

♀

1 The next item on our agenda, as you can
2 see, is an opportunity to take another look at our
3 vision and goals as an Alliance.

4 We're halfway through -- a little more than
5 halfway through the calendar year, and it's a good
6 time to take stock of where we are to assess our
7 progress at the midpoint and then decide whether we
8 want to go off in some new directions. I think
9 we've just concluded a discussion that indicates one
10 of real interest on e-prescribing, and make sure
11 that we're comfortable with the vision document that
12 we adopted at our first meeting.

13 The four principles are on the screen, and
14 you have a hard-copy handout, as well. These are
15 the principles that guide our deliberations, and we
16 might just take a minute to look at them, to make
17 sure that we feel comfortable with them as guidance
18 for the Alliance's deliberations.

19 Personally I think they're general enough
20 so that they give us a good framework for our
21 discussions, and don't preclude new ideas such as
22 the focus on e-prescribing, but just take a look at
23 them and see if you feel comfortable with them.

24 We've kept them as our guiding principles
25 for these seven months, and I think we've

♀

1 accomplished a great deal so far. I think some kind
2 of flexibility is important. The general nature of
3 these principles makes it possible for states to go
4 down different paths as they address the various and

5 Alliance Goals and Closing.txt
6 complex issues of health IT.

7 States obviously are laboratories of
8 innovation, as we know, and they're testing a lot of
9 different solutions, some of which we've heard about
10 today, so we want to focus on some action-oriented
11 activities, as Phil indicated, to put a bow around
12 something and show our colleagues that we're moving
13 in a concrete way toward some real action on behalf
14 of the Alliance. So that really ought to, I think,
15 be more the focus of our next six months.

16 But are you comfortable with these four
17 principles? Any concerns or objections?

18 DR. SUNDWELL: I just would ask the
19 Committee's indulgence to consider a refinement of
20 No. 4, or consideration of another bullet. And you
21 have to understand, I'm prefacing my remarks by
22 saying I am the representative of ASTHO, the
23 Association of State and Territory Health Officers,
24 and I'm wondering if public health is sufficiently
25 represented in the fourth bullet. It may be, but
there are -- and you will hear from my colleagues

194

1 when you get the report later this year -- a list of
2 ideas how electronic health might enhance our public
3 health efforts collectively in the nation.

4 I worry a little bit about you all are
5 focusing so much on electronic medical records or
6 personal health information, that we'll overlook
7 opportunities to improve public health through
8 electronic data management and exchange, as well,
9 and maybe -- and so I'll just invite your
10 discussion. Maybe it's captured in No. 4, but I

11 think from what I've heard from previous meetings,
12 there's pretty good consensus that public health is
13 important, as well.

14 GOVERNOR JIM DOUGLAS: I guess I
15 assume that's what the essence of No. 4 is. If it's
16 not clear, we certainly could enhance it.

17 Just to elaborate a little, can we go to
18 the next slide, which is a diagram of our
19 objectives, in terms of using health IT, and you can
20 see that the fourth one there is clearly an
21 improvement of the overall health of the population,
22 so I think we understand that's one of our key
23 objectives, Dave.

24 DR. SUNDWELL: That's fine.

25 GOVERNOR JIM DOUGLAS: Well, let's
195

1 move to the next slide, then, which is a discussion
2 of our current directions, and you can see the first
3 three are the charges to the three task forces that
4 we've heard reports from today. We've adopted some
5 recommendations on the first two. We'll take the
6 third task force recommendations up at our next
7 meeting, and as we made it very clear during our
8 earlier discussion, continue to refine, and either
9 become more or less specific as appropriate, with
10 the recommendations we've already approved.

11 And I think, Phil, your suggestion was an
12 excellent one, that we want to tie this back to the
13 National Governors Association, so that all of our
14 colleagues are engaged in these initiatives, and we
15 have a February meeting of the NGA in Washington,

16 where we'll look at some policies coming out of the
17 various committees, so that would be a good time to
18 have a discussion of some specific recommendations
19 from the Alliance.

20 So these are the three we've been working
21 on, and then other issues for consideration --
22 e-prescribing, as we've had a very good discussion
23 about today -- and then another idea that I might
24 present for your consideration is business models
25 for health information exchanges. We've had some

196

1 discussion of how they work. We had the visit to GE
2 Healthcare this morning to see what they've been
3 doing with a lot of their provider clients.

4 Does it make sense that that be an area
5 that we focus on, because we've got to transform
6 theory into reality and real action, so if you're
7 agreeable, we'll work that into our work plans, as
8 well.

9 The next slide is some key activities going
10 forward. Some suggestions, such as developing some
11 tools, a guide on recommendations to assist states
12 in forming plans for health IT. Select some states
13 to support in that development.

14 I think the way things seem to go in reform
15 is that states are the labs of innovation, as I
16 suggested earlier, and we often are way ahead of our
17 federal counterparts in setting agendas and
18 implementing them, and I think now is the time when
19 our national capitol seems particularly -- you pick
20 the adjective -- not as innovative, let's put it
21 that way -- as many of our states, so I think it

22 makes a lot of sense to empower some states to move
23 forward to determine some best practices, and see
24 what we might share.

25 As I mentioned to you earlier, we have a 197

1 group in Vermont called VITAL that is one such
2 approach, and then there are certainly others that
3 are under way around the nation.

4 So does it make sense to kind of develop
5 some tools to help states support their statewide
6 innovations and then share these best practices?
7 Sandy?

8 MS. PRAEGER: One of our congressmen
9 has introduced legislation called the Independent
10 Health Record Trust Act of 2007, and I think we
11 probably should have somebody from the NGA look at
12 it and figure out if there's something that, from
13 our perspective, we want to do in terms of
14 supporting or offering suggestions to making it
15 better.

