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(1:05 p.m.)

GOVERNOR DOUGLAS: Let's reconvene. Thank you for your flexibility. We're trying to stay on our revised schedule. The next item is a presentation on the American Health Information Community successor transition. I'm going to invite Assemblyman Conaway to lead us in this discussion.

MR. CONAWAY: Thank you, Governor. We have with us two distinguished presenters discussing the transformation, if you will, of the American Health Information Community from a government entity to a public/private partnership. We'll start with Mr. Arthur Hamberschlag, who has long experience with health administration with LMI, who received contracts to look at this transformation of AHIC 1.0 to 2.0 as it were. To be followed by Ms. Cronin, Director of the Office of Programs and Coordination at the Office of the Coordinator for Health IT. She was previously with CMS and has worked extensively in the field of patient safety, health service research and clinical trial coordination. We'll start with

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Mr. Hamberschlag.
MR. HAMERSCHLAG: Thank you very much. I'd like to thank you for the opportunity to be here and bring you up to speed on how we're doing on establishing the AHIC successor organization.

6 (Slide)
7 MR. HAMERSCHLAG: Here's a brief agenda
8 for you. I'll be happy to engage in questions or
9 discussion with you as we go. This is just a one-
10 sided presentation. It'll probably be pretty dull,
11 so I appreciate your comments as we go. That would
12 be fine. But before I get started, I'd like to give
13 Kelly a chance to say hello and any comments she'd
14 like to make.

15 MS. CRONIN: Good afternoon everyone.
16 It's nice to be here to talk to you about what we're
17 doing to help plan and establish the successor
18 organization as far as the health information
19 community. As many of you might know, Secretary
20 Leavitt has placed significant importance on placing
21 public and private governance across this whole
22 agenda, so we have some agreement among stakeholders

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1 on how to move forward as a country, how to set
2 priorities and how to oversee during the execution of
3 this agenda as we proceed and there are really
4 important links to the states, both state government
5 and state public/private efforts. I hope we can give
6 you a brief overview of this whole process and how
7 it's really state coordinated as we proceed.

8 (Slide)
9 MR. HAMERSCHLAG: I'm assuming that this

10 group is familiar with how we got to where we are.
11 I'm not going to go into discussions of health IT and
12 why it's so important. Again, I assume you all
13 understand that and support the notions of adoption
14 of health IT. Very quickly, President Bush issued an
15 executive order in April 2004 announcing his
16 commitment to the notion of health IT.

17 For me, it's been a wonderful example of
18 the power of the bully pulpit because up until that
19 point, while there may have been some number of folks
20 who were focused on that issue and very excited by
21 it, it certainly was not on the national agenda. I
22 think in the years since it has been much on the

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1 national agenda. And again, just points out the
2 power, if you will, of setting the agenda on the
3 federal level and being able to demonstrate and
4 articulate the extraordinary potential value of
5 widespread adoption of health IT.

6 The Office of the National Coordinator was
7 established as a result of the executive order. It
8 created some structures that you are, I'm sure, are
9 familiar with--HITSP and CCHIT. More importantly,
10 Secretary Leavitt created the American Health
11 Information Community, chartered the Federal Advisory
12 Committee to make recommendations to the Secretary on
13 how to accelerate the development and option of
14 interoperable health IT. AHIC was initially designed

15 to sunset and it was initially give way to a
16 public/private partnership and that's really the work
17 that we're about.

18 (Slide)

19 MR. HAMERSCHLAG: In August of 2007, HHS
20 issued a white paper sort of describing the work at
21 hand. AHIC's successor will bring to it a number of
22 public and private not-for-profit and for-profit

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1 entities that represent all sectors of the health
2 community, an open marketplace, if you will, where
3 all the parties come together and make consensus
4 decisions to help ensure adoption of interoperable
5 health IT.

6 In January 2008, a grant was granted to
7 the LMI Brookings team in the form of a cooperative
8 agreement with ONC. We're happy to work with
9 Brookings. They could not be here today, but they
10 did ask me to pass on their regards. A couple of
11 quick points here. The grant was made in the form of
12 a cooperative agreement. By that, we mean that ONC
13 and others are full participants with this as we go
14 about the work of establishing the successor
15 organization. A commercial endorsement here--LMI is
16 medium-sized, not-for-profit government consulting
17 organization that's been around since about 1963, 800
18 people, \$200 million. It's a not-for-profit focus on

19 helping the federal government succeed and we consent
20 about 50 percent Department of Defense and about 50
21 percent the civilian agencies, and work in every part
22 of the federal government.

