

22 GOVERNOR BREDESEN: I'd like now to
1 introduce Dr. Rhonda Medows and Mr. Tony Rodgers,
2 who are co-chairs of the Health Information
3 Communication and Data Exchange Taskforce. Rhonda
4 is commissioner of the Georgia Department of
5 Community Health, and she leads the agency
6 responsible for the purchasing, planning and
7 regulation of health care programs including
8 Georgia's Medicaid and PeachCare, the health care
9 program for kids and state health benefit plan.

10 Tony is director of the Arizona Health
11 Care Cost Containment System, AHCCCS. He's
12 responsible for the state Medicaid and children's
13 health insurance program. He's also leading a
14 collaborative effort for state Medicaid agencies to
15 receive Medicaid transformation grants and further
16 advance health information technology initiatives
17 for the Medicaid program.

18 Tony and Rhonda, I turn it over to you.

19 DR. MEDOWS: Good morning, Governor
20 Douglas and Governor Bredesen, and hello again,
21 Governor Vilsack. It's been a while. The last time
22 I saw you I was in Florida. I moved.

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1 MR. VILSACK: Not far.

2 DR. MEDOWS: I'm making my way up the
3 cost. It's a pleasure too see all the members of
4 the Alliance again, and we are very grateful to you
5 for allowing us to provide you with additional

6 input. What we'd like to do first, if you don't
7 mind, is to review the charge of this taskforce and
8 to briefly review the set of recommendations that
9 this Alliance has already adopted.

10 The taskforce was charged with providing
11 support to you regarding the appropriate roles of
12 publicly funded programs, and that includes
13 Medicaid, the state health benefit plans, SCHIP and
14 public health programs. And we were supposed to be
15 supplying to you -- and I hope we achieved this --
16 information regarding the opportunities, barriers,
17 and then the development of recommendations and
18 solutions through those recommendations for your
19 consideration.

20 Our recommendations stem from what we
21 believe to be the role for state or publicly funded
22 programs with respect to the development of HIV, as

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1 well as cooperation and coordination with provide
2 sector entities. In summary, in terms of the set of
3 recommendations that you have already adopted, we're
4 going to do through these in a very brief manner,
5 given the time constraints.

6 My co-chair is already advising me that I
7 have left something out, but this time he's correct.
8 In your folder is a chart, should you wish to follow
9 along with me. And on this chart -- it says Health
10 Information Communication and Data Exchange
11 Taskforce -- is the list of recommendations written

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12 out in completion for your review. I was just going
13 basically go over the highlights for you so that
14 when we move into the new recommendations and
15 several requests for considerations of revisions or
16 clarification, you will have a reference point.

17 The seven recommendations that you have
18 already adopted as the State Alliance include 1)
19 that legislation and executive order be created by
20 states to demonstrate leadership support for the
21 development and implementation of health information
22 exchange, 2) that states began with formal planning

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1 as well as the development of a road map on how
2 health department information exchange was to be
3 implemented and developed. No. 3 was the
4 development of a designation of a single state
5 authority that would act to coordinate state
6 government efforts cross the board for all state
7 government programs and agencies.

8 No. 4 was the development of a flexible
9 financing mechanism. And this is one of items that
10 we have additional information for you on and will
11 ask for consideration for a revision later on in
12 this presentation.

13 No. 5 was the investment at the state
14 level in staff training and education so that there
15 would be work force competency in the area of
16 development and implementation of health information
17 exchange.

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18 No. 6 was the support of the adoption of
19 certified systems as well as the use of standards,
20 whether the states decided to implement first or in
21 some combination personal health records, electronic
22 medical records, or e-prescribing.

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1 And No. 7 was the recommendation that
2 incentive or reimbursement programs be developed to
3 reward Medicaid and SCHIP providers in their efforts
4 to invest in health information technology. So,
5 members of the Alliance, those at a high-level are
6 the seven recommendations already presented to you
7 and already adopted by the Alliance.

8 We would like to proceed now with the new
9 recommendations that focus more on public health and
10 state health benefit plans, and then later we'll
11 have again a few revisions for your consideration.

12 I'll turn it over to Mr. Rodgers.

13 MR. RODGERS: Thank you, Dr. Medows.

14 Rhonda and I have had a real good time
15 with this taskforce. She's the sister I never had,
16 younger sister.

17 (Laughter.)

18 MR. RODGERS: I would like to start by
19 thanking the taskforce members for all the time they
20 spent -- we had very robust dialogue and
21 discussions -- and the commitment that they made to
22 making the meetings and the number of hours that

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1 they spent analyzing all the recommendations and
2 findings. We engaged in a lot of complex
3 conversations. And as you'll see in our
4 recommendations, there are a number of issues that
5 the taskforce felt very strongly about, and we hope
6 this will be valuable to you.

7 We also want to thank the University of
8 Massachusetts Medical School Center for Health
9 Policy for doing such extensive research on our
10 behalf. They were a group led by Jay Himmelstein,
11 Shaun Alfreds and Eric Masters and discussed many of
12 the challenges faced by publicly funded programs
13 that are trying to engage in health information
14 exchange.

15 With representatives from the state public
16 health that made presentations on Medicaid and state
17 employee health programs, we had significant
18 discussions that we will talk about. Something that
19 I was struck by was that the interviewees that we
20 talked to were very open and clear on both their
21 challenges, their issues, and what they would like
22 to see come out of this effort. And I'm very

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1 pleased to say that I think the framework that we're
2 going to give you will help drive revisions of
3 health system transformation, which is what this is
4 all about, not just health technology.

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5 I also want to thank our staff and staff
6 of the NGA who worked with us. We had a great group
7 of individuals, both knowledgeable and very
8 professional, and we really appreciate their
9 support. The presenters that helped with their
10 expertise and guidance that they gave us really
11 helped us with our deliberations.

12 I also want to say that the work of this
13 particular taskforce, which is very intriguing to me
14 because we're in the process of health information
15 development within our own state, that what we came
16 up with were well-considered recommendations. And
17 they are based on our discussions as a taskforce,
18 and I hope that you will consider them carefully.

19 I'd like to start with our first
20 recommendation which dealt with public health. This
21 recommendation states, "States must review their
22 policies and laws for intra- and interstate data

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1 exchange to remove barriers as appropriate to ensure
2 that public health information systems are
3 interoperable across state jurisdictions, including
4 local, county and state. These information systems
5 must have the capability to document and track, as
6 appropriate, demographic information that reflects
7 the needs of diverse populations within our states
8 for the purpose of identifying opportunities for
9 community intervention, reducing health disparities
10 and improving overall health outcomes. In addition,

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11 public health information systems that depend on
12 population data must be linked with data from all
13 relevant state agencies."