16 I don't know how long ago it was
17 introduced, but I've got a copy of it if -- but
18 that's -- it is out there and it is a -- it would be
19 a federal approach. The purpose, it says, of the
20 act, is to provide the establishment of a nationwide
21 health information technology network, to improve
22 care quality, promote wellness, ensure medical
23 information is available in usable forms, produce a
24 more efficient marketplace, and the coordination of
25 medical information, and ensure that privacy

Alliance Goals and Closing.txt
1 security and confidentiality of patient health
2 information is secured and protected.

3 GOVERNOR PHIL BREDESEN: Well, if we
4 had known that was in the Congress, we could have
5 just forgotten about this one.

6 MS. PRAEGER: Well, I think -- you
7 know, I think we have a great opportunity for some
8 input. It's a long way from being passed.

9 GOVERNOR JIM DOUGLAS: Well, that was
10 what I was going to gently suggest, that at our
11 first meeting in January, you may recall that Phil
12 and I broke away from lunch and met with Senator
13 Kennedy, the Chairman of the Health Committee, and
14 he has reintroduced his legislation, along with
15 Senator Hennessey, I believe, to provide some grants
16 to states for IT initiatives, but -- or it's come
17 out of one committee of the Senate. I don't know if
18 there's going to be any money attached, and so I
19 don't want to hold out a great deal of hope that
20 some of these federal initiatives are approved, but
21 we can hope and urge and try to move them along,
22 Sandy.

23 MS. PRAEGER: Yeah, well, I'm not
24 saying I've endorsed this in any way. I just wanted
25 to make everyone aware that it's out there. It has
199

1 a lot of cosponsors. But, you know, it's -- they're
2 heading after the same goal, and it may be -- we may
3 be able to use the fact that they're interested in
4 this to leverage some of that cooperation we were
5 talking about, too.

6 GOVERNOR JIM DOUGLAS: Well, there is
Page 6

Alliance Goals and Closing.txt

7 interest, clearly, on the part of some in Congress,
8 and we want to capitalize on that if we can, and, of
9 course, some of our recommendations are directed
10 toward the Federal Government, so I don't want to
11 suggest they aren't of any use as we move forward
12 but the states are moving very well, as we've seen,
13 in designing and implementing models of health IT
14 that I think we want to encourage.

15 Well, one suggestion we were chatting about
16 with the staff is to select a few states to support
17 as they develop their innovations, which is always
18 very difficult, but probably a good approach, in
19 terms of getting something solid in place in some
20 states, and then see how they do in developing our
21 recommendations, of course, as they go forward to
22 implement their plans, and then see what kind of
23 models they present and where we go from there.

24 Brian?

25 MR. DaVORE: I just have one concern,
200

♀
1 and just in the first bullet on the set of tools,
2 and can I get -- you're putting together, I guess, a
3 list of best practices. HIT seems really broad to
4 me. That encompasses everything from telemedicine
5 to email consultations to EMR. I think it might be
6 best if we put together a toolbox based on the
7 things that we've been working on, which is a
8 licensure, and the things that we think we have --
9 the state has control over.

10 I'm not sure -- I think HIT is a little too
11 broad and the state has very little control over

Alliance Goals and Closing.txt
12 driving technology in the state, whereas other
13 things which are higher pain points in the toolbox
14 might be more beneficial to the states.

15 GOVERNOR JIM DOUGLAS: I think what we
16 would do is base the toolbox on the topics we've
17 discussed in the recommendations we've approved, so
18 I hear what you're saying, Brian. Thanks. Joy?

19 MS. PRITTS: I just would like to make
20 this group aware of the future steps of the Health
21 Information Security and Privacy Collaborative, so
22 that we're aware of what they're doing next and
23 potentially making sure that we coordinate our
24 activity with them, because they also are planning
25 on developing tool kits in some of the areas that
201

♀
1 we're looking at. For that, the Health Information
2 Security and Privacy Collaborative was the 34-state
3 and territory project that was undertaken by HRQ
4 under contract with Research Triangle, and they had
5 a first phase where with they looked at their
6 privacy laws, as we heard this morning, and their
7 next phase, they're forming collaborative groups
8 among the states, so, you know, there will be five
9 states that are looking at issues like consent and
10 some of the other topics that we're also
11 considering. And I do have here a list of states --
12 they've got everybody to sign on to at least look at
13 this except for 11 states and territories, and it
14 would be helpful if every state was part of this
15 process. It's my understanding that there may be
16 funding attached to these work group collaboratives
17 as they go forward.

18 GOVERNOR JIM DOUGLAS: Thanks, Joy. I
19 think we know we're not the only group of Americans
20 who are thinking about IT in the health field. It's
21 certainly good to have some coordination and know
22 what these other organizations are doing, and I
23 think our staff do keep in touch with them from time
24 to time.

25 Kathleen, could I ask you to explain to me
202

♀
1 and my colleagues how the policy academy process
2 works within NGA, which might be a structure for
3 proceeding to help some states implement some of
4 these ideas?

5 MS. NOLAN: Absolutely. The way that
6 we traditionally try to work with a number of
7 states, a small number of states, on real
8 implementation is what we call our policy academy
9 vehicle, which is traditionally a competitive
10 process, by which we put out both an RFP, but an RFP
11 that includes a framework for how we think things
12 might go, or a couple of different types of
13 approaches for how these can work, and I think that
14 the Alliance could really help set that framework
15 up -- here's our best findings on how this might
16 proceed -- and then do a competitive process by
17 which states come in and tell us where they are,
18 what kind of resources they could bring to the
19 process, and then do an interstate learning process,
20 where we get experts together, we do consultations
21 throughout a year, 18 months, et cetera.

22 Traditionally, that doesn't always include

23 funding, but we think that this is a place where, if
24 we were going to do this kind of thing, it would
25 have to be a funded activity where states would

203

1 receive funds to begin to set these things up, begin
2 to pull from what's already going on in their
3 states, et cetera, so it often includes a needs
4 assessment, an analysis -- a landscape analysis --
5 of what's going on, and then progress forward has to
6 be demonstrated and monitored by NGA, as well as
7 what we would think in this context would also be
8 the Alliance working to learn what we don't already
9 know, from having states actually get involved in
10 putting these things into place.