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1 (Slide)

2 MR. HAMERSCHLAG: This slide is intended
3 to illustrate a couple of things. One, the grant was
4 really given in three stages. Stage 1 through 4 is
5 really set up for LMI/Brookings to act as convener.
6 Our job is to bring together, in an open and
7 transparent fashion, the interested parties in the
8 health IT community. We formed four working groups
9 or planning groups. The planning groups have worked
10 on issues of governance, transition, sustainability
11 and membership. These work-planning groups are
12 really about the issue of setting up the key
13 organizational and structural entities of the new
14 organization. I'll talk a little bit more about
15 those planning groups in a minute.

16 If you'll look at the blue part of
17 that graph, it's really designed to illustrate the
18 LMI/Brookings role is much larger in Stage 1. It
19 decreases in importance or effort in Stage 2. That's
20 when the new organization itself is formed and comes
21 up to speed. And when Stage 3 of the grant is
22 awarded, the intent is for the successful AHIC

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1 successor organization to be fully operational and
2 our role really sort of passes on. If we are
3 successful, our role will be decreasing as time goes
4 on and the ability of AHIC successor organization to
5 stand up and take on some new roles and
6 responsibilities.

7 (Slide)

8 MR. HAMERSCHLAG: What is the organization
9 all about? What is its purpose? I will summarize
10 the statement up there. It's really a draft that
11 came out of one of the planning groups I'll refer to.
12 I'll just touch on a few key words here. Sustainable
13 public/private partnership, the vision is to realize
14 interoperability that engages individuals, providers
15 and institutions and the whole purpose of health IT
16 is to improve health care quality, safety and
17 efficiency and accessibility.

18 Finally, through adoption of health IT, it
19 will improve and maintain the health and well being
20 of individuals and communities in the United States.
21 Those statements are hard to argue with and we
22 execute that we will have been successful.

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1 There's a lot of discussion about scope
2 and exactly what the organization will be doing--
3 accelerate and coordinate interoperability
4 initiatives, prioritize stakeholder requirements to
5 encourage adoption and interoperability, advance the
6 harmonization of technology standards, continue to
7 advance the certification of products, which will
8 help adoption in the marketplace and ultimately to
9 oversee and facilitate the nationwide health
10 information network or NHIN, something that ONC is
11 working very hard in establishing, and we will help
12 with the oversight and governance of that.

13 (Slide)

14 MR. HAMERSCHLAG: Why is this new
15 organization needed? I discussed before in AHIC 1.04
16 it's a sunset. The successor organization,
17 hopefully, is intended to maintain the momentum
18 gained over the past three years. The notion of
19 health IT and widespread adoption and the benefits of
20 health IT are really very much in the public
21 discourse right now. Secretary Leavitt's been very,
22 very clear that he wants this maintain to accelerate

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1 the momentum that's been generated around those
2 issues. Also, to take the notion of health IT into
3 the total environment, if you will, being sponsored
4 by the federal government and to the independent
5 sustainability of the public/private partnership.

6 (Slide)
7 MR. HAMERSCHLAG: The AHIC principles are
8 worth discussing. The organization should exist for
9 the purpose of individual consumer benefit. At the
10 end of the day, it's improved health care quality and
11 efficiency for the individual. It should establish
12 and enhance the trust between stakeholder and health
13 IT is a very busy market with lots of different
14 players--vendors, consumers, providers and so on.
15 They all have parochial interest and different points
16 of view. The intent is that the successor
17 organization helps provide a marketplace and a
18 meeting place for those viewpoints to come together
19 and to really make decisions that ultimately enhance
20 the public good. So I think it's important that we
21 understand that this successor organization is really
22 designed to have a public purpose and to create a

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1 public benefit.
2 (Slide)
3 MR. HAMERSCHLAG: I'll give you a little
4 more specifics now. Where are we now? We are in
5 Stage 1, really establishing the basic framework of
6 the successor organization. I'd like to make one
7 point. We are creating an organization. We are not
8 solving health IT problems that exist. We've got
9 lots of people come up to us and say you've got to do

10 this. You've got to do that. This needs attention.
11 Our response is pretty much we know. We agree with
12 you, but that's not what we're about here. What we
13 are really doing is creating an organization that can
14 contribute to solving those problems, but at this
15 stage of the game we're really setting up that
16 organization.

17 I want to emphasize that LMI/Brookings is
18 the convener. We're bringing stakeholders together.
19 We're not really in a decision-making role. Key
20 activities are design the governance structure,
21 address incorporation and legal considerations,
22 design the membership processes, address the issue of

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1 financial sustainability over time, and develop a
2 transition process from AHIC 1.0 to AHIC 2.0. This
3 sounds pretty dull, but I can assure you for those of
4 us in the middle of it, it's pretty detailed and
5 pretty challenging. I'm sure Kelly will agree with
6 that.