14 I think in terms of this particular
15 recommendation, we had a number of speakers and
16 expertise that helped us frame this. We believe
17 that it's critical, as governors look at their
18 responsibility for the overall public health within
19 their state, that they make sure that their systems
20 are interoperable and that they're able to interface
21 with both exchanges and electronic health records as
22 they're developed. Currently what we see is silos

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1 that cause public health to be disconnected from the
2 ability to exchange health information.

3 There is also a lack of common
4 architecture, even within the state, in terms of
5 public health, Medicaid, and other programs, and so
6 it's going to be very important that states
7 establish that common health information
8 architecture and framework that will drive the
9 development of future systems in public health.
10 That includes not only the technology framework but
11 also the data standards and data definitions.

12 And it must be understood, as states kind
13 of raise all boats to achieve a widespread use of
14 electronic health information and exchange that
15 data, that public health in particular has a
16 difficult time moving forward without the adequate

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17 resources that the state must provide to their
18 public health agencies.

19 There's also a limited number of standards
20 today at the national level that we could find that
21 would help states. We are hopeful in the future,
22 though, that additional national standards will be

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1 created so that all public health agencies will have
2 kind of a common set of standards. Our taskforce
3 visited the Fulton County Health Department in
4 Atlanta, Georgia, and I appreciate Dr. Medows'
5 arranging for that. And the staff there revealed
6 that they face some of the problems that I just
7 mentioned, building systems that meet their needs
8 and that can communicate through these exchanges
9 with state as well as local jurisdictions.

10 Now, one of the things that we observed
11 was the fact that within states the structure of
12 public health is different. Some states have a
13 dominant state agency public health focus. Others
14 have a local county public health focus. And other
15 states have a city public health focus, so this is
16 an additional challenge.

17 But even with this challenge it must be
18 understood that we need a common set of
19 approaches -- I'm sorry -- we may not have a common
20 set of approaches, but we definitely need a common
21 outcome. And that's what we would recommend drive
22 our understanding of this recommendation.

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1 Rhonda.

2 DR. MEDOWS: Our second recommendation for
3 your consideration also addresses public health.
4 And the recommendation is that states require public
5 health systems to actually follow the standards
6 being developed by the Health Information Technology
7 Standards Panel, once those recommendations have
8 been formally and completely evaluated and then
9 formally approved by Secretary Leavitt.

10 During the multiple interviews that were
11 done by both the consultants and during our site
12 visits with the Fulton County Health Department and
13 other public health officials at the state, county,
14 and national level, common theme again has been the
15 need for having standards in order to have a common
16 system developed and to have software systems that
17 could actually communicate with each other
18 regardless of the level of government and regardless
19 of the users. So this is a recommendation again to
20 use those standards, once they are completely
21 evaluated and then publicly noted for use in public
22 health systems.

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1 MR. RODGERS: The -- one of the things I
2 would like to comment on, on this particular

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3 recommendation before I go to the next one, is that
4 I was impressed and observed that many of our public
5 health interviewees were a little frustrated by the
6 lack of federal direction in this area and that
7 there seems to be some, I would say my observation
8 was, uncertainty as to the role that the federal
9 government should play in public health standard
10 setting because public health has traditionally been
11 a state function. But I think it's going to be very
12 important that the State Alliance consider this
13 issue.

14 On the next recommendation, this
15 recommendation is, "All electronic health records
16 systems supported by state funding must have public
17 health functionalities to support objectives for
18 bidirectional exchange of data across clinical care
19 and public health. Upon purchasing or upgrading
20 publicly purchased health information systems,
21 states should establish specific plans for
22 continuing maintenance and staffing."

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1 Now, with electronic health records, many
2 times we're focused on our health care delivery
3 system, our personal health delivery system. And
4 oftentimes public health seems to be neglected or at
5 least late to the table. I think it's important for
6 consideration that the states set direction and
7 leadership that assures that the implementation of
8 provider-based electronic health records, whether

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9 driven by the state or by health information
10 exchanges, regional health information exchanges,
11 have public health connectivity and functionality.

12 This is going to be important not only for
13 the EHR and physicians to have access to information
14 from public health, but as we mentioned,
15 bidirectionally. The public health department needs
16 that for biosurveillance and for population health
17 management.

18 The receiving and sending of electronic
19 health information between public health and
20 electronic health information exchanges can really
21 provide an opportunity for states to increase their
22 real time ability to see public health outbreaks.

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1 And so whether it's disease reporting to commissions
2 or whether it's information on a specific question
3 from physicians, this will really give us an
4 opportunity, once public health is connected through
5 these exchanges, to have more real time control of
6 the public health outbreaks.

7 Rhonda.

8 DR. MEDOWS: I think one of the things, if
9 I can just add to that, is that sometimes in our
10 rush as a state to actually get health information
11 exchange on board, we realize that there's a need to
12 have public health at the table, but we're not
13 always good on a consistent basis at getting public
14 health to be at the table from the onset.

15 But what Tony is describing is that there
16 needs to be a very concerted effort that when we
17 build these executive advisory councils or any other
18 governing body that we use, that not only is there a
19 seat that has a little place card that says "public
20 health," but that the person at the table is truly
21 an individual within public health actually engaged
22 in the building of health information exchange and

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1 understands the value in both provider services
2 being delivered as well as population health needs.

3 Our next recommendation, No. 4, is also
4 with respect to public health. And it is
5 essentially is addressing a need that we noted with
6 the University of Massachusetts survey of public
7 health officials, and it reveals concerns about the
8 level of experience that current staff had and the
9 need for staff to have more education, more
10 training, so that it can actually be more effective
11 as we build a 21st century health care system with
12 health information technology and exchange in place.

13 So it means that current staff and new
14 staff coming in will have to be the education to
15 build the new skills that are needed, including
16 those skills in informatics itself. But in
17 addition, there needs to be also some degree of
18 cultural change in general education from leadership
19 all the way down to the front line workers in these
20 programs. There's also a need for resources,

21 meaning money and financing, to actually not only
22 train and build, but to retain the talent and to be

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1 able to compete for new talent with our brethren in
2 the private sector.

3 So the taskforce recommendation reads,
4 "Governors should make available resources (i.e.,
5 funding made available in state budgets) to public
6 health agencies under state jurisdiction to support
7 their ability to secure staff experienced and
8 educated in public health informatics and to train
9 their existing workforce to develop leadership and
10 maintain competency in this area. As staff
11 expertise is developed states should also consider
12 multi-state collaboration (i.e., networking and
13 sharing expertise) if an effort to increase
14 workforce capacity."

