were added members that we really needed to round  
23 out our group as we discussed the issues.

24 We also today are planning to share with  
25 you our first two recommendations that are coming

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1 out of our group. And so with that, we'll move  
2 forward with our presentation.

3 Looking briefly at the charge for our  
4 group, we were charged with supporting the State  
5 Alliance on issues regarding regulatory, legal, and  
6 professional standards that have an impact on the  
7 practice of medicine, nursing, and pharmacy, and to  
8 look at what barriers are there that we can be  
9 looking at removing to create an interoperable  
10 electronic health exchange method that can be  
11 implemented.

12 Since first handed this charge in February,  
13 we've been receiving many presentations from many  
14 different groups on these topics. We have requested  
15 work products on each of the areas that we've been  
16 charged with.

17 We will be receiving our first work product

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18 to start looking at, related to licensure, at the  
19 end of this month. So just to know that what we're  
20 sharing with you today is somewhat preliminary, and  
21 as we move forward, we'll be more concrete in our  
22 recommendations that we move forward with for you.

23 Licensure, liability in relation to health  
24 IT and electronic health information, and  
25 credentialing have become the top issues that we

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1 have been many looking at within our work group, and  
2 we've also touched on state laboratory, and some of  
3 the comments from some of the other presenters  
4 access of patients to their lab work has been an  
5 issue that we wanted to look at within our group.

6 So with that in mind, just to touch on some  
7 of the key questions that we've been being looking at  
8 in the different areas. Related to licensure, some  
9 of the questions that we've been asking are what are  
10 the benefits and challenges surrounding various  
11 compact models and licensure schemes, and how can  
12 they be applied to e-health activities?

13 What are states' credentialing requirements  
14 for physicians, pharmacists and nursing  
15 professionals, and should there be a nationwide set  
16 of core credentials for these professions?

17 We've also considered questions related to  
18 CLIA and physician liability in electronic health  
19 information exchange. From the beginning, licensure  
20 became a real top priority for our group and, you  
21 know, you may ask a question, Why is that?

22 We're looking at more and more people going

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23 from state to state to seek specialty care. We're  
24 seeing consumer protections that need to be  
25 considered as we're going through that e-health  
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1 environment in the exchange of information.

2 We're also seeing where the licensure  
3 process whereby physicians, pharmacists and nurses  
4 are licensed can sometimes create barriers when  
5 looking at receiving care in various states or  
6 across borders. We've even talked in our groups  
7 which -- and I know in North Dakota, we have  
8 institutions where they're sending their x-rays as  
9 far as like Australia and different places like that  
10 be to read, and come back into the state, and I see  
11 nods of heads and smiles in the group that that's  
12 happening elsewhere, and the physician will sign off  
13 on it when it comes back to the institution. So  
14 we're seeing where exchange of information is  
15 frequently going across borders.

16 We also have looked briefly at four  
17 approaches which I'll talk about as we go on  
18 today -- common licensure, online applications,  
19 licensure compacts, and reciprocity.

20 As we've been having our deliberations and  
21 having our presentations from the various groups,  
22 one thing that we have talked about is the common  
23 licensure application form.

24 In particular, the common licensure  
25 application form is also known as CLAF, CLAF, and  
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1 that was developed by the Federation of State  
2 Medical Boards. The CLAF is designed to streamline

3 the process for applying for license in multiple  
4 states.

5 With this form, the states are allowed to  
6 add state-specific information, and as a group we've  
7 very much recognized that states have their  
8 particular items that they want to gather  
9 information on, and so in any type of core form that  
10 we would put forward, we would want to see that  
11 states could add additional information.

12 But in an effort to help streamline the  
13 licensure process for physicians, for example in  
14 Ohio, the State Board of Medical Examiners has  
15 started a national pilot testing of the common  
16 licensure application form. They're utilizing CLAF  
17 also in Kentucky and New Hampshire, so we are seeing  
18 different states that are using those types of  
19 forms.