7 (Slide)

8 MR. HAMERSCHLAG: What have we done so
9 far? We've hosted a couple of meetings, public
10 meetings March 10 and April 8. Of course, being a
11 technology kind of thing, we had a webcast. You can
12 participate in person, on the web or by conference
13 call. We received a significant level of
14 participation and interest from a very broad set of

15 stakeholders. Everyone from consumer advocates to
16 vendors to providers, hospitals and so on. We've
17 been very, very pleased at the interest and
18 participation from people across the spectrum.

19 As I said before, we've convened four
20 working groups, planning groups that will help make
21 recommendations about some of the key attributes of
22 this new organization-- more than 80 individuals.

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1 Really a very impressive skill set and experience set
2 have joined these planning groups. The four planning
3 groups that you see up there are around organization
4 and governance chaired by John Tooker. Membership by
5 John Perlin, business sustainability John Glaser and
6 AHIC to successor organization, Lilee Smith-Gelinas.
7 If you're familiar with any of these individuals, I
8 can tell you they're extraordinarily talented,
9 extraordinarily capable and extraordinarily committed
10 and we're very fortunate to have their participation
11 as we go down this road.

12 (Slide)

13 MR. HAMERSCHLAG: There's also Phase 1.
14 What will be accomplished? We will incorporate the
15 AHIC successor. We will out the interim By-Laws,
16 interim CEO and interim board of directors. That
17 will be coming up pretty quickly.

18 (Slide)

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MR. HAMERSCHLAG: Next steps, Phases 2 and

19
20 3.

21 (Slide)

22 MR. HAMERSCHLAG: Establishment of the

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1 permanent By-laws. This is pretty critical for this
2 organization. We'll get into the details of what
3 will membership mean, what are the classes
4 membership, what are the membership dues, will they
5 be to scale according to the type and size of the
6 organization? What will the benefits and
7 responsibilities of membership mean? What decisions
8 will be made by the dedicated leadership by the
9 board, by the members themselves? What about certain
10 critical issues that will have to be decided by the
11 membership and perhaps by more than the simple
12 majority, double majorities and so on?

13 This translates into why people will want
14 to joint this organization? What will we be doing
15 that will attract people to come in, participate and
16 articulate their interests and concerns to this
17 organization? If we can articulate a clear value
18 proposition and articulate a means for people to be
19 heard and deal with their agenda that's being
20 advanced along with the national agenda, then I think
21 we will have created a successful organization.

22 Phase 3, which should be done by the end

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1 of December, we will hopefully by that point
2 established a permanent board of directors. We will
3 have a permanent CEO. We'll have staff on board and
4 the successor organization will be transitioning from
5 the AHIC organization to itself. I'm going to stop
6 here because I've probably talked too much and too
7 quickly. Kelly has a few things to talk about--what
8 all this means to the states.

9 MS. CRONIN: I just want to give you some
10 context with how these similar kinds of activities
11 are playing out on the state level.

12 (Slide)

13 MS. CRONIN: Approximately 75 percent of
14 states now have some form of planning or
15 implementation of public/private activities to
16 advance interoperability and establish operations for
17 health information exchange on a statewide basis.
18 They're either playing a coordination function across
19 stakeholders by convening all the stakeholders and
20 deciding on how do we proceed given that we have six
21 different approaches to health information exchange
22 across the state or perhaps there is a PHR platform

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1 being initiated at one place and a RHIO at another.
2 How do we organize all this in a way that really
3 meets all the needs across states and across
4 stakeholders within that state?

5 It's an impressive amount of activity.
6 Much of this is providing governance at the state
7 level. Again, representing all these different
8 interests, including state government. State
9 government, in many cases is engaged in convening or
10 supporting these efforts. So there's quite a bit of
11 activity to build from and to link to as we get the
12 national effort underway. Particularly, you'll see
13 the areas in the country where they'll be receiving
14 some type of federal support from various federal
15 agencies. Trial implementation data is a little bit
16 old, I should say, because now the Cleveland clinic
17 and Kaiser and the federal agencies that plan to
18 connect to the nationwide network, as is
19 demonstrated, by the end of this year. So there are
20 17 organizations that will be participating in
21 sharing data across the country to demonstrate that
22 this can happen across a wide of group of geographic

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1 areas and providers.