15 MR. RODGERS: The next recommendation
16 focuses on something that is often left out in
17 thinking about health information technology and its
18 implementation, and that is the role that executive
19 leadership plays and the importance of having
20 executive leadership that is knowledgeable about how
21 to provide leadership for this kind of transitional
22 or transformational process.

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1 So our recommendation is that the
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2 governors should make resources available "and seek
3 outside expertise to support the development of
4 executive leadership and programmatic management in
5 the areas of public health informatics, change
6 management, project management, health information
7 IT provider and consumer communication, outreach and
8 involvement, vendor management and systems thinking
9 competencies."

10 With the ability to exchange information
11 and to have additional opportunities for public
12 health to protect the health of the population,
13 there are a new set of core competencies that are
14 necessary. I'm struck by the fact that I often see
15 system failures, significant system failures across
16 states, significant dollars both in terms of time
17 and budget, and so I've optimized the result. You
18 have to ask yourself: Why is that true?

19 Well, part of it, I believe, with us as
20 leaders, is that we have to better understand how to
21 lead these transformational processes within our
22 organizations. And to do that, governors need to

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1 make sure that their executive leadership understand
2 how to accomplish these very significant changes and
3 that the programmatic leadership within public
4 health and other agencies also understand their role
5 in integrating these technologies and new tools into
6 their operational processes.

7 But also I'm struck by the fact that

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8 systems also fail because it takes longer than we
9 expect, it costs more than we expect, and sometimes
10 the scope constantly changes. And I'm brought to
11 the same conclusion that I had when I used to do
12 facility planning for hospitals. You would get
13 started, and a year later someone, a doctor, would
14 start changing the requirements on you. You would
15 end up in this constant cycle of planning, never
16 being able to get out of it, and the costs would go
17 up and go up.

18 I remember one time we made so many
19 changes in the plans over a five-year period that
20 the plans themselves cost more than the hospital
21 cost to build, and you don't want that in
22 information technology. So what we are saying is

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1 that these are new skills, and these skills need to
2 be available if you're going to drive this
3 transformation within your state.

4 Rhonda, did you have something else?

5 DR. MEDOWS: I'm going to move on to the
6 next recommendation, No. 6. This recommendation is
7 addressing again public health. The focus on this
8 one is the unique role that public health
9 departments have and the opportunity that they have
10 to help us with consumer education and engagement in
11 the use of health information, as well as their role
12 until public health itself.

13 As I've said, one of the things that we

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14 noted and we kind of already understood to some
15 extent is that public health departments, whether
16 it's counties or however it is divided up in your
17 state, are a trusted source of information to their
18 individual communities. And as such, they are
19 providers of care. They are providers of
20 immunizations, vaccines. They are the source of
21 disease surveillance, and they are a source of
22 assessing population health and doing analysis for

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1 population planning.

2 But in addition, every day there are
3 individuals who come in as patients/consumers, and
4 this is an opportunity for public health officials
5 and staff to be able to educate the public coming in
6 those doors to health information exchange and to
7 educate them on their use as well as their right to
8 having access to personal health data.

9 In addition to improving the efficiency of
10 health care delivery in terms of improving the data
11 reporting processes that public health departments
12 do, this is great for a population, again, health
13 assessment planning. But it is critically
14 important, we think, that we actually use this
15 opportunity to engage the consumer so the consumer
16 can receive education. They can receive training on
17 how to access their own information for their own
18 personal health needs and also education on how to
19 understand what that information is actually saying

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20 to them.

21 In addition, the public departments can
22 also be a resource to provide some assistance with

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1 health care literacy and can also be a source of a
2 location for provision of cultural and
3 linguistically appropriate information to the people
4 in the community that they serve.

5 So the recommendation for No. 6 is that
6 "State public health departments should expand their
7 mission to engage consumers and promote the benefits
8 of health information technology and health
9 information exchange. Public health should avail
10 itself the opportunity that EHRs provide and connect
11 with providers and assist them in pushing
12 consumer-specific and health education. Public
13 health should enable direct consumer access to
14 personal health information databases that they can
15 operate" -- and that is a key point, that they can
16 access and operate -- for example, "immunization
17 registries, newborn screening, lead testing
18 programs," etc. "As a participant in e-health
19 activities, public health should also provide
20 resources to help build health literacy and ensure
21 cultural and linguistic appropriateness."

22 MR. RODGERS: Our next recommendation is

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1 regarding state roles for implementing the HR and
2 health information exchange capability. And there
3 was -- for a recommendation that we have on the
4 overhead at this point, there was a lot of
5 discussion and very strong alignment around this
6 particular recommendation and the goal that we are
7 challenging states to achieve.

8 That recommendation is that "Governors
9 should ensure that in the planning and collaboration
10 of around health information exchange that every
11 child must have a patient-centered electronic health
12 record that is transferable to other providers and
13 accessible to individuals by 2014. At a minimum,
14 the record should include guardianship information,
15 newborn screening, family history, growth,
16 immunization, birth history, problem lists,
17 medications, and allergy data."

18 Now, this was very important to all of us
19 because we felt that, driving this effort, children
20 would benefit right now the most from this. This
21 does not mean that states shouldn't pursue
22 broad-based adoption and ability to exchange health

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1 information for all populations, but we felt that at
2 least states and governors should commit to children
3 getting electronic health information. We've had a
4 number of physicians talk about its importance and
5 the frustration they have, even across where you

6 have border states, where you have Maryland and
7 Washington, DC and Virginia and children that move
8 around within those states, and how frustrating it
9 is not to have the ability to have a common or
10 single view of a child's health history.

11 We also note that you have recommendations
12 about e-prescribing. We think this is a good model
13 in terms of pushing states in a common collaborative
14 effort around the children's electronic health
15 record. We believe that the technology has advanced
16 such that this is very doable within the time frame
17 that we have suggested.

18 And as we've said, children's health,
19 which is important to us all, we think will have
20 great benefit in having this opportunity or this
21 single view of a child's health as they move within
22 the state or as they move to other states. And it

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1 can have great impact on other agencies, whether
2 it's your child protective services or other --
3 certainly in public health, etc. in being able to
4 monitor the health of our children.

5 So the taskforce was energized and adamant
6 about this particular recommendation and feels that
7 it jump-starts a lifelong and important public
8 record for the population of all states of the
9 United States.