11 GOVERNOR PHIL BREDESEN: May I just
12 ask a further question on that? I know that in
13 Tennessee, a lot of times either a member of my
14 administration, a state legislator, will come back
15 from a conference or a meeting or something or other
16 with a good idea, okay?

17 And so, has NGA ever, or would it make any
18 sense with this kind of thing, to think about
19 something -- it could be a year down the line from
20 now, but trying to find a way to bring together at
21 one of these meetings a much larger group, where we
22 could do a much more structured presentation of what
23 our results had been so far, bring in some real
24 expertise on some of those issues? Is that
25 something that NGA has ever done?

204

1 MS. NOLAN: Yes, in a few places, and
2 in fact, we just did one on health reform broadly

3 about a month ago in LA, which is exactly that kind
4 of process.

5 GOVERNOR PHIL BREDESEN: Was that in
6 association with another meeting, or?

7 MS. NOLAN: It was just ours.

8 GOVERNOR PHIL BREDESEN: We have a lot
9 of people going to NCSL or Boston, and maybe you
10 could think about tying something onto one end or
11 the other of that.

12 MS. NOLAN: Absolutely, and in fact,
13 we do have, in this contract, a proposal for a
14 national meeting that would be -- and I can't
15 remember the timing for it -- I believe it's
16 sometime in early 2009, but we can could --

17 GOVERNOR PHIL BREDESEN: But I think
18 the trick is not to get everybody who's got a point
19 of view to push, but get some of those legislators,
20 get some of those health commissioners and the like
21 in those states there.

22 MS. NOLAN: Absolutely.

23 MS. HARRELL: I'd like to tag onto
24 that, as well. I think that's an absolutely
25 fantastic idea, and to do it either at -- to tag

205

1 onto something like NCSL, or ALEC, or any of those
2 kinds of organizations, and have a component of
3 them, maybe approach them, to do something so that
4 you hit a broad spectrum of all legislators and have
5 some kind of a presentation at one of those -- I
6 would say both of those meetings, because you get a
7 different group at each one. But also, I think

8 that's one of the questions I had had earlier,
9 dealing with model legislation, guidelines, things
10 of that sort. I would like to see when -- you know,
11 when we're talking about developing a guide, I think
12 we need to be as specific as possible for states to
13 have that whole laundry list of things that can be
14 done, very succinctly, very clearly, so that a
15 legislator can go back to the state and say -- give
16 them -- give it to the health policy staff and say,
17 okay, draft me some legislation that's going to do
18 this.

19 Look at our statutes, see what we need to
20 do to make that happen. So we're quite specific in
21 what we do, so that we have this toolkit that you're
22 talking about, and we can give it to people at this
23 kind of meeting, and you have the ability to spread
24 that across the country very rapidly.

25 GOVERNOR PHIL BREDESEN: Yeah, my ²⁰⁶

♀
1 thought would be -- what we've done so far is kind
2 of taking testimony and having people meeting. This
3 would be a more produced version of the thing, of
4 taking these things that really did give people some
5 tool kits that they could work with. But I just
6 offer that as a suggestion as you talk about this.

7 GOVERNOR JIM DOUGLAS: Well, sounds to
8 be like it's well received, Phil. Richard?

9 MR. MOORE: Yeah, I think along those
10 lines, that the proposals that we have kind of have
11 to answer the question, how does this help my
12 constituent? Well, many legislators are not
13 particularly -- technology scares them. There

Alliance Goals and Closing.txt

14 probably are a couple of governors in that category,
15 too, that have trouble with even email, let alone
16 health information technology and privacy issues, so
17 I think it really has to be -- in order to get the
18 average legislator supportive of either legislation
19 or funding, especially when there might be groups
20 like some of the docs that don't want to move to
21 e-prescribing or hospitals that don't want to spend
22 the money, or whatever that is, will be pushing
23 back, they have to know, you know, what are the
24 messages that we're saying that these things will do
25 for your constituent to make it worth your devoting
207

1 some political capital in coming forward and
2 supporting it.

3 And I think that has to be tied in with any
4 of the suggestions we make, you know, how does that
5 help, and then what are some of the steps that we
6 can get to bring other players like the physicians
7 that are not particularly technology interested, or
8 think it will cost them too much money or time, some
9 techniques that might work that would bring them on
10 board, so it's-- there's less resistance when we
11 have to support it.

12 GOVERNOR JIM DOUGLAS: A lot of good
13 ideas. I want to be sure Kathleen has enough
14 direction from the Alliance. Well, you can handle
15 it. But do we agree generally that we want to
16 develop a toolkit, list, a guide, sensitive to
17 Gayle's recommendation that it be specific enough to
18 be useful, and states then can pick and choose,

Alliance Goals and Closing.txt
19 obviously, among the ideas that might be relevant to
20 their situations, and that they need to be useful
21 for the good of our constituents.

22 A meeting of some kind, perhaps attached to
23 a national gathering of legislators that would
24 provide a greater exposure to these issues for
25 policymakers?

208

1 Are you comfortable with the policy academy
2 idea that Kathleen outlined to work on a competitive
3 basis with some states to implement our
4 recommendations? This is not immediate, obviously,
5 but as we develop them? Ken?

6 MR. SVEDJAN: Well, just Governor, a
7 question along that line, how does the policy
8 academy vehicle actually work? I mean, for any
9 state that were to compete and be awarded this, does
10 NGA go in and work with the executive branch, or do
11 you enlist the legislative branch, or how do you do
12 that?