2 (Slide)

3 MS. CRONIN: I also wanted to point out
4 that one of the purposes for these public/private
5 efforts on the state level is to make sure that this

6 agenda is not necessarily controlled by any
7 particular corporate interests; that it's actually
8 health information exchange viewed as a public good
9 and that these conveners across the states can meet
10 and make decisions together and decide, along with
11 state government, how best to proceed.

12 It is an important function and these
13 governance entities are really sitting between state
14 government and the private sector, trying to take all
15 the different stakeholder considerations into
16 account--all state governments typically at the table
17 and involved. It is important that in many cases
18 they are recognized by state governments either
19 through contracts, legislation, executive orders.
20 There are many ways state governments can recognize
21 these efforts. There are a lot of important
22 considerations around how should these organizations

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1 be advancing policies and practices when health
2 information exchange actually starts to become
3 operational across geography. Certainly, they need
4 to be mindful and compliant with state law, but they
5 could perhaps even be informing any needed changes on
6 a state level; also on a federal level. So we do
7 think it's important for a state government to be
8 leveraging policy levers to not only create
9 incentives, but to obviously advance public programs.

10 Much of your work, I think, at a taskforce
11 level this year will be looking specifically at that
12 and there are some areas of this country,
13 particularly smaller states like Delaware and Rhode
14 Island that have small geographic areas where they
15 can take a statewide approach to technical
16 operations. So they're not only playing a governance
17 role they're actually moving forward and trying to
18 advance technical operations.

19 With all this experience across the
20 states, we think there's an awful lot to learn from
21 in terms of how do you best convene these
22 stakeholders and how do you provide them with a true

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1 public/private governance function.
2 (Slide)
3 MS. CRONIN: We do see an important role.
4 We thinking these activities to AHIC 2.0, the one for
5 establishing the new legal entity--there are many
6 representatives from these efforts across states that
7 are now on the planning groups. They're informing
8 the establishment of AHIC 2.0 and it's being
9 contemplated and thinking through how can these
10 interest and these activities be represented at the
11 board level through membership or voting procedures
12 or setting priorities. How can these different state
13 level activities be taken into account? I think that
14 we're lucky to have several very experienced people

15 at the state level participating and making those
16 explicit links because we think they're quite
17 important to maintain and really formalize as this
18 organization heads that up.

19 (Slide)

20 MS. CRONIN: I think everyone recognizes
21 the need to better coordinate state, federal. State
22 meaning state government and statewide meaning

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1 public/private, national and federal activities.
2 Clearly, the state government role--the federal role
3 is instrumental in advancing this whole agenda. We
4 have a lot of work underway, not only for this group
5 but elsewhere to clarify the appropriate role for
6 government in many instances. But we see this
7 activity, even though it will be taking on a national
8 orientation, really should represent everyone's
9 interest across the country. That's why we believe
10 it's particularly important when we formalize the
11 board structure to determine how best will this
12 organization be set up and operate. That a lot of
13 activities across the country, particularly those
14 that are quite mature, are taken into account as this
15 organization is really established and set up to be
16 functioning.

17 Those are the main points we wanted to
18 cover today. There will be plenty of time for

19 questions and answers and discussion.

20 MR. HAMERSCHLAG: Just to reinforce one
21 thing Kelly said, when you live and work in
22 Washington it's easy to see the world from a

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1 Washington perspective. But clearly, health care in
2 general and health IT specifically, is an area where
3 the states have a very, very significant role to play
4 as we think about creating the AHIC successor
5 organization. We're very attune to that and just the
6 fact that ONC is willing to make that part of the
7 agenda from Day One, realizing the important role of
8 the states that that thinking has carried through.

9 Last, just a bit of advertising, if you
10 will. Basically, it says if you want to find out
11 what's going on we have the website. The newsletter
12 we put out every so often. There's a way to make
13 comments to us. We look at those every day. There's
14 a public meeting on June 4 at Brookings. You can
15 register for that. You can participate in person or
16 by webcast. You can do it by conference call. We
17 hope there will be a lot of interest in other states
18 in that public meeting because that's going to go out
19 to that four planning groups who are going to tell us
20 what they're then recommending for this new
21 organization. So that should be a quite interesting
22 meeting on June 4. Why don't we just stop there and

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1 see if we have questions or comments?

2 MR. CONAWAY: Questions? Dr. Tuckson?

3 DR. TUCKSON: First of all, let me say
4 that as an active participant in the process let me
5 congratulate you on how far you've come. One quick
6 question and a comment, on your slide with the state
7 level activities, your map and the pin pricks.

8 MS. CRONIN: These are activities that are
9 being conducted on a statewide basis, whether it's
10 coming from executive order, legislation or governors
11 opting for adopting a commission or formal governance
12 to be performed across public/private sectors and the
13 specific dots are referring to federal funding.