10 DR. MEDOWS: Our next recommendation is
11 with respect to an opportunity that we have across

12 state or publicly funded programs for both Medicaid
13 SCHIP and state health benefit plans and, to a
14 certain extent, in public health where the provision
15 of clinical care is still being provided. The
16 opportunity is for us to recognize that some states
17 are already moving to the medical home model in
18 terms of having a patient have a medical home.

19 In addition, most states are also making
20 the effort to look at the quality of care as well as
21 the health -- the outcomes of health care from the
22 delivery of care through these publicly funded

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1 programs. The combination of the two, the medical
2 home and the desire to look at the quality of care
3 delivery as well as health outcomes is an
4 opportunity where health information exchange can be
5 used as a very effective tool to achieve
6 improvements and enhancements in these areas.

7 The recommendation from this taskforce is
8 that "As states -- in cooperation with private
9 sector efforts -- plan quality and health outcome
10 improvement initiatives and redesign the care
11 delivery system by establishing patient-centered
12 primary care medical homes in their Medicaid" and
13 pretend that you see up there SCHIP as well as
14 "state employee health programs. They should also
15 drive electronic HIE development and health IT
16 adoption."

17 Members of the Alliance, it makes perfect

18 sense to us that if we are going to have a central
19 focus of care, a cruise ship coordinator, if you
20 will, for medical care for an individual person, a
21 primary or a medical home, that that person would be
22 able to better do the job if there was a system in

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1 place in which all data, health care information
2 data, flowed to and from that person's medical home.
3 Tony agrees with me.

4 (Laughter.)

5 MR. RODGERS: We had -- it was an
6 interesting conversation about the medical home and
7 what it is. And with electronic health records, the
8 opportunity for a physician to have, as we
9 mentioned, that single view as it relates to serving
10 the members and to broaden their impact on the
11 person's wellness to allow greater communication
12 between the physician and the patient is
13 significant. And so we think that that is really an
14 important aspect as we look at the deployment of
15 these tools.

16 I'd like to go on to the next
17 recommendation, which involves state employees. And
18 we have integrated recommendations we have made
19 about state Medicaid agencies and the value that --
20 what we've recommended about state, other state
21 publicly sponsored programs, would have to a state
22 employee health benefit plan.

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1 So our recommendation is that "State
2 Medicaid agencies and state employee health benefit
3 plans should develop consumer engagement tools,
4 including educational materials that provide
5 information on the benefits, content and functions
6 of health IT systems, as well as safeguards and
7 protections for consumer health data."

8 We think that this is a real opportunity
9 for the states to leverage the efforts in Medicaid
10 and SCHIP and with public health to also look at
11 state employees. I know as an agency director I
12 have over 1600 employees who report to me, spread
13 throughout the state. It's extremely most important
14 to me to know what their health status is. And I
15 would think it's important to governors and other
16 health benefit administrators in a state to
17 recognize that we bring people into our environment,
18 and many things affect their health.

19 And what we have demonstrated is that the
20 availability of electronic health records can
21 improve both quality and reduce costs. So there are
22 two things that the state health state employee

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1 health plans can achieve if we can also focus on
2 getting electronic health information and health
3 information exchange available for our state
4 employees.

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5 We also think that this is an opportunity
6 to educate our employees about the importance of the
7 new technology, electronic health care. And it
8 gives us an opportunity to ensure that protections
9 are available, not only to our Medicaid and SCHIP
10 members, but also to our state employees using kind
11 of a common initiative or approach. So we think
12 this is a very important recommendation and
13 opportunity for states on that.

14 DR. MEDOWS: I'd like to add that I
15 recently had the pleasure of actually hearing from a
16 consumer as someone who actually has access to her
17 own personal health records as well as feeling a
18 level of comfort that her physicians did as well.
19 And I promise you I really wasn't going out to sell
20 anything. She volunteered the information. There
21 was no duress involved in this conversation. But I
22 asked her what is it that she thought she actually

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1 gained from having the access.

2 And she said initially she was a little
3 bit concerned about privacy and security, but she
4 actually got to benefit from the fact that when her
5 father was in the VA and he had multiple
6 consultations across different specialties, she
7 never had to ever carry, or act, as she said, a
8 courier of her father's medical records because
9 everywhere she went in the system, that physician or
10 consultant already had the record, had already had

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11 an opportunity to review it, and then when she
12 brought him back to his internist that doctor
13 already had the consultation notes. So she thought
14 that was so much more improved so she could focus
15 more on actually urging her father keep his
16 appointments and actually incurring his efforts
17 around that then.

18 She enjoyed also the benefit of having,
19 when her child required specialty care, having again
20 the records precede them to the appointment, having
21 the doctor and staff already be able to anticipate
22 what was needed. And then when going back to their

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1 medical home again, the recommendations referred
2 would already be known by the primary care
3 physician.

4 She appreciated only having to make one
5 trip to the pharmacy, because this doctor also had
6 e-prescribing, so that meant that the prescription
7 was already at the pharmacy waiting for her, so she
8 didn't have to bring her 3.5 kids with her to the
9 pharmacy to drop off the scrip, go back home, and
10 then come back to get the prescription. Again she
11 reminded me that she was a very busy woman and she
12 had other things that she needed to do. But she
13 enjoyed all of that.

14 She also was able to enjoy that when she
15 was concerned about her test results, she was able
16 to go online and look up her test results. She had

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17 to do three secret codes and do a retinal scan, but
18 still she was able to see her own test results, and
19 there was an explanation written in English for what
20 that test result meant. So she was a perfect
21 example of a consumer who actually not only was able
22 to overcome privacy and security concerns but she

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1 was also able to see the benefit of what electronic
2 health reasonable inference can do.

3 GOVERNOR BREDESEN: Thank you both very
4 much. I think that covers -- as a mechanical thing,
5 I think if we can conclude this session over about
6 the next 10 minutes or so, we can then run just a
7 hair over and still give the third set of
8 recommendations a fair hearing that they require.
9 So let's begin with any questions or clarifications
10 that you might have.

11 Senator?

12 SENATOR MOORE: On the state
13 recommendations, number one, where did the 2014 come
14 from? Was there any particular magic to that date
15 or does that coordinate with some other grander
16 scale? How does that work?

17 MR. RODGERS: Well, there were two
18 considerations. One, we wanted to give a date that
19 was realistic but also provided a sense of urgency.
20 We looked at 2012 versus 2014. We felt that some
21 states probably could achieve it earlier, but we
22 wanted to give -- because of the timeline to roll

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1 these out, etc., we wanted to create a sense of
2 urgency but also be realistic.