13 MS. NOLAN: Absolutely. In fact, the
14 requirements as well as the entire concept is one of
15 cross-sector and cross-party engagement. So
16 traditionally any state engaged in policy academy
17 has to assemble a team. The team must come from the
18 private sector where relevant, consumers can be part
19 of that process, legislators, and relevant executive
20 branch representation. It must be at a level of
21 decision- and policymaking level. It cannot be sort
22 of left to people who might not have the ability to
23 actually change the direction. So it is very much a
24 structured process where it must be teams

♀ 25 representing all the relevant parties, or at least
209

1 as many as we can get into the room and get by in
2 the beginning. Traditionally, those teams will
3 grow. One of the goals is often to bring 12 people,
4 maybe, to the meeting itself, but there's a lot of
5 correspondence back and forth, and then additional
6 meetings that happen back in the state with 40, 45
7 people, so there's a lot of ways, but it is
8 absolutely cross-sector. It is not exclusive to the
9 executive branch, or even to a single agency. We
10 believe that the best application of this model is
11 to things that require that kind of collaboration.

12 MR. SVEDJAN: But Governor, if I may
13 continue, the point person in this, however, would
14 be the governor, the sitting governor; is that
15 correct?

16 MS. NOLAN: We run them as NGAs
17 through the governor's office, and the governor must
18 select the team and sign off on the team is the
19 process that we use. We have used others and worked
20 in other ways with NCSL in the past to make sure.
21 We do some -- in order to demonstrate you have the
22 right team, if you have a different party leadership
23 at the legislature, you have to demonstrate that you
24 don't just have your own folks; you have the team
25 that can make the change.

♀ 210

1 GOVERNOR JIM DOUGLAS: Brian?

2 MR. DaVORE: Governor, I apologize if
3 I'm being somewhat redundant, but I just want to

4 make sure that -- I think what we're doing here is
5 fantastic. We're really broadening our scope and
6 seeing everyone and go, but just in response to
7 Representative Harrell, how long of a laundry list
8 do you want? I guess my concern is that we make
9 such a long laundry list, you got 50 states, you may
10 pick all over that place, and what you end up doing
11 is you accomplish interesting stuff throughout the
12 U.S., but you don't really have enough mass of any
13 one specific thing to really go and move and change
14 health care.

15 I guess I want to emphasize, and then I'll
16 get off my soapbox, that this is a pretty narrow and
17 a pretty short laundry list and it's pretty
18 specific, and it has some teeth again, just so when
19 you go back to your states, it isn't A to Z, pick
20 and choose as you will, but it's pretty -- here's
21 two things that, you know, this committee and the
22 NGA has basically signed off on.

23 And then the next process are the academies
24 and those kinds of things are, as you begin to lay
25 track down the road, what do those things lead to,

211

1 but you can broaden once you get some early wins,
2 and maybe that's being redundant, but again, just
3 want to emphasize that point.

4 MS. HARRELL: To respond to that, if I
5 might, what I was suggesting is that certainly
6 within the framework of principles that has been
7 established for us in our goal, really our direction
8 of this organization, in this group, so that we are
9 limited to the things that we have discussed, the

Alliance Goals and Closing.txt

10 different task forces that we've discussed and
11 e-prescribing, which we've kind of added to that
12 list today. So your concern is certainly was with
13 health information technology being too broad, but I
14 think we're within the task forces, the reports we
15 get back, the preliminary reports we're getting now,
16 and develop that laundry list within that framework.

17 MR. DaVORE: I apologize. I live in
18 the fear of AHIC, since I live in that on a weekly
19 basis, and we get grand in scope, and we lose kind
20 of our original vision, so --

21 GOVERNOR PHIL BREDESEN: No, I
22 think -- and believe me, I think you're preaching to
23 the choir around this table about the need to find
24 some specific things. I just think we need to pay
25 some attention as good politicians, as many of us
212

1 are, to communicating that to the people who can
2 actually make that happen, and not have dead trees
3 on a shelf somewhere of a nice report we've
4 produced.

5 GOVERNOR JIM DOUGLAS: Richard?

6 MR. MOORE: You might want to explore
7 the possibility, in NCSL, at least every other year,
8 and they've talked about even every year, there's a
9 meeting for the legislative leaders -- which are
10 usually like the speakers and presidents and
11 majority leaders.

12 There's also an NCSL Health Chair's
13 Project, which includes not just the chair of the
14 Health Committee, but folks who might be chair of

15 the appropriations committees that deal with health,
16 and it might be worth exploring with NCSL if they
17 could try to have those two meetings overlap, and
18 involve at least some portion of the Governor's
19 Association, if not the whole NGA meeting, at least
20 some key folks, so you'd have some of the
21 health-related folks that are interested, the
22 legislative leaders who could make it happen, and
23 the governors who could initiate the policy. It
24 might be worthwhile trying to focus on that kind of
25 a group.

213

♀

1 GOVERNOR JIM DOUGLAS: Thanks,
2 Richard. Sandy or Hardy?

3 MS. PRAEGER: Kind of along that same
4 line, I mean, we're talking about getting buy-in
5 from all of the interested parties, and you've
6 proposed this notion of having a large meeting. I'm
7 wondering if we also want to think about going --
8 reaching out to some of their associations and
9 offering to get on their agenda at their meetings,
10 and I -- certainly, Jane and I can offer the NAIC as
11 a venue. We have a Health Insurance Committee that
12 would be very interested in this.

13 I would think the AMA and some of the other
14 medical professional associations would be
15 interested, like the American Hospital Association,
16 so I don't -- maybe that's too much work, but it is
17 a way of, you know, going to them and also, I mean,
18 having a report that could be presented, and let --
19 and get buy-in that way.

20 MS. NOLAN: Can I propose we actually
Page 18

21 do an outreach plan, because I think it gets back to
22 our original discussion about what happens to these
23 recommendations, as well as where we're going with
24 this guide, and maybe it's a two-phase process,
25 maybe it's -- you know, maybe it's got a couple

214

1 different components, but to think about the fact
2 that in January, we're going to have some pieces,
3 and then later we're going to have a guide and some
4 tool kits, et cetera, and maybe some states doing
5 it, so I think we need to be staging this out and
6 then bringing that back to you all, and make sure
7 that we have buy-in like that from the different
8 representatives here of the different organizations,
9 but also that it makes sense from where you're
10 thinking these recommendations are going.