14 DR. TUCKSON: That doesn't include the
15 things that are arising in the states without the
16 governors necessary following.

17 MS. CRONIN: Right. Some are without the
18 governors' involvement, but they're statewide not
19 necessarily within pockets of the states or pocket
20 geographic areas.

21 DR. TUCKSON: I don't know if you were
22 here earlier. We had a fairly useful conversation in

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1 my mind about how will states be able to, if they
2 desire, to harmonize and synergize with national
3 standards, whether they're national standards around
4 data exchange, national standards around the
5 performance measures that are going to be used to
6 collect the data--all of those kinds of domains. Are
7 you basically optimistic--this is almost the worst of
8 all worlds. Here we were. We almost had a national
9 set of standards with everybody sort of playing by
10 the same playbook and we were a part of that, the E-
11 Health Alliance, were tangentially related. Now, all
12 of a sudden it's going to go out of business and
13 there is this new hope that something else will take
14 its place. Is it going to be there and can the
15 governors and the NGA assume that we're going to have
16 success here and there will be a safety net to take
17 over this function or are they going to be left
18 hanging?

19 MR. HAMERSCHLAG: I was at the last AHIC
20 meeting where Secretary Leavitt was very clear that
21 there are risks associated with leaving the current
22 structures in place and political risks, funding

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1 risks. There are also risks in transferring
2 activities from the current AHIC to the new
3 organization. He was very pointed in saying if it's
4 not ready to stand up I'm not going to transfer the
5 functions. We'll keep this thing going until it's

6 ready to go.

7 On a personal level, I think we will have
8 this organization stood up and I think it will be
9 attractive to stakeholders, both public and private.
10 I think that includes the states. If people are
11 willing to participate and they give it their energy,
12 look at it as a place where those energies can be
13 furthered, I personally look on it as a place where
14 something can be done. In fact, a place where these
15 things can accelerate because they won't have all the
16 constraints of the federal advisors. Kelly may want
17 to comment as well.

18 MS. CRONIN: One of the things that this
19 group has going with it is they have sort of a
20 history of making standards work. There are
21 processes in place. We're just looking for the
22 leadership across stakeholders to formalize this and

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1 make it work. What AHIC has been able to do there
2 have been limitations because of federal laws around
3 that about what you can truly do in terms of a
4 public/private partnership? As long as government is
5 at the table making decisions with all these other
6 stakeholders in a fair and balanced manner, and we're
7 able to provide the seed funding to get this
8 established, everyone is very hopeful that we're
9 going to continue. There has been too much invested

10 over so many voluntary hours over three years that
11 every group, whether it's the industry groups, or the
12 informatics communities, hospitals, physician groups,
13 health plans--everyone seriously invested in this.
14 Everyone wants to see it succeed. It's just a matter
15 of getting E-Health down in the last couple of months
16 so we can stand it up.

17 Let me just add also that I think we're
18 all working in a time of a lot of change and there's
19 been discussions in the government's planning groups
20 about how we need to make sure that the members of
21 Congress, governors and really everyone who is very
22 engaged and interested in this agenda and its

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1 successor needs to understand what we doing and they
2 do understand that there's broad stakeholder support,
3 and then it's likely that we'll see success. It's a
4 matter of who comes in, in the next administration.

5 SENATOR MOORE: I'm wondering if there
6 shouldn't be some vision for AHIC 2.0 to require that
7 the exchange would be state chartered or something
8 like that. That there'd be some way that the
9 governor or the administration of the state or the
10 state government collectively has some role. I think
11 a charter could vary between something that's totally
12 private, something that's quasi, and something that
13 might even be state. So the charter could be broadly
14 defined, but it seems to me it might be risky for an

15 exchange to be developed totally in ignorance of the
16 state government with no connection.

17 In our area the wonderful large health
18 care systems it could probably be health information
19 exchange, but there's some real concern that the
20 would want to become the dominant health system in
21 the state to the exclusion of some parts of the
22 state. And I think we want to make sure with the

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1 charter that they understand their role and the state
2 government's role in that in order to make sure that
3 the formal connection is there.

4 MS. CRONIN: A great point. We can take
5 that back to the planning groups. There's been a lot
6 of concentration on that very issue and I think that
7 one of the recommendations that has been discussed
8 with the sort of sister projects the state level
9 projects is to have formal recognition of these
10 activities by the state government that it's legally
11 viable. There are some states where you cannot
12 participate as a board member on these types of
13 entities. But to the extent it is possible, we think
14 the link is very important and to formalize it
15 through a charter or other mechanism is also quite
16 important.