3 MR. SENSOR: Why don't we get that
4 particular recommendation up. Just a point of
5 clarity, that's not speaking about just children
6 that are in state-funded programs? We're talking
7 about all children?

8 MR. RODGERS: That's correct.

9 MR. SENSOR: Thank you. And a follow-up
10 if I could. Largely, like all the recommendations,
11 I appreciate the hard work you've done. As I read
12 through them, the recommendations 4 and 5, slides 39
13 and 40 -- those are recommendations that the
14 governors set aside funds for experienced staff and
15 executive leadership -- those felt a tad
16 prescriptive to me. You know, most of what you're
17 talking about are desired outcomes. In this case
18 you're telling governors sort of how do we get
19 there. I'm not an elected official, but --

20 GOVERNOR BREDESEN: We've heard that
21 recommendation in other areas as well.

22 MR. SENSOR: Thank you.

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1 MS. PRITTS: I have a question for
2 clarification on Public Health Recommendation No. 1.

3 In the last sentence, there's a recommendation that
4 public health information systems that depend on
5 population data must be linked with data from all
6 relevant state agencies. My concern there is the
7 distinction of what is a relevant state agency. Are
8 you envisioning that as being limited to agencies
9 that provide public benefits or also including
10 things like immigration and law enforcement and
11 things of that nature.

12 MR. RODGERS: There were a number of
13 agencies, and different states do have current
14 linkages with public health. They typically are
15 paper linkages where they send paper back and forth.
16 And what we were saying is that as you look at
17 public health and its need to have these data,
18 whether it's information that's contained in
19 databases as relates to Medicaid, databases as
20 relates to health services, if, for examples a state
21 agency operates its own health services division, we
22 felt that knowing that different states were

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1 different, we say said, "If they're relevant, you
2 really need to connect public health to it as you
3 look at this health information exchange."

4 What we're just trying to say is think
5 about public health and how it's going to have to
6 interface so it can get the relevant data that it
7 needs.

8 MS. PRITTS: So what you're really talking

9 is pretty much limited to kind of what's the public
10 benefit type situation. There's some concern in
11 this area. There's some tension and concern in this
12 area in slide 36. There are many states that
13 have stated that, in some portions of their laws
14 that govern agencies, that they can exchange health
15 data with other states if they have comparable
16 protections of the information, such as how it can
17 be used by other state agencies.

18 So what happens there is, though, there's
19 the states -- you're trying to get the states to
20 align in the first part. But the definition in the
21 second part as to what is relevant is that there are
22 some states that view this linkage as being

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1 primarily for public health benefits. There are
2 others where some people would clarify it as being
3 kind of a mission creep where the information is
4 linked, not only for public health to benefit from
5 the linkage, but for other purposes, such as law
6 enforcement to benefit from the information that is
7 available for public health purposes. And those are
8 some concerns that I think should be on the table.

9 DR. SUNDWALL: I apologize for missing the
10 first part of your presentation, but as soon as I
11 walked into the room, it was music to my ears. You
12 were making a case for public health that is much
13 appreciated.

14 Rhonda, I don't know if you were here

15 earlier, but I'm now a full voting member, so we do
16 have a voice at the table, and we appreciate that
17 very much. Much of what you do say does seem like
18 the ideal, and I appreciate that. But I also, now
19 that I work for a governor who has competing
20 interests and worthy causes, it does seem a bit
21 prescriptive.

22 I'm going to ask staff to distribute to

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1 the committee members here some examples of our
2 state that is very mature in e-health and the things
3 we've done. In fact, I don't mean to be bragging or
4 parochial, but we are down the road quite a ways
5 and have done many of the things you were talking
6 about. Just yesterday the legislature passed a bill
7 giving the health department authority to adopt
8 standards for clinical data exchange like the
9 insurance commission has for administrative. We do
10 include the immunization registry, the birth defect
11 registry, and we're going to have -- hopefully have
12 a statewide clinical data exchange. So all the
13 things you're talking about are much appreciated.

14 I think it's easier for me in that I have
15 Medicaid as part of the health department. It's one
16 of those states with the umbrella agency where we
17 can leverage Medicaid with public health interests,
18 and it is a mutually beneficial relationship.

19 But anyway I want to thank you for your
20 recommendations, but just with a caveat that the

21 language -- you need to be careful about the "musts"
22 or "needs" or "shoulds" and make sure these are

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1 objectives we all agree upon without making an
2 unfunded mandate for states.

3 MR. RODGERS: Thank you. We did
4 appreciate that. We were encouraged to be as
5 prescriptive and specific as possible, so if we've
6 gone a little overboard, okay. But what you say is
7 very important, I think. I believe states that have
8 the leadership in their public programs, whether
9 it's public health, whether it's Medicaid or health
10 services, are ahead of the game and have greater
11 success.

12 What we're saying is for the other states,
13 the states that have not moved forward, they're
14 going to need this leadership, and governors are
15 going to need to have individuals within their
16 health system or their public health organizations
17 or their health care organizations be knowledgeable,
18 because you have no credibility if you do not have
19 the knowledge.

20 And so we're just making this as a general
21 both observation and finding, that if you've already
22 developed it, if you have already have it and are

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1 comfortable with it, fine. But many states have
Page 30

4. HICDE 10 45.txt

2 not, and we heard that over and over again.

3 GOVERNOR DOUGLAS: Jim.

4 GOVERNOR GERINGER: In your
5 recommendations, you -- I guess maybe it's just the
6 way I interpret this. For the public health portion
7 that leads to say public policy, legislative and
8 executive as well as informing the public, there's
9 clinical to public health data exchange. And one of
10 the recommendations there needs to -- there's a
11 recognition that we have to continue the maintenance
12 of staffing.

13 And that maintenance would be the
14 maintenance, be it change detection or just
15 certifying the currency of the information, so that
16 when a legislator or a governor makes a
17 recommendation regarding population health, it's
18 based on the most consistent, accurate information.

19 Did you have discussions about who
20 authenticates the proper placement as well as
21 maintenance of data that's used, not only for
22 physician practice or medical provider practice, but

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1 also to educate the public or to educate and inform
2 public policymakers?

3 THE WITNESS: Yes, we did have those
4 dialogues. The -- this was one of the reasons why
5 we felt expertise within public health and the other
6 state health programs is so important, because that
7 leadership then drives solutions to those policy

4. HICDE 10 45.txt

8 questions. The -- each state is a little different.
9 In some states we found that it was the county or
10 the city that had the predominant role in public
11 health and validation of information coming from
12 health information exchanges. And in other cases it
13 was the state that had the dominant role.