20 Some objectives of the uniform application  
21 are to facilitate health care practice across state  
22 lines, to reduce the burden faced by applicants  
23 seeking licensure in multiple states, to reduce  
24 administrative redundancies that encourage  
25 uniformity, and to facilitate the mobilization of

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1 physicians to disaster-affected areas. And we see  
2 with the bioterrorism efforts that are going on in  
3 many states, many agreements going on between  
4 states, where they need to mobilize physicians and  
5 nurses and other health care professions in just a  
6 short period of time.

7 Also, another area would be to maintain the

8 Opening and Taskforce Presentations.txt  
9 same level of public protection as current  
10 regulatory system, and then to assure state medical  
11 board revenues are sufficient to fulfill regulatory  
12 responsibility to protect the public.

13 Some concerns that have come through in our  
14 conversations is how they really felt the  
15 disciplinary action of practitioners should remain  
16 with the state boards that they're licensed under.

17 Another area w's online licensure  
18 applications, and there we had an example from the  
19 North Carolina Medical Board where they recently  
20 implemented online licensure applications for  
21 medical doctors and for doctors of osteopathic  
22 medicine. According to the North Carolina Medical  
23 Board, online licensure applications have not only  
24 reduced the time frames for obtaining a license, but  
25 also reduced administrative errors.

26 A concern had been identified by many 78

27 speakers that had presented to our group, just the  
28 length of time it took to get through that  
29 application process and how long it took to actually  
30 get people in the workforce.

31 Some components of the online licensure  
32 application may include a secure web portal to  
33 access the application, 24/7 access to licensure  
34 application, links to the website of medical schools  
35 and health care entities to obtain contact  
36 information for validating credentials, and instant  
37 upstates on the status of licensure applications.

38 There's a few other items that were on the  
39 slide that you could review yourself.

14 Another area was the licensure compact.  
15 And the Board of Nurse Examiners and the National  
16 Council of the State Boards of Nursing have  
17 implemented a national, or a nurse licensure compact  
18 that allows for mutual recognition between states.

19 North Dakota is one of the 22 states that  
20 is currently in the compact, and that does apply to  
21 registered nurses, licensed practical nurses,  
22 licensed vocational nurses. However, it does not  
23 apply at this point in time to advanced registered  
24 nurse practitioners. And so it's basically the RNs  
25 and the LPNs that are able to be a part of the

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1 compact.

2 Nurses regulated under the compact must be  
3 licensed in the state of residence, and so, for  
4 instance, if someone is working in South Dakota or  
5 Montana, compared to North Dakota, they would  
6 maintain their North Dakota licensure.

7 Right now there are, as I said, 22 states  
8 that have implemented the compact, and Rhode Island  
9 is planning on coming on board in the coming year,  
10 and so that is increasing.

11 There are two keys to the success of the  
12 nursing community in implementing this, and one is  
13 the ability to reach broad community consensus on  
14 the need for interstate licensure and the  
15 development of a widely accepted model based on  
16 mutual recognition. And it is interesting, as you  
17 know, I'm from North Dakota. We do have Montana and  
18 South Dakota in the compact. Minnesota has not come

19 Opening and Taskforce Presentations.txt  
on board with the compact yet. So our surrounding  
20 states, two of the three have joined that.

21 Since 1998, the nurses have successfully  
22 promoted the introduction of legislation and  
23 adoption of state laws that allow them to practice  
24 across the borders in the states that have adopted  
25 the compact.

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1 The last area that I'll touch on is  
2 reciprocity, and a good example of the reciprocity  
3 model currently as utilized by state boards is the  
4 National Association of the Boards of Pharmacy  
5 Electronic License Transfer Program. This program  
6 enables licensed pharmacists to reciprocate an  
7 existing pharmacist license from one state  
8 jurisdiction to another, and it utilizes uniform  
9 licensure requirements.