17 I should also point out that the State of
18 New York and other states are contemplating the role

19 of accreditation or some self-regulatory model to do
20 formal accountability, which would hopefully be more
21 than perhaps than just a one-state approach.
22 Perhaps, it will evolve into something that could be

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1 local, state or national, which also plays into this
2 idea of having, perhaps, a more formalized and
3 recognized governance structure.

4 MR. CONAWAY: Mr. DeVore?

5 MR. DEVORE: Just a clarification, can you
6 walk me through what the seed funding means? The
7 question around that is, is it a one-year contract?
8 At the end of the year it ends? I guess my concern
9 is that it's a grant or money that's coming from the
10 federal government? Correct?

11 MR. HAMERSCHLAG: Yes, Stage 1, which is
12 four or five months, \$2 million. Stage 2, that's a
13 \$3 million grant. The intent right now is to have
14 the successor organization up and running where the
15 grant is actually transferred from the LMI/Brookings
16 partnership to the successor organization. We'll
17 probably need to continue to provide some support to
18 the organization, but Stage 3 of the grant begins in
19 December 2008. That's for \$8 million. That should
20 go directly to the successor organization. The
21 intent is to fund a lot of the activities from the
22 current AHIC and also to help so that you can get a

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1 kick-start into its new role, so transition funding.
2 MR. DeVORE: Let me just be a pessimist
3 here and say that on month 12 we've got a new
4 administration coming in and they set priorities.
5 Who knows, a clean slate. That's typically how they
6 work. I just want to hear what your Plan B is
7 because I've never seen anything where Plan A ran
8 perfectly from A to Z. What's your Plan B until HHS
9 comes in and says successor organization Godspeed, go
10 with the good wind behind you, but you'll get no
11 money from me. At that point will Brookings say
12 thank you for participating in AHIC 2.0. Please send
13 your check in for \$100,000 tomorrow to help sustain
14 us? I'm trying to figure out what this looks out
15 with Plan B in place and not just Plan A working
16 perfectly.

17 MR. HAMERSCHLAG: There's a planning
18 group, which I think is still planning lead by John
19 Glaser and he's probably the smartest guy in that
20 field you can find, but he's working on the
21 sustainability model. He's working on budgets over
22 the out years. He's working on income estimates.

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1 There's been a lot of debate about membership and
2 membership dues. Obviously, the thinking about it
3 now is that membership dues will be substantial as a
4 different part of the revenue stream, but it will not
5 be 100 percent.

6 Certainly, I think the plan is that \$8
7 million should be coming from the current
8 administration, but it will come about--personal
9 opinion again. This is nothing official, but if that
10 \$8 million grant does not come about, then I think it
11 would really be a real challenge for the organization
12 to take over all the activities of the current AHIC.
13 In that case, at that point, the federal government
14 and states--if it doesn't have that money to take on
15 all those duties, what is the value to the
16 marketplace? What's the value proposition to really
17 further the ideas of the values of health IT? I
18 think it's pretty certain, personally, that the \$8
19 million will come about.

20 MS. CRONIN: Even if under a continuing
21 resolution, we still have some money being carried
22 over because this current year has been budgeted \$5

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1 million for this activity. That's why--

2 MS. PRITTS: In AHIC 1.0, there's a
3 substantial concern among some people at the state
4 level that some of the use cases really didn't
5 reflect the priorities of the states and didn't

6 really have a recognition that the states should play
7 a part in this proceeding. In the current phase that
8 you're in now what part of phase representation is
9 there among these various workloads?

10 MR. HAMERSCHLAG: Well, certainly people
11 from outside the Beltway--I guess one that comes to
12 mind is Laura Evans from New York, who's very
13 involved in the network out there. There are
14 probably a lot of others who could come to mind, but
15 we made sure that we tried to get people from a wide
16 geographic area of California, New York and so on. I
17 don't know if there are any officials.

18 MS. CRONIN: Laura Adams, who leads the
19 efforts in Rhode Island, although she's not
20 officially in state government. She works
21 extensively with state government. I think there are
22 at least one other state government representative

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1 and at least two other state representatives in terms
2 of what going on in their state, links to overseeing
3 their public/private effort.

4 MS. PRITTS: Any governance people?

5 MS. CRONIN: Actually, Laura Evans who
6 chairs the governance work group has been thinking
7 through a lot of issues.

8 MR. CONAWAY: Just some questions, if I
9 may. In your white paper, you talked about making

10 sure that the AHIC include the ability to make
11 decisions. I'm wondering if you could give me
12 examples of the kinds of decisions AHIC should be
13 expected to make in the future.