11 Are there groups that were we're not
12 reaching out to that our recommendations really need
13 to be about? Maybe we need to be at the medical
14 boards, as well, but bring something back to you
15 that walks through what we think might be the best
16 use of it and see if we've got it right.

17 GOVERNOR JIM DOUGLAS: Sounds like a
18 good idea. Hardy, did you want to --

19 MR. MYERS: Just very briefly. In the
20 wake of the last meeting, a couple of my friends in
21 Oregon have been very active in this area, arranged
22 a meeting with Dr. David Lansky of the Markle
23 Foundation. As many of you may know, he is very
24 concerned about the fact that the current payment
25 and financing systems -- I'm just reading from a

215

Alliance Goals and Closing.txt

1 little summary he gave me -- do not reward
2 information sharing. In fact, they disincent it.
3 And he believes that, in pursuit of what he calls a
4 stable policy architecture, a key goal should be to
5 create one in which HIT investment is stimulated.

6 I mention this only because I think, as our
7 recommendations take more and more concrete form, I
8 think it would be worth -- and to the extent we're
9 trying to provide, at least in part, some measure of
10 possible guidance to suggestions for action, state
11 and federal, that we would be sure that we at least
12 consider whether we've adequately addressed with
13 strategies, address strategies that have the goal of
14 not just of a technological soundness and
15 functioning of the system, but the goal of spurring
16 investment in HIT.

17 And I think this third work group, the one
18 that led off today, is the one that's going to take
19 us most directly in that area, because Dr. Lansky is
20 a strong advocate of state payment policy changes
21 that can have that effect through purchasing
22 decisions and so on.

23 GOVERNOR JIM DOUGLAS: Herb?

24 DR. CONAWAY: That's, I think, a very
25 critical point. I've been meeting with some folks
216

1 trying to drive innovation in insurance products and
2 other things in the state, and this point about
3 reimbursing physicians for their proactive effort in
4 disease management, with a -- my hope is that with
5 the broad application of these information systems,

Alliance Goals and Closing.txt

6 that we will have the ability to reach out and grab
7 those patients that tend to be noncompliant, make
8 sure that you meet your goals for a diabetic, let's
9 say, your quarterly A1Cs, your annual urine
10 albumins, et cetera, and when that doesn't happen,
11 then incent physicians to do the disease management.

12 One of the big sort of decisions that
13 governments are going to have to make, as you think
14 about disease management and chronic disease
15 management is how you're going to do that in a
16 cost-effective way.

17 If you corporatize it and remove it and
18 bring it outside of the physician's office, I think
19 you're going to pay a lot more for it for one thing.
20 Maybe you'll get the same amount of benefit, but
21 wouldn't it be better, at least from my point of
22 view, to have that disease management process driven
23 in a physician's office as part of the
24 doctor-patient relationship, and use that to change
25 the way we deliver -- we physicians deliver health
217

1 care, to make it more proactive, to get people in,
2 to deal with some of the barriers to compliance that
3 we see, and to use this information to do that, but
4 that means that the insurance companies and the
5 state, who pays for a lot of health care, is going
6 to have to change -- you know, we're going to have
7 to develop the codes to pay for that, because right
8 now it's not paid for, which means it's not done.

9 So that's a very important point. I think
10 it's probably a follow-on to what we're doing with

11 this effort, but I think that one of the -- the true
12 value of this, going down the road, is going to be
13 getting at this question of how we use the payment
14 system to incentivize preventive medicine and
15 disease management.

16 GOVERNOR JIM DOUGLAS: Marshall?

17 DR. RUFFIN: Well, two related
18 questions, or two related observations: The
19 fee-for-service system in the United States, it
20 drives us to procedures, rather than to think about
21 the patient long term, and it does dissuade us from
22 investing in electronic records onever time. What
23 we're really paid to do is document our procedures
24 with which we get paid.

25 But the two most sophisticated health

218

1 information exchanges in the world are both based on
2 fee-for-service systems, although one's in Taiwan
3 and one is in New Zealand, both of them do depend on
4 public funding for the architecture, and they're
5 both based on single-payer systems, although both
6 countries do have private health insurance for the
7 more affluent. Even in England, as you know, about
8 a quarter of health care is paid for by private
9 insurance, and England is building a similar type of
10 network.

11 So culture becomes really important in
12 this. The physicians in New Zealand and in Taiwan
13 do an incentive to produce procedures, but there's
14 also an expectation that they'll take care of
15 patients long term, and the information systems
16 support that. So part of this is cultural.

17 I think a key issue that we're not dealing
18 with yet, and maybe it's because we all assume and
19 the sort of the benign behavior of the people who
20 built networks, is that these networks become more
21 valuable the more people use them. That's an
22 inherent quality of a utility.

23 Now, we haven't talked about utilities yet
24 here. But we can trust in the benign leadership of
25 the folks who've created SureScripts, and I think
219

1 it's a benign leadership with all the right
2 intentions.

3 But imagine that the pharmacies that own
4 SureScripts decided that there's some policy related
5 to health information exchange they didn't like, and
6 they didn't want to connect their network, or
7 participate any longer in some national network.
8 There's an impli -- or imagine that the American
9 Medical Association organized all the physicians to
10 share a common medical record, and then they didn't
11 like a policy, and perhaps no longer participated in
12 health information exchange. I think we need to
13 deal with sort of the public trust issues and
14 protect -- maybe have wording in here about publicly
15 available networks.

16 DR. CONAWAY: I couldn't agree with
17 you more about that. I believe -- and along with
18 this toolkit idea the things the states need to do,
19 I think this is a public utility, that it operates
20 like that, the incentives -- someone argued that,
21 you know, physicians aren't doing this, that, and

Alliance Goals and Closing.txt
22 the other thing.

23 They're not doing it, because it's not in
24 their financial interest to do it. You know, we
25 built roads, we have electric companies, telephone
220

♀
1 companies. Those are public investments that are
2 made. Train systems, public transit. We know we
3 need to do it. It doesn't pay for itself, but we
4 fund it because we know, we recognize it as a public
5 good. I think that gives us great public benefits.