10 It serves as a clearinghouse that screens  
11 the applicants' licenses for status and disciplinary  
12 actions, verifies background information,  
13 examination grades, internship hours, and other  
14 state licenses and legal issues. It's still up to  
15 each state board of pharmacy to determine  
16 eligibility for reciprocity in accordance with the  
17 state laws, and so consistently through all of the  
18 examination we have done, we also, again, have  
19 identified the need for state-specific information  
20 to be coming through in whatever processes were  
21 implemented and recommended.

22 Now I'm going to turn over to Rowen.

23 DR. ZETTERMAN: Thank you very much,  
24 Darlene. As you heard earlier, I currently work for

♀ 25 the VA health care system, and this is a health care 81

1 system in which, if you hold a license in any one  
2 state, you can practice, providing you're properly  
3 credentialed and privileged, in any other veterans  
4 health care system in the country. This allows us  
5 to do telemedicine readily across state borders, and  
6 we have a very rural state, as you might guess, in  
7 Nebraska, and we're part of an integrated service  
8 network of upper Midwest states -- the Dakotas,  
9 Nebraska, Iowa, and Minnesota, and we can actually  
10 easily carry out telemedicine across all those  
11 boundaries. However, on the private side, you'd  
12 have to be licensed individually in each one of  
13 those states in order to carry out the activities of  
14 telemedicine across those borders.

15 As a consequence, we looked at a variety of  
16 things about licensure, and we found, for example,  
17 that about 80 percent of the states allow online  
18 licensure applications for nursing applications.

19 But in fact, most state pharmacy boards do  
20 not utilize online applications, despite the fact  
21 that actually the licensure examination itself is an  
22 online application that the pharmacists already use.

23 And as far as the states goes, there are  
24 only four states that use online applications for  
25 medical licensure, but in fact, a lot of that means 82

♀ 1 printing out the online application, writing it out  
2 by hand, and subsequently sending it on to the state  
3 by mail.

4           As a consequence, you can find out that  
5   licensure often takes many months, and we find  
6   amongst my physician colleagues that it may take  
7   four months or more to actually get through an  
8   application process that might even require an  
9   in-person visit to that particular state to gain a  
10  license.

11           All of these things obviously limit the  
12  capabilities of telemedicine for physicians. Now,  
13  you all know better than I that this is a very  
14  important issue for each state, because they're  
15  protecting their citizens' health by making sure  
16  that there's proper licensure of health care  
17  providers in each state, and that only qualified  
18  competent physicians, for example, can practice  
19  within those states' jurisdictions.

20           However, there often are common elements  
21  that each of the states utilize, and ask similar  
22  questions about the training, education, and a  
23  variety of things. But beyond that, state to state,  
24  we've heard that there are enormous differences in  
25  the things that many use.

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1           For example, some don't require continuing  
2  medical education for application, and some require  
3  as many as 50 hours of continuing medical education  
4  per year. Some don't require criminal background  
5  checks, but some do for all new applications that  
6  are coming in.

7           As a consequence, it's no surprise that I  
8  see online companies that now will assist physicians  
9  in applying to states for a licensure, and in fact,

10 one company that I found actually will help you gain  
11 licensure in all 50 states, but it doesn't tell how  
12 many trips I have to take or how many different  
13 requirements for HIV training or ethics training or  
14 the other independent variables that are all there.

15 As a consequence, we've developed two  
16 recommendations that seem logical and common sense  
17 as an approach for you to consider.

18 The first is that we would recommend that  
19 all state medical, nursing, and pharmacy boards work  
20 to implement online applications for licensure.  
21 This would be easy. Most of them have common  
22 elements that all can utilize, and it would be of  
23 great benefit, we believe.

24 In addition, we would suggest that a State  
25 Alliance recommend that these same groups develop

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1 common licensure application forms and the state  
2 medical boards adopt the Federation of State Medical  
3 Boards' CLAF, or common licensure application form.  
4 These exist in many forms, but in fact can be  
5 brought into uniformity of content. It would allow  
6 timeliness of application, and it of course would  
7 advance interconnectedness for all of the states for  
8 these various practices.