14 So we were trying to set a broad framework
15 that this information does need to be updated and
16 that there's an all new set of competencies that are
17 going to be required and must be maintained within
18 these agencies.

19 Once you start down this road, then
20 there's an expectation that the staff will be able
21 to maintain these systems, maintain the authority to
22 authenticate, etc. and that if that changes in the

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1 future because of staff cutbacks or inability to
2 maintain their expertise, that this could really be
3 problematic in terms of electronic health
4 information's exchange and its security.

5 GOVERNOR BREDESEN: There's at least two
6 more people I've seen.

7 Michelle, just an administrative question
8 here. Obviously, there's some more questions on
9 this, and we want to give the other set of
10 recommendations their fair share. Would it make
11 sense to carry this on for a few more minutes and
12 then maybe split the other one back, the second
13 half, onto the beginning the after-lunch period or

14 something like that?

15 MS. LIM WARNER: Yes, that would be
16 perfectly fine.

17 GOVERNOR BREDESEN: I just want to make
18 sure that the third set of presentations get a fair
19 hearing.

20 MS. LIM WARNER: Absolutely. And their
21 recommendations actually work with well with your
22 afternoon discussion.

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1 GOVERNOR BREDESEN: Okay. So could we
2 maybe give you a little bit longer and then --

3 GOVERNOR DOUGLAS: Yeah, as long as Sallie
4 and Bill's schedule will accommodate that. Does
5 your schedule permit that?

6 MS. HUNT: Sure, that's fine.

7 GOVERNOR BREDESEN: Okay. We'll go on
8 with this, and if there's time to begin making a
9 presentation, that's great. But if not, we'll move
10 it into the afternoon. Our experience so far is the
11 mornings are very busy and in the afternoons we
12 usually end up breaking early anyway, so we'll try
13 to give it the full discussion that it requires.

14 Stephen?

15 MR. PALMER: Thank you. In looking at
16 some of the revised recommendations, particularly
17 around funding and health IT in the Medicaid
18 program -- I'm looking at the revised
19 recommendations, 1, 3, and 4. With respect to

4. HICDE 10 45.txt

20 flexibility in funding or paying for person health
21 records or payment incentives for health IT
22 adoption, the governors and legislators are not the

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1 only ones that might need to have a say in how to
2 establish that flexibility. What kind of
3 discussions have you also had about working with our
4 federal partners on enabling them to have the
5 funding flexibility?

6 DR. MEDOWS: We had multiple, multiple,
7 multiple discussions and inclusions of information
8 from our federal partners. We also had information
9 come from the provider communities themselves about
10 what they thought would be something that would be
11 of interest to them and what could possibly work to
12 be a true incentive for them to participate. And
13 what we came up with was again a broad level of
14 recommendations to try to at least make sure that
15 the ability to pool finances in order to address
16 common goals across state programs as well as to
17 bridge some of the federal programs was in place.

18 In terms of the incentives our taskforce
19 is made up of multiple members with multiple
20 personalities and philosophies and interests. The
21 gamut of how to incent the providers ran anything
22 from "Why should we have to incent them?" to pay for

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4. HICDE 10 45.txt

1 participation to pay for performance to grants to
2 provide startup costs. So it was quite, quite
3 varied in terms of how much of a carrot and what
4 kind of a carrot to use to incent them to
5 participate. But I guess the short answer to your
6 question is yes.

7 MR. PALMER: Just a very quick follow-up.
8 Is it your impression then that the recommendations
9 that you all have laid out are possible without a
10 change in federal policy?

11 DR. MEDOWS: These recommendations can be
12 carried out at the state level. It would be best if
13 we could actually coordinate with them, yes.

14 MR. PALMER: But for the Medicaid program,
15 for instance, it can be done the general revenue
16 funds rather than federal funds?

17 DR. MEDOWS: Actually I think there is an
18 ability to do Medicaid waiver to achieve a federal
19 match to go with the state funds. It's just done at
20 more of an administrative match level, rather than a
21 benefit level.

22 GOVERNOR BREDESEN: Joy.

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1 MS. PRITTS: Yes. I'm going to my
2 technology ignorance here. On slide number 38,
3 there's a recommendation that "All electronic health
4 record systems supported by state funding must have
5 public health functionalities to support objectives

6 for bi directional exchange." Do those systems
7 currently exist, and how prevalent are they?

8 MR. RODGERS: The applications that we're
9 talking about do exist. In some cases states have
10 developed their own ability to exchange information.
11 The key -- what we believe is some of the key
12 functionality is, one, the ability of a physician to
13 report on reportable diseases directly through the
14 exchange, the ability to send messages to the
15 physician about outbreaks or other issues, the
16 ability to get the information from registries,
17 disease registries or other registries, into the
18 public health database and to push out reports to
19 physicians that would help them in their clinical
20 decision support. So those are some of the
21 functionalities we talked about, and those do exist.
22 It's a matter of configuring both your data in terms

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1 of standard data and configuring your health
2 information exchange to integrate those
3 applications.

4 MS. PRITTS: So it sounds like that there
5 are applications that exist but perhaps data is not
6 sufficiently standardized to make this really
7 function at the moment. So maybe this should be
8 phrased in a more foresighted fashion that, you
9 know, when you're purchasing this or supporting the
10 EHR at the provider level, that it must do this
11 right now, because otherwise I think that you're

12 maybe erecting barriers as to what they may be
13 willing to do.

14 MR. RODGERS: We did make the assumption
15 that with the effort that the federal government is
16 putting into credentialing the HR systems, that they
17 have accommodated how data will be exchanged, etc.
18 in terms of standards. And I think in another
19 recommendation we highlight the fact that public
20 health systems as they upgrade must think about
21 these new standards of data definitions, data
22 standards and communication standards that they'll

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1 have to meet in order to have that interoperability.
2 So we do talk a lot about interoperability, but it
3 may not come out as much in this particular
4 recommendation.

5 MS. PRITTS: I guess my point is right now
6 this functionality would not be very useful for some
7 providers, because the public health system may not
8 be able to communicate with them, right?

9 THE WITNESS: Well, if you mean do the
10 public health agencies have the ability right now to
11 exchange data?

12 MS. PRITTS: Yeah.

13 THE WITNESS: Some do. Some are working
14 on it. Some have not started.

15 MS. PRITTS: I'm just suggesting that this
16 be reworded a little bit to take into account what
17 we can and what we will be able to do.