6 I -- I think that this health information
7 technology, this system that needs to be developed
8 is like that, and so it's going to require a lot of
9 public investment for the good of everybody.

10 Yes, the government's good at capturing
11 revenue, we can do that, but I think government at
12 the end of the day is going to have to drive it, and
13 I think the public, quite frankly, is going to -- I
14 believe, and I might be wrong about this, clearly --
15 is going to trust that information being held by the
16 governments, is going to be required to follow
17 rules, established in law by the legislatures, and
18 when you see that you have credit card companies
19 that lose your information and all sorts of things
20 that go on there, I think that the public is going
21 to trust the government having some ongoing role at
22 the bottom of it.

23 They can't be privatized off there, because
24 I think people will have a sense that they've lost
25 control of it then, and will be concerned about
221

♀
1 using it.

Alliance Goals and Closing.txt

2 DR. RUFFIN: If I can just disagree a
3 little bit with Herb, I wasn't suggesting that
4 because there are characteristics of a utility, the
5 government needed to pay for it, because the
6 government's really never paid for the electric
7 systems or the water systems -- entrepreneurs did --
8 but the government's controlled it as a public
9 trust.

10 DR. CONAWAY: I agree. I probably
11 said it the wrong way.

12 MR. MYERS: I didn't understand
13 Dr. Lansky's focus, when he met with me, to be the
14 question of do we organize as fee for service or
15 some other way, as opposed to how do we incentivize
16 IT, however the practice is otherwise organized, so
17 that we don't reward -- and we don't reward
18 redundancy, duplication, what I think he called
19 information-poor decisionmaking. How do we reward
20 those kinds of achievements, apart from however else
21 the delivery of the service is being organized,
22 which I know is a very big issue itself, but --

23 GOVERNOR PHIL BREDESEN: On the slide
24 that Jim put up there a little bit ago about the two
25 things we were looking at down the road, this idea
222

1 of a sustainable business model, which may be a more
2 prosaic way of saying what you're saying, I think
3 everybody feels is right at the core of the issue,
4 and there's lots of different ways of looking at
5 that, but I think that is very much on the agenda of
6 this group.

7 GOVERNOR JIM DOUGLAS: Steve?

8 MR. PALMER: As we go forward and
9 start talking -- if we do start to talk about
10 sustainable business models and so on, one way to
11 characterize some of the alternatives in that space
12 will be, as, on the one hand, kind of the RHI0-type
13 paradigm, Regional Health Information
14 Organization -- formed as a utility-type model, and
15 on the other hand, a sort of model that Commissioner
16 Praeger mentioned through the independent health
17 record trusts or health record banks, as they're
18 sometimes referred to, which is far closer to the
19 financial banking model.

20 As Assemblyman Conaway mentioned, a lot of
21 these networks that have been developed
22 historically, were developed by government or with
23 government involvement, but if we think about the
24 electronic networks that connect banks together,
25 connect an ATM to a bank, connect different cell

223

1 phone, or allow you to use different cell phones on
2 different networks, those were not created by
3 government. So there are clearly different models
4 for establishing these sorts of interoperable
5 records. The utility model is one way to do it; the
6 health record banking model is another way to do it.
7 So these -- as we start thinking about sustainable
8 business models, that might be a good structure
9 within which to look at it.

10 GOVERNOR JIM DOUGLAS: David?

11 DR. SUNDWELL: Just very quickly, an
12 example of that -- and I don't want to sound

13 parochial here, but the Utah Health Information
14 Network is ten years old. It is not a for-profit
15 entity. It's all the stakeholders -- the hospitals,
16 the doctors, the insurance companies -- but they pay
17 a very, very modest fee, there's no opportunity for
18 profiteering, but it's worked very well, and it's
19 sustainable, as opposed to some RHI0s that have gone
20 out of business because they can't do it.

21 So there are hybrids. It's not a
22 government-run thing; it's a collaborative for us,
23 but it's a not for profit, which I think is the key,
24 which might not make General Electric happy or some
25 others, but it can work without paying big bucks for
224

♀
1 a vendor to do it.

2 GOVERNOR JIM DOUGLAS: Gayle?

3 MS. HARRELL: I think this is
4 certainly the direction -- the future direction we
5 need to go. Our task right now certainly is to
6 propagate electronic health medical records and to
7 make sure that we get the system in place moving
8 forward.

9 Certainly that overall business model, as
10 we move forward, has many, many phases that it can
11 move into. And it may not be a universal phase. It
12 may be a different -- there may be a different model
13 for each state, depending on how that state views
14 things.

15 Certainly in Florida, we kind of have the
16 public service commission model that we use for our
17 utilities. They're all, you know, either publicly

18 traded companies or maybe city-run utilities or
19 whatever, but we have a public service commission,
20 who pretty well writes the rules and regulations
21 that ultimately control them, make sure that they do
22 things within appropriate bounds, that you don't
23 have a SureScripts saying, I'm not going to play
24 anymore -- they have to play -- and you set the
25 rules and requirements within pretty much a

225

1 private-sector-driven system, and that may work in
2 Florida for -- and I like the utility model as we
3 see it in Florida. Other states may decide that
4 they want a Massachusetts-run information network or
5 whatever, but those decisions will be made state by
6 state.

7 What I think our task is, is to first get
8 the systems -- get the knowledge base out there,
9 empower states to make those decisions to push
10 forward, and give them that toolbox that we're
11 talking about with a variety of kinds of things out
12 there that they can use to move forward.

13 The next step, of course, is continuing the
14 business model to keep it operational. Some of that
15 happens in first stage, some of that happens in
16 second stage.