9 I would like to point out that that there  
10 are a number of areas of support for these  
11 activities. The American Medical Association is  
12 supporting the Federation of State Medical Boards'  
13 CLAF application process, as is the Osteopathic  
14 Association similarly supportive, and of course, as

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15 you've heard, the Federation of State Medical Boards  
16 have already set up their own application process  
17 they would like each state to utilize. We look  
18 forward to working with you further in respect to  
19 these recommendations. And I'll turn it back to  
20 Darlene to let her tell us where we will go next.

21 DR. BARTZ: So these two  
22 recommendations that we've provided to the Alliance  
23 today are only the first two in what we hope will be  
24 a series of recommendations, and we will have more  
25 recommendations and more policy statements

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1 concerning licensure that we will be presenting to  
2 you in October.

3 We are scheduled, as far as next steps of  
4 the task force, to continue our discussions on the  
5 various licensure models and compacts in September.  
6 And as I stated earlier, we do have like a work  
7 product coming to our work group end of this month  
8 which we'll begin our deliberations on.

9 We're also scheduled to discuss the  
10 possibility of streamlining credentialing  
11 verification systems, as well as harmonizing  
12 pertaining to personal access of laboratory test  
13 results, and we will examine liability issues that  
14 may arise in the electronic information exchange  
15 context. So we look forward to continuing to work  
16 on these agenda items, and then also to continuing  
17 to work with you on these issues. And that  
18 concludes our report today. Thank you.

19 GOVERNOR JIM DOUGLAS: Well, Darlene  
20 and Rowen, thank you very much indeed. Sandy?

21 MS. PRAEGER: On the credentialing  
22 issue, that's a problem we've dealt with in our  
23 state, in Kansas, because the physicians complain  
24 that one of the the hindrances in getting paid is it  
25 takes a long time for them to get them credentialed.

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1 And we've adopted the CAQH model for credentialing,  
2 which many health plans are using, which is an  
3 online system. It isn't without much angst that we  
4 are doing this, but I don't know, have you all  
5 looked at that as a possible -- it seems like many  
6 health plans are using that, so we've already got a  
7 lot of standardization from a credentialing  
8 standpoint, and that may be a good model that's out  
9 there.

10 DR. ZETTERMAN: At this point we've  
11 dealt with the larger issue of licensure, rather  
12 than credentialing, per se, but there certainly are  
13 a number of products out there. In the State of  
14 Nebraska, for example, our County Medical  
15 Association in Omaha has gotten virtually every  
16 health plan to utilize a common application form,  
17 and we actually do the initial credentialing for all  
18 the hospitals except for the VA health care system  
19 except for Omaha and Lincoln, which are our largest  
20 areas. By filling that out, you actually complete  
21 the application form for all of them. So yes, there  
22 are a number of things out there, and I agree that  
23 it's a big issue for the practicing physician.

24 GOVERNOR JIM DOUGLAS: January?

25 MS. CONTRERAS: Thank you, and thank

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1 you for your presentation. Speaking from an Arizona  
2 perspective, where I work for Governor Napolitano,  
3 sometimes it's hard when we talk about health  
4 information technology, we really try to talk about  
5 it in a way that it will connect with an average  
6 person in our state. This is the kind of work that  
7 really would help us, because this is a windfall.

8 If we can make some progress on this, this  
9 is addressing workforce issues, which in growing  
10 states like us, I mean, this is really important.  
11 So thank you.

12 MS. BARTZ: Thank you.

13 DR. ZETTERMAN: I would add a comment  
14 that in fact this may be a patient issue, as well,  
15 that's very important, because sometimes patients  
16 want to communicate with their physician for greater  
17 advice than what they might get in a telephone  
18 conference, which is legal in all states that I'm  
19 aware of, but in fact, they'd like to refer their  
20 husband, wife, child, best friend, to their same  
21 physician in another state, and if telemedicine  
22 could be easily accomplished across those borders,  
23 this would be a great patients rights issue.