14 MR. HAMERSCHLAG: I think that was
15 intended to address governance issues that the
16 organization be sufficiently flexible. That those
17 issues are on health IT and health adoption came
18 about they would not be locked into such a narrow,
19 proscribed approach or business model that it found
20 itself irrelevant, but in fact, that health IT came
21 about. The membership--the board of directors were
22 free to take positions, to take actions around those

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1 issues. Basically, that it not be too narrowly
2 defined or prescribed in what it can or cannot do.

3 MS. CRONIN: I can give you a specific
4 example of a decision I think would be around
5 priority setting. They have a very thorough process,
6 either by membership or by some kind of extensive,
7 inclusive process where all stakeholder opinions were
8 taken into account, including states and the board
9 would be finalizing the decision on a given set of
10 priorities that would drive the interoperability
11 agenda and could also, perhaps, inform how funding
12 activities might be played out in terms of governing
13 of health information exchanges. Those are probably
14 the different major types of decisions that would be

15 made--how to govern health information exchanges.

16 Once that becomes more mature, there will be a whole

17 other set of considerations and decision-making.

18 As it's understood now, being contemplated

19 now these decisions would have impact on the

20 membership. So if there were a very broad-based

21 membership, part of the rights and obligations of

22 being a member would be to comply with those lower

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1 level decisions.

2 MR. CONAWAY: You mentioned in the health
3 information exchange, presumably, does that mean that
4 there's going to be a role for governance of a
5 national network, let's say? I think there's
6 probably some consensus on that as a matter of fact,
7 so do you believe that you'll have some statutory
8 authority from Congress that would give governing
9 authorities that latitude over a national network?
10 Are you anticipating that?

11 MR. HAMERSCHLAG: I don't think the
12 actions are really that advanced right now. There
13 will be some inherent authority within this
14 organization so that within the next two years there
15 will be some sort of governance structure set up that
16 will allow oversight of health information exchange
17 across different parts of the health care system.
18 They could do that in a variety of forms. One could

19 be accreditation, accrediting bodies if you wanted to
20 participate in the network that goes beyond, perhaps,
21 a regional network or an institutional network. You
22 have to meet certain basic requirements to

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1 participate in that network. You'd have the baseline
2 set of policies or requirements that assure that you
3 are a responsible actor in the system. That also
4 down the road could be--I imagine Congress might want
5 explicit authorities, but this is a new and evolving
6 concept and there's a lot that isn't understood over
7 the next many months before anything is formalized.

8 MR. CONAWAY: I just might have a
9 question, but the last one I have is that authority
10 certainly makes it critically important that there is
11 the broadest possible stakeholder participation that
12 is achieved and that no stakeholder has some
13 predominant influence over these deliberations. I'm
14 wondering what steps you anticipate taking? For
15 instance, my predilections are in here to board of
16 directors. Is it going to be appointed by the
17 President? How do people become members? Is the
18 current leadership just going to transition its job
19 over into this AHIC 2.0? These questions of how one
20 becomes a member, how broadly based the membership
21 is, how representative it is so it's not controlled
22 by any particular entity are very important in terms

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1 of taking important operational roles and how this
2 works in the country.

3 MR. HAMERSCHLAG: That's all I laid out
4 fairly clearly from ONC. At the very beginning, they
5 sent out some white papers on general principles that
6 said just that, that the organization has to be
7 established in such a way that it would not be unduly
8 influenced or dominated by a particular corporate
9 interest, that it had to operate for the public good.
10 For example, it was very explicit that there has to
11 be allowance made for consumer representation and
12 that the governance group that's studying those
13 issues right now has been very explicit that
14 consumers have to be represented in a very specific
15 way. There's a lot of discussion going on right now
16 about how is the board sustained. Is it a self-
17 sustaining member in operation with election by
18 membership if, for example, you membership associated
19 around providers, vendors and so on? There's still a
20 lot of discussion.

21 I guess I would say the answer to the
22 question is still in development, but the question is

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1 one that's on the table right now.