17 GOVERNOR JIM DOUGLAS: Brian?

18 MR. DaVORE: I'm going to push again
19 back a little bit on the business model and
20 sustainability. I think what you're talking about
21 is fantastic, although I would probably add a caveat
22 that you should focus on a specific population
23 within a state, and that would be the Medicaid

24 group. I think trying to build a business model for
25 the state that includes public and private --

226

1 anybody who's been around long enough to see the
2 CHINs of the '90s, the RHI0s of the 2000s, I think
3 those are on a path -- I'm not trying to be a
4 pessimist, I'm being a realist -- I think within the
5 next two years, you'll have five -- maybe five RHI0s
6 that survived, because nobody can define a business
7 case.

8 The state has the ability to build a
9 business model and create an exchange around a
10 population that it has control over and writes the
11 checks for. It doesn't write the checks for private
12 insurance in a state, so again, I'm just going to
13 push a little bit on narrowing who you're going to
14 build that for, get some proof of concept, because
15 to go out and do it on a large scale, whether you're
16 providing a tool kit for any state to do it on a
17 broad scale, incorporating what's happening on, you
18 know, statewide health exchange, or even, you know,
19 even smaller populations, I think is problematic.

20 GOVERNOR PHIL BREDESEN: Yeah, but
21 remember, the word business model is not intended to
22 be limited to how does a for-profit business work
23 with it. I mean, a business model is this is a
24 utility funded by the government, and in a lot of
25 ways, this looks like the classic lighthouse that

227

1 you have learn about in Ec 1 in college as being,
2 you know, something that needs to be substantially

Alliance Goals and Closing.txt
3 funded in that way, so just please don't interpret
4 business model or a discussion of that in a narrow
5 sense.

6 MR. DaVORE: But I think the earlier
7 discussion was the issue is we can't get IT
8 investment until we change the reimbursement
9 structure. It's not so much a business model; it's
10 really how could a state reimburse differently for a
11 specific population to begin to change behavior to
12 show an ROI on investment. It's not so much
13 creating a for profit, nonprofit. It's changing the
14 paradigm of payment.

15 GOVERNOR PHIL BREDESEN: Maybe. I
16 mean that's one way of looking at making a business
17 model, but I think we probably can invent about
18 three others sitting around the table here. You
19 know, I mean I could easily make the argument that,
20 you know, in the end, since I've spent a lifetime of
21 trying to change the behavior of doctors with no
22 success whatsoever on any count, maybe that's a
23 difficult, you know, maybe that's difficult and you
24 just say look, this is something you start out, you
25 mandate lightly in some way, you provide public

228

1 funding to do it. I'm not even arguing that's the
2 right way to do it. All I'm saying is I think
3 you're picking one -- by saying that, I think you're
4 picking one possible way of going at the
5 sustainability of this and saying that's what has to
6 happen. All I'm asking is before we dive in on
7 that, let's just step back one notch and take a look
8 at what the possibilities might be.

Alliance Goals and Closing.txt

9 DR. CONAWAY: And that's been said,
10 too. How do you -- I do believe that there are huge
11 benefits for states, clearly. when you look at
12 public employees and the commitments over time. New
13 Jersey, I'm told, has a 30 billion dollar long-term
14 commitment to deal with the health care of its
15 current and retiring population -- Medicaid
16 population. If the government, as I think it
17 should, make important investments in this area, how
18 do you -- I'm a physician, I've got, you know, maybe
19 10 percent of my population is Medicaid. I've got
20 Medicare, I've got commercial, I've got all of that
21 in my office. I'm going to use one system.

22 So when the investment's made -- if I'm a
23 government, I'm making this investment, you are
24 getting advantages across commercial insurers, the
25 federal government, because those patients are being
229

♀
1 seen in my office, and they're now use willing a
2 health IT platform that I, as a government, funded,
3 so I don't see how you separate out just those parts
4 of the health care landscape that where the
5 government's involved with it, because I think, if
6 physicians are providing the care and hospitals are
7 providing the care, they are going to use that
8 system to provide care to everybody.

9 GOVERNOR JIM DOUGLAS: Our goal wasn't
10 to design the business model this afternoon, but to
11 agree that it's an issue for consideration, and I
12 think it is, based often what we've heard here, and
13 so we'll add that to e-prescribing on our list of

14 topics to move forward on. And I think we're very
15 sensitive to the points that you've made, Brian,
16 that we're not talking about everything
17 technological, but the focus of the recommendations
18 of the task forces and the scope of the Alliance's
19 work within the principles that we've established.

20 So do we agree on, that these two further
21 issues? Do we further agree on the idea of
22 designing a toolbox or set of guides for states to
23 consider?

24 Do we agree on an outreach strategy, as
25 Kathleen suggested, to other organizations, which
230

1 may involve presentations at their meetings or our
2 own meeting in conjunction with another organization
3 to be determined?

4 Do we like the policy academy idea that
5 Kathleen outlined, to bring in some experts and have
6 a competitive process for states to begin to
7 implement some recommendations of the Alliance and
8 share some best practices?

9 MS. NOLAN: Yes.

10 MS. HARRELL: A, B, and C and D and E.

11 GOVERNOR JIM DOUGLAS: Am I leaving
12 anything out that we talked about? Well, then,
13 let's move forward on those bases, and this is kind
14 of a short time between this meeting and our next
15 one, but that's okay. Kathleen's up to it. Phil?

16 GOVERNOR PHIL BREDESEN: Let's see if
17 anyone else from NGA's in here. Kathleen needs a
18 raise before the next meeting.

19 MS. NOLAN: Ray left, but you know --

Alliance Goals and Closing.txt

20 GOVERNOR PHIL BREDESEN: Everybody
21 call Ray and tell him that Kathleen needs a raise.
22 The final item on the agenda was an opportunity for
23 public input. We have no public comments signed up.
24 I would ask, before we close, if there's any members
25 of the public in the room who would like to take a
231

1 two-minute opportunity, or something, to say
2 something to the committee. Yes, sir?

3 MR. DIETRICH: Hi, David David
4 Dietrich, Virginia Northern. Many of you know me
5 from the e-health Initiative. As far as the toolkit
6 goes, I think it's a great idea, but as many of you
7 know, when I was with e-health, we spent a year
8 working on a toolkit that could be utilized by the
9 states, so I would think that you could go to both
10 Markle and Ehigh and HIMS.