24 GOVERNOR JIM DOUGLAS: Herb?

25 DR. CONAWAY: In New Jersey, we had  
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1 just in the past year or so, we've had some very  
2 tough laws on licensure of nurses. We had an  
3 infamous case where a nurse killed a number of  
4 patients, and so we put in criminal background  
5 checks and other things, and when I tried to bring

6 the reauthorization of the nursing compact through  
7 my committee, the governor's office said don't move  
8 forward, so of course we didn't. Do you have any  
9 thoughts on how we might be able to be involved with  
10 a compact, since we've had, we would think, a very,  
11 very high standard for nurses to operate in our  
12 state. Given our past experience, we're not going  
13 to track back away from criminal background checks  
14 and other various tough kinds of requirements for  
15 licensure. Any thoughts of how we can harmonize  
16 ourselves with what other states are doing?

17 DR. BARTZ: We have spent some time  
18 talking about criminal background checks, and right  
19 now it isn't something that I would say is mandated  
20 as part of the nurse compact agreements in the 22  
21 states. I know in our state, we had a significant  
22 amount of legislation that dealt with criminal  
23 background checks, identifying the different  
24 agencies that could request them in our state, and  
25 we are a part of the compact, the intent is that

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1 they are going to be doing criminal background check  
2 on a certain number of applicants every year until  
3 eventually all of them have criminal background  
4 checks completed on them.

5 It is something that we have had  
6 conversation on and we may come out with some  
7 recommendations, because we do see that as a very  
8 significant issue.

9 DR. CONAWAY: Just one more, if I may.  
10 Have you had any discussions on the liability

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11 question? I'm sitting in New Jersey, in fact,  
12 there's one going on now with St. Luke's in, I  
13 guess, it's West Virginia, I think, or St. Louis?  
14 Kentucky? Anyway, what happens when -- if there's a  
15 question about a medical malpractice? What  
16 jurisdiction? Have you talked about that aspect and  
17 what jurisdiction will apply? Would the patient who  
18 lives in New Jersey bring his or her case in New  
19 Jersey, will they have to the other state? How does  
20 that work? Whose law applies in that setting?

21 DR. ZETTERMAN: We had a presentation  
22 from the states attorneys general, and it is my  
23 understanding that no case has yet come up with  
24 this. Someone can readily correct me if they  
25 know of a case, but, in fact, as was mentioned

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1 earlier by other panelists, this is an area of case  
2 law and of other issues that will require some  
3 refinement, so I'm unaware, actually, of a case in  
4 which that's actually happened at this point in  
5 time.

6 GOVERNOR JIM DOUGLAS: Dave?

7 DR. SUNDWELL: I just can't resist  
8 commenting on how welcome this information is. As a  
9 doctor of a certain age who's gotten licenses in  
10 California, Massachusetts, District of Columbia, as  
11 well as Utah, this is Heaven.

12 The idea of online licensure is what I'm  
13 talking about. Because in the old days, I can't  
14 tell you how many weeks it took to get faxed or to  
15 get original copies of things and transcripts and  
16 letters from your dean. This is real progress, and

17 we should be grateful, even with the workforce  
18 issues as you mentioned.

19 Also, we're going to talk about  
20 e-prescribing this afternoon, but a fascinating  
21 development, thanks to online checking of people, I  
22 can now prescribe in almost every state. And we're  
23 a mobile society, and I've had patients in the last  
24 months call me from Georgia, Florida and New Jersey  
25 the most recent, and what they do, even though I'm  
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1 not writing a controlled substance, it seems they  
2 check my DEA number electronically, which means they  
3 have confidence that I am in fact a licensed  
4 physician of some standing, and that I can qualify  
5 for a DEA number.