4. HICDE 10 45.txt

18 GOVERNOR BREDESEN: Which number is that?

19 MS. PRITTS: Number 3, slide 38.

20 GOVERNOR BREDESEN: Okay.

21 REPRESENTATIVE CONAWAY: Can I make a

22 comment on that?

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1 GOVERNOR BREDESEN: This right here?

2 Okay. All right.

3 REPRESENTATIVE CONAWAY: May I make a

4 comment on that?

5 GOVERNOR BREDESEN: Please.

6 REPRESENTATIVE CONAWAY: I think that, you

7 know, there are a number of things that occur in

8 this area. One thing that wasn't mentioned, when

9 you begin to have data aggregated, you can also be

10 identified. And public health agencies can use

11 prevalence of disease conditions to direct any

12 initiatives to the public health agency maybe to

13 effect an impact on some prevalent disease in their

14 population: diabetes, hypertension, smoking, issues

15 that are reported.

16 I think one of the things about this is

17 that as diagnoses are reported -- for instance, we

18 have to report on tuberculosis cases, and that

19 information now hits the public information system.

20 It actually, I think, would be easier for folks to

21 recognize those, be easier for physicians to do,

22 because it's just part of their documentation as

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1 they go through their work.

2 That diagnosis now sits up at a central
3 server or at a peripheral server and can now be
4 grabbed by the public health agency, and then either
5 through the electronic system, or as it's done now
6 through a paper system and a phone call and a fax,
7 you have the engagement of the public health agency.

8 So I think that there are a number things
9 here that -- you know this is going to be
10 incremental. There are a number of things that are
11 going to be able to happen early. There are a
12 number of perhaps more advanced processes that will
13 happen as the network is built out. But I'm not
14 sure that changes need to be made to this as it's
15 outlined here.

16 MR. RODGERS: I just wanted to make a
17 comment. We were thinking that as states fund EHRs
18 or EMRs through whatever mechanism of flexible
19 funding, that they consider requiring standards of
20 those EHRs or EMRs that they will have this
21 bidirectional communication capability and
22 functionality, so that's what our thinking was.

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1 GOVERNOR BREDESEN: Governor.

2 GOVERNOR GERINGER: I do quite a bit work
3 in this area, and it seems to me that technology is
4 not the limitation; it's the description of how you

4. HICDE 10 45.txt

5 do it. For instance, it's possible now with the
6 technology that we have that for any change made,
7 like a doctor posting a notice of a tuberculosis
8 diagnosis, it's put in that database system or a
9 central repository and then pushed out or replicated
10 to anyone else who has already been authenticated to
11 have access to it. They can maintain it on their
12 records.

13 Likewise, if public health makes some
14 change in their database and it's replicated on to
15 the central server or to the clinical area, the
16 technology is there to do that. The question is:
17 Is the culture capable of accommodating that?

18 I think that's the difference here. This
19 is asking that we go ahead and catch up with the
20 technology, as I read it.

21 GOVERNOR BREDESEN: Other questions,
22 thoughts, ideas? Okay.

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1 In the interest of time, I think a number
2 of these questions, what I call No. 8 -- I'm looking
3 off my sheet here -- which is the one we've just
4 been talking about, ought to be pulled out. Are
5 there any others that ought to be pulled out, or can
6 we tackle the rest of them as a single unit? It
7 could take 10 minutes going around voting "aye" or
8 "no" on these.

9 SENATOR MOORE: Just as within the revised
10 recommendations, it may be presumptuous to assume

4. HICDE 10 45.txt

11 that governors and the state legislatures would be
12 allies.

13 (Laughter.)

14 GOVERNOR BREDESEN: We're willing.

15 If I pull out the "All electronic health
16 systems supported by state funding" and lump the
17 rest of them together, can we consider them that way
18 or do we need to vote on them independently? Is
19 there any technical reason why we should do it
20 independently? Michelle?

21 MS. LIM WARNER: No.

22 GOVERNOR BREDESEN: Is there any other one

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1 that someone would like to pull out? Do you have a
2 problem?

3 DR. RUFFIN: I'm not certain. I heard
4 Herb support No. 8.

5 REPRESENTATIVE CONAWAY: Yes.

6 GOVERNOR BREDESEN: But I think Joy wanted
7 some things out. I think -- I marked that as
8 there's some further discussion due on No. 8 and
9 maybe a modification on it.

10 MS. PRITTS: I don't vote, so.

11 GOVERNOR BREDESEN: Well, I mean if
12 there's need to be discuss. I've pulled No. 8 out
13 to vote on separately, and I think discuss is
14 appropriate and necessary at that time. I'm lumping
15 the rest of them today.

16 DR. SUNDWALL: Just a question on process

4. HICDE 10 45.txt

17 because I'm a new voting member and I need to know
18 what I'm voting for. If we vote to approve these,
19 does that mean that subsequently staff can look at
20 them as far as rewording, or is it cast in stone?
21 I'm just wondering if, while I entirely, completely
22 enthusiastically support the intent, I also,

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1 representing a governor, have some concern about
2 some of the directive language. Can that be
3 reworked or do we vote -- does this cast in stone
4 the NGA report?

5 MS. LIM WARNER: Well, all these
6 recommendations will be incorporated as part of your
7 first report, which we're currently drafting. So
8 you will have the opportunity to revise that report
9 however way you feel is appropriate to make sure
10 that your voice is accurately represented.

11 GOVERNOR BREDESEN: Is that in another
12 meeting or is that by distribution?

13 MS. LIM WARNER: That is by distribution.

14 GOVERNOR BREDESEN: Okay.

15 There were also -- I may have been too
16 quick here by organizing this a little bit. There
17 also were some objections or some thoughts about
18 this idea of the prescriptive language that was in
19 there. Really, I think it's probably 9, 10, and 11
20 down here. Why don't I just pull them out so we can
21 take them separately as well, okay?

22 All of the items, except for 8, 9, 10, and
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1 11, the remaining items on this page, could I have a
2 motion to approve them in full? Second?

3 Discussion? All those in favor?

4 (Several "aye" votes were cast.)

5 GOVERNOR BREDESEN: Opposed?

6 (No negative votes were cast.)

7 GOVERNOR BREDESEN: All right. Let's take
8 No. 8 individually, which is the "All electronic
9 health records supported by state funding must have
10 public health functionalities" issue.

11 MR. DE VORE: Can that issue be addressed
12 instead of saying "must," say "should"? That will
13 get the ball rolling in the right direction but not
14 require it.