11 They all have tools that might be utilized,
12 so you don't have to recreate the wheel. We wrote
13 roadmaps in Arizona, Kansas, Texas -- Steven left --
14 New Hampshire, Minnesota, and then there's other
15 progressive states where, you know, we had
16 substantial discussions, like Tennessee and
17 Vermont -- you know, working with Ned Helms and --

18 GOVERNOR JEANNE SHAHEEN: I take
19 exception to that remark, that you just lumped all
20 those states in, and then you said, "and the other
21 progressive states..."

22 MR. DIETRICH: No, no, no, okay. And
23 it's recorded, too. But no -- well, Governor, the
24 states that we had written HIT roadmaps for --

25 helped write HIT roadmaps -- in other words, those
232

♀

1 that we just kind of advised and worked tangentially
2 with, so the point being that you don't have to, you
3 know, go to all this work because bandwidth is an
4 issue. I mean, Kathleen is going to need a double
5 raise, you know, to do the toolkits, and so I
6 think -- I think there's some things that you can
7 already utilize that are there, and so I just wanted
8 to let you know that, you know, don't duplicate your
9 efforts.

10 GOVERNOR PHIL BREDESEN: Thank you
11 very much. Any other members of the public or
12 people who'd like to say anything? If that's the
13 case, I recommend that we adjourn this meeting.

14 GOVERNOR JIM DOUGLAS: Well, we've
15 certainly covered a lot of ground, Phil, haven't we,
16 today, starting with our visit to GE Health Care
17 this morning. And I appreciate everybody rolling
18 out bright and early. We thought about an
19 involuntary universal wakeup call, but you all
20 handled it very well on your own, so I'm grateful
21 for that.

22 Before we wrap it up, I just want to ask
23 members of the Alliance if they have any other
24 comments that they want to make before we adjourn
25 this meeting? Sandy?

♀

233

1 MS. PRAEGER: Governor, I just want to
2 say that it's been a pleasure being here in cool
3 Vermont, where it's 102 or 3 back home.

4 GOVERNOR JIM DOUGLAS: Well, it was
Page 34

Alliance Goals and Closing.txt

5 about 50 this morning, I guess, and the next few
6 mornings will be equally cool.

7 GOVERNOR PHIL BREDESEN: Oh, stop it.

8 GOVERNOR JIM DOUGLAS: You should
9 extend your stay. Anyway, we're -- Gayle, go ahead.

10 MS. HARRELL: I'd just make one
11 comment, also. I'd like to invite everybody in
12 Florida in February, where the weather will be
13 equally delightful in February, when it's 40 below
14 here in Vermont.

15 But I also would like to complement the
16 staff. You all have done a remarkable job, and a
17 lot of information here. We so appreciate all your
18 hard work, and think that the ideas and things that
19 are coming out of this group are going to be very
20 beneficial to all the states, and thank you,
21 governors, for your leadership.

22 GOVERNOR JIM DOUGLAS: We like 40
23 below. Ice fishing is great. Brian?

24 MR. DaVORE: I'll just make a quick
25 kind of announcement. Several of you know the Dosi
234

1 Initiative. I think Anne Chapman testified in front
2 of this group, which is the employer-driven personal
3 health records initiative. It is going to be
4 hosting an event in Nashville.

5 The day before, this group will meet on the
6 3rd of October, so as you kind of think through your
7 travel plans, if you'd like to hear more about it,
8 it is proceeding forward despite some recent press.
9 Some new founders will be announced, and some more

10 definite kind of roadmap laid out, so if you want to
11 come learn about that, the invitation is open.

12 I can get that site forwarded to Kathleen.
13 If you want to come learn and you're already going
14 to Nashville anyway for that final meeting of 2007,
15 then the invitation is open, so --

16 GOVERNOR JIM DOUGLAS: And if you have
17 any issues to put on the agenda for that meeting,
18 please let Kathleen know. Obviously we're going to
19 get further reports from our task forces, and we'll
20 give you an update as to how we're doing on these
21 new items that we've talked about today, but if you
22 have any agenda items, please get to her in advance.
23 So Phil, it's October 3rd? What's the temperature
24 going to be about?

25 GOVERNOR PHIL BREDESEN: It will be
235

1 about 50 in the morning, and sunny in the daytime.

2 GOVERNOR JIM DOUGLAS: I see.

3 MS. NOLAN: Michelle, is it the third
4 or the fourth?

5 GOVERNOR JIM DOUGLAS: 3rd, I think.
6 That's what I thought.

7 MS. NOLAN: Somebody knows.

8 GOVERNOR JIM DOUGLAS: Well, they'll
9 be in touch. Anything else? Herb?

10 DR. CONAWAY: On the e-prescribing, if
11 when you look at that, Kathleen, to consider this
12 idea of sort of an ASP, a centralized model, where
13 the software sits and then is accessed, and also
14 think about costs. You know, is it -- what might a
15 state, if it wanted to support this, what might a

16 state wish to spend to get it moving?

17 GOVERNOR JIM DOUGLAS: Well, if
18 there's nothing further, I thank you all for coming
19 to Vermont. Come again real soon. We're adjourned,
20 thank you.

21 (Meeting adjourned at 4:08 p.m.)

22

23

24

25

♀

236

1 CERTIFICATION OF TRANSCRIPT

2 I, Norma J. Miller, RPR, Court Reporter and
3 Notary Public, hereby certify that the foregoing
4 pages, numbered 2 through 234, inclusive, are a true
5 and accurate transcription of my stenographic notes
6 of the meeting of the State Alliance for E-Health,
7 held in Burlington, Vermont, on August 15, 2007, and
8 transcribed by me.

9 Dated this 18th day of August, 2007.

10

11

12

Norma J. Miller

13

14 My commission expires 2/10/11.

15

16

17

18

19

20

Alliance Goals and Closing. txt

21

22

23

24

25

♀