6 But that's great progress. I think it's  
7 good for patients. It certainly makes the practice  
8 of medicine easier, and I think we -- I just want to  
9 take note that we appreciate where we've come from  
10 where we were thanks to electronic health data  
11 management.

12 DR. BARTZ: Thank you.

13 GOVERNOR JIM DOUGLAS: I think it's  
14 good to hear we're moving in the right direction and  
15 we're making it easier for credentialing, for  
16 prescribing, for the delivery of health care, and  
17 we'll make even more progress, won't we, as an  
18 alliance in the months and years ahead. We want to  
19 turn to the recommendations, but I'd be happy to  
20 invite questions for any of the three task forces  
21 before we do. Steve?

22 MR. PALMER: One thing that you all  
23 might look at, as we move forward with the practice  
24 of medicine area, is really, you know, our overall  
25 goal in this is trying to get the health care sector

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1 to adopt IT at the same rate that some sectors have  
2 adopted IT to really focus on and improve their core  
3 competency.

4 One thing that you all might look at is  
5 ways that the health care sector, and the practice  
6 of medicine in particular, are different from other  
7 industries where market pressures have driven the  
8 market participants to adopt IT, as opposed to the  
9 health care system, where those same market  
10 pressures have not necessarily been brought to bear,  
11 and looking at recommendations for trying to bring  
12 some of those market pressures to bear. So that  
13 rather than just having us throw a lot of money at  
14 the issue to try to get them to adopt, that the  
15 market actually drives that adoption.

16 DR. CONAWAY: Just, I guess, one, by  
17 way of request. You all have a number of folks that  
18 came and offered testimony, and I don't know if it's  
19 in here somewhere and I just haven't found it, but  
20 it would be helpful for me to know who were the  
21 testifiers, people, you know, who they worked for,  
22 who has consultancy, what kind of an entity,  
23 business or otherwise, because the people who offer  
24 testimony obviously have a lot to say about the kind  
25 of policy recommendations that are made, and as one

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1 who receives policy recommendations all the time --

2 drug reps coming in and talking to me at the  
3 office -- it's always good to know what the  
4 perspective is so that you can make an appropriate  
5 decision, so that would be the request.

6 I guess the other question is, I guess, for  
7 all of you, more particularly for Dr. Medows, and  
8 that is, this question of sustainability and  
9 captured revenue. I had a conversation this morning  
10 at GE. Health care insurance companies probably  
11 could save a buck or more each with each kind of --  
12 if you convert from paper to electronic, there's a  
13 savings there that accrues to the health care  
14 company. One of the ways that physicians and others  
15 who are different is because all these benefits will  
16 accrue to somebody else.

17 For us it's a revenue hit on productivity  
18 and a lot of investment with declining revenues, and  
19 malpractice costs going through the roof. So how do  
20 you -- how do we capture these revenue streams?  
21 Hospitals saving money on reporting, labs saving  
22 money on reporting; how do we capture these revenue  
23 streams to drive the acquisition in deployment of  
24 this technology where it needs to be -- in the  
25 primary care physician's office, pediatricians, 94

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1 family practice folks, internists -- so that we can  
2 get patients using this and using it to advance  
3 health care? And how do we make the transition? Do  
4 we start to grab the money now? Do we wait for some  
5 adoption first? I don't know how we can put the car  
6 before the horse to try to grab this money. Any

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7 thoughts on how we get the cash to do this job?

8 DR. MEDOWS: Assemblyman, I wish that  
9 I had the answer right now today, because I could  
10 probably -- never mind. This is on the record,  
11 right?