15 REPRESENTATIVE CONAWAY: I have to say
16 that I think there needs to be a strong statement
17 made in favor of supporting public health and their
18 objectives. And I think that unless there is a
19 strong statement made by this body, there might --
20 that we might lose an important functionality for
21 disease management, for public health. And I think
22 we -- you know, I think we should make a strong

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1 statement.

2 GOVERNOR BREDESEN: As matter of process

3 here, would please someone move this one on for
4 consideration?

5 SENATOR MOORE: So moved.

6 GOVERNOR BREDESEN: Okay. Do you want to
7 propose an amendment here?

8 SENATOR MOORE: I suggest here that in
9 that second line we remove the word "should" and
10 instead put "must." I think it still gets to work.

11 REPRESENTATIVE CONAWAY: I seconded the
12 wrong thing. I'm opposed.

13 GOVERNOR BREDESEN: Is there a second to
14 that? The motion fails.

15 GOVERNOR DOUGLAS: I'll second to put it
16 on the table.

17 GOVERNOR BREDESEN: No, it's been put on
18 the table. We've agreed to that.

19 I'm talking now about your amendment. Is
20 there a second to that amendment, that we should
21 change the word "must" to "should"? Okay, it fails
22 for lack of a second. Further discussion on this

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1 issue?

2 DR. SUNDWALL: As the state health
3 officer, I just want to back up Herb's comment.
4 This is something we need to step forward on. It
5 exists. It's not a technological barrier.
6 Many health systems are already doing this
7 interoperability all the time. We just need to make
8 sure public health exchange is strongly supported.

4. HICDE 10 45.txt
GOVERNOR BREDESEN: Joy?

9
10 MS. PRITTS: Those comments do address my
11 concern, which was as I said when I opened this
12 discussion, I don't know what is in this, and I
13 didn't want to require things that weren't really
14 out there and available to the physicians.

15 GOVERNOR BREDESEN: Other comments? Okay.
16 No. 8, all those in favor?

17 (Several "aye" votes were cast.)

18 GOVERNOR BREDESEN: Opposed?

19 (No negative votes were cast.)

20 GOVERNOR BREDESEN: We now have a set of
21 numbers 9, 10, and 11 to consider. The issue that
22 was raised was the issue of the prescriptiveness of

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1 the language. Would someone move these as a group
2 for consideration?

3 SENATOR MOORE: I move.

4 GOVERNOR BREDESEN: Senator? Second?

5 (The motion was seconded.)

6 GOVERNOR BREDESEN: Discussion?

7 Jim.

8 GOVERNOR GERINGER: I don't know if we've
9 spent much time at all on our role as policy
10 recommendations and prescribing how things should be
11 done, in other words the what versus the how. I
12 think that's where legislators and governors usually
13 step back and say "whoa." You know, that's a
14 Wyoming term.

15

(Laughter.)

16

GOVERNOR BREDESEN: In Tennessee we say

17

"wooeey."

18

(Laughter.)

19

GOVERNOR GERINGER: Okay. How should

20

we -- and I'm just asking -- how should we

21

differentiate between prescribing how it should be

22

done and just saying these are the policies that

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could be and should be implemented in order to

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support the health information exchange? So I don't

3

know if the panel wants or the co-chairs want to

4

help explain that or not, but it seems we ought to

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at least differentiate between prescribing how and

6

adopting the what or the policy.

7

GOVERNOR BREDESEN: And your concern

8

refers most specifically to these ones that are on

9

the table here? Further discussion on that?

10

Tom?

11

THE HON. MR. VILSACK: When did governors

12

become so sensitive that they object to a taskforce

13

that they've established to give them some direction

14

basically saying, "This is important enough that you

15

ought to provide the resources"? Obviously if the

16

governors don't want to provide the resources, they

17

don't have to. For that matter, legislators

18

probably ought to be involved in this too, because

19

they're actually the ones that provide the

20

resources.

21 REPRESENTATIVE CONAWAY: I have a question
22 on No. 10, "seek outside expertise." Is that

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1 outside government or outside of the jurisdiction?
2 You know, I thought -- I didn't know if that was the
3 point of concern for people that had questions about
4 No. 10, in which case you could strike that and
5 still leave, you know, the -- if that was the
6 concern. I mean I like all of it the way it is, but
7 if folks had concern about "seek outside expertise,"
8 maybe that could come out.

9 GOVERNOR BREDESEN: Tony?

10 MR. RODGERS: It was brought up as one of
11 the findings of some of the presentations that some
12 states felt they were restricted from going out and
13 getting, whether it's industry expertise or other
14 expertise that could help them in their dialogue.
15 And so we're just telling the governors, "You need
16 to, where appropriate, seek outside expertise or
17 allow your executive leaders to seek that outside
18 expertise to advise you to make sure that what we're
19 saying or what's going to happen is going to
20 integrate."

21 GOVERNOR BREDESEN: Other comments? All
22 right.

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1 I'm sorry. Senator?
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2 SENATOR MOORE: Following up on what
3 Governor Vilsack suggested, if we put in 4 -- well,
4 on here it's 4 and 5, but I think you have 9 and
5 10 --

6 GOVERNOR BREDESEN: Yeah.

7 SENATOR MOORE: -- "Governors and state
8 legislatures" in both those cases. And then on the
9 last one, rather than -- I don't know if state
10 health department departments on their own should
11 expand their mission. It seems to me governors and
12 state legislatures should expand the mission of
13 state health departments too.

14 GOVERNOR BREDESEN: Should I offer that as
15 an amendment?

16 SENATOR MOORE: Yes.

17 GOVERNOR BREDESEN: Second?

18 MR. SENSOR: Second.

19 GOVERNOR BREDESEN: Discussion of that
20 amendment?

21 Do you have that Michelle, what we're
22 talking about?

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1 MS. LIM WARNER: I got it.

2 GOVERNOR BREDESEN: All right. All those
3 in favor of amending those recommendations in
4 that fashion?

5 (Several "aye" votes were cast.)

6 GOVERNOR BREDESEN: Opposed?

7 (No negative votes were cast.)

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8 GOVERNOR BREDESEN: Okay. Back to the
9 main question. All right. So adopting what I call
10 9, 10 and 11, the ones we've been talking about
11 here, all those in favor of adopting those
12 recommendations as amended say "aye."

13 (Several "aye" votes were cast.)

14 GOVERNOR BREDESEN: Opposed?

15 (No negative votes were cast.)

16 GOVERNOR BREDESEN: Thank you. Thank you
17 for that.

18 Jim, with your permission, I think
19 probably the thing to do is break now and reconvene
20 and give the next presentation an honest
21 presentation. And I'm sorry about that. I just
22 sort of took over your time. I'm sorry.