12 GOVERNOR JIM DOUGLAS: Being broadcast  
13 on the worldwide web.

14 DR. MEDOWS: Thank you. No, actually  
15 we've asked some of the same questions, but I think  
16 what we are first, as a task force, actually  
17 addressing is what is the benefit of the value to  
18 each of the stakeholders. Now, it may be that it's  
19 easier to see the benefit or value to a health plan,  
20 in terms of running your systems more effectively  
21 and more efficiently. And you can actually probably  
22 predict or anticipate what the value would be to a  
23 hospital system that is able to act more, or operate  
24 more efficiently, as well, with such a system in  
25 place.

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1 There are some benefits to the physician.  
2 They may not be as obvious, but I know that as a  
3 physician in Mayo Clinic, I was spoiled. Everything  
4 that I needed was on one little flat-screen  
5 computer, and I had every document that I could  
6 need: Labs, x-rays, notes, consultants' notes, my  
7 notes from way back when, and I didn't even have to  
8 decipher my own handwriting, which is an amazing  
9 thing. But I digress.

10 There was a lot of information that was  
11 made available to me, and I have to tell you  
12 something, that when you are a family physician and

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13 you are seeing patients every 10 to 15 minutes,  
14 because that's the crunch time, never mind the  
15 routine physical appointments, which are like a  
16 blessing -- well, except if you've got somebody with  
17 15 problems, but anyway, when you're on that kind of  
18 a crunch time, there is an actual value and a  
19 benefit to having access to that information right  
20 then, on time, and in a comprehensive manner, so  
21 there may not be a dollar amount that we can all  
22 just automatically assign to it, there is definitely  
23 an operational efficiency that I as a physician  
24 enjoyed by having those systems in place.

25 What I think what I was trying to speak to <sup>96</sup>

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1 before is we know that we have to find a way to put  
2 an objective monetary value on these things. We  
3 know we have to do that. I think the job of the  
4 task force, and with you, is trying to figure out  
5 how to do that objectively.

6 When we have talked about who's going to  
7 get the most benefit and the biggest bang for the  
8 buck, it usually comes back to the health plans  
9 itself. But we do have to recognize that other  
10 components do benefit.

11 We talked about, like I discussed with  
12 Representative Harrell, was the issue of trying to  
13 figure out how do we encourage adoption, how do we  
14 encourage participation in the beginning, because we  
15 know that if we don't get folks to the table, we  
16 don't have any hope of down the road, having a  
17 successful platform, and if it's the most basic

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19 component, like an electronic medical record in the  
20 doctor's office, what do we do to help them see the  
21 value, and I know that for myself, the way that I  
22 saw the value is having to actually experience it.  
23 And the way that I was able to experience it is  
24 because somebody put that initial investment up  
25 first.

So it may be, whether it's a payer -- and  
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1 by the way, the payer would include us -- doing some  
2 type of incentive program to get them to the table,  
3 and then having them understand, as we go throughout  
4 years that return on investment, that may be more  
5 what we have to work to, but I do not have a magic  
6 answer right for you. I wish that I did.

7 GOVERNOR JIM DOUGLAS: We have, I  
8 should note, some detailed reports from the Health  
9 Care Practice and Information Protection Taskforces  
10 in our packets that we can look at at our leisure.  
11 Jane?

12 COMMISSIONER CLINE: Thank you,  
13 Governor. To your point, I think that getting a  
14 buy-in is a challenge because, you know, I come from  
15 a state that we have a large number of family  
16 practitioners that have reached the 55 age, and so  
17 for them to want to put the investment into changing  
18 their whole practice, that presents another  
19 challenge, and I'm sure I'm not the only rural state  
20 that has that type of challenge.

21 And also to your point, one of our health  
22 plans is working with their provider network to move  
23 forward in some type of subsidization, because

24 they've approached us to make sure that it wasn't a  
25 form of rebating or something that wasn't in

98

1 violation of the law. Because it is going to take  
2 some creativity of that nature, particularly when  
3 you're dealing with a lot of family practitioners  
4 that are at or near the retirement age.

5 GOVERNOR JIM DOUGLAS: Other questions  
6 of our task force presenters today?

7 Why don't we move to the recommendations,  
8 then.