2 MR. CONAWAY: Dr. Sundwall.

3 DR. SUNDWALL: Thank you very much. This
4 is fascinating. I don't think I've ever seen so much
5 effort gone into sustain a policy bridge between
6 administrations. I have a bit of experience over a
7 few decades in Washington. It's just astonishing the
8 amount of effort that's gone through to make sure
9 this is sustained. It's complimentary. I don't mean
10 to be critical of it in any way, but I would hope
11 that this whole effort is relatively lean and
12 uncomplicated, serving as a bridge because I'm just
13 certain as I can be that health IT is going to remain
14 important to whichever administration assumes power.
15 They're very vested purchasers of health care.
16 Public health we're very, very dependent on
17 electronic data exchange. I'm sure you're aware of
18 the CDC and FDA monitors and some of the electronic
19 monitoring capacities. I would just hope that there
20 is some sense that this is a bridge to the next
21 administration's version of what ought to be the
22 federal law. Though, I'm not assuming the federal

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1 government should be highly regulatory or mandating,
2 but they are going to have an interest. I just can't
3 imagine AHIC 2.0 in the private sector as being a
4 substitute for a significant federal role.

5 Again, like you, I'm supposing this is

6 going to be the case. But I'm pretty confident--I'll
7 bet money on the next administration having a
8 significant investment and therefore wanting a
9 presence and a federal policy that would supersede
10 this AHIC 2.0--just a comment.

11 MS. CRONIN: I think there is an extensive
12 discussion, both internally and with the planning
13 efforts on that issue. I think that clearly everyone
14 within ONC views that population health it needs to
15 be first and foremost. So one of the aspects of
16 setting this is up is that you need to be sensitive
17 to a lot of the business interest and advance this
18 whole agenda in a way that's going to drive adoption
19 in the private sector and at the same time you have
20 to be able to think in a clear and thoughtful way how
21 government-related priorities--priorities within the
22 public interest are also going to be considered in a

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1 serious way and a fair and balanced way, along with
2 these other more business-oriented interest.

3 But I think clearly that the federal
4 spending and programs, policies authorities were
5 actually in the middle of working out the details of
6 what that looks like because there's something that's
7 going to happen internally within government, both
8 state government and the federal government to
9 advance all of this. That won't play out in its

10 entirety through an AHIC 2.0 process. A lot of that
11 will be internal deliberations and planning policy
12 development clearly in the privacy and security. The
13 policy development is going to have to stay with the
14 federal government.

15 AHIC 2.0, as it matures, if it does take
16 on a successful governance role and health
17 information exchange could, perhaps, further promote
18 those federal laws and state laws and develop
19 practical ways that they could be implementing these
20 in a way that creates a more seamless system.

21 We're very mindful of the importance of
22 the federal role and hope that as we stand this

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1 organization up we'll be working together across all
2 these stakeholders. The federal role is clearly
3 articulated and that ONC's role in future is clearly
4 articulated so that the next administration or the
5 next sub-cabinet level appointee comes in they're all
6 going to have a clear understanding of all that went
7 into this and how it all fits together.

8 MR. HAMERSCHLAG: This has to be part of
9 the federal agenda. How that plays out I think
10 obviously is yet to be determined. I do think--what
11 I've observed is that we have an extraordinarily
12 broad range of interests who are voluntarily
13 participating in this. They are engaged. Any new
14 administration is going to see an extraordinarily

15 high level of agreement on health IT. It's really
16 national. It would be almost impossible for any
17 group to ignore that. The question is what sort of
18 leadership does it take? How effective? How does it
19 play out? It's on the agenda.

20 REPRESENTATIVE HARRELL: I would just like
21 to make one additional comment. This is a bipartisan
22 group and whoever wins the election is going to move

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1 forward with this and it's certainly in the national
2 interest. The one thing here, again, we are state
3 legislators. We're state governors. We're state
4 attorneys general. It needs to be important to us as
5 a State Alliance that the state perspective be
6 acknowledged and that the role of the state, the very
7 important role--states are the cauldron and a lot of
8 this has all bubbled up from states. As you develop
9 this that the states are active participants and that
10 that governance role takes place and whatever the
11 qualifications to be a member of this do not negate
12 or lessen the role of the state. I think that's
13 extremely important that we be equal partners on the
14 table.

15 MR. CONAWAY: Ms. Pritts.

16 MS. PRITTS: I had a question here about a
17 proposed initial scope of AHIC as it's written here.
18 4.3 say to advance the harmonization of technology

19 standards and policies, including those to protect
20 confidentiality, privacy and security. Is this all
21 supposed to be related to technology or is it also
22 the policies related to confidentiality, privacy and

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1 security?

2 MR. HAMERSCHLAG: The current thinking
3 certainly is that if the federal government and the
4 states really have to lean on issues associated with
5 privacy and confidentiality and security that that
6 role, I think, is that the successor organization
7 will want to play a supporting role and we agree that
8 parties on these areas are important and they should
9 not be ignored and that they will become part of the
10 standard adoption process that this organization will
11 be a part of. Certainly, we don't say this
12 public/private partnership will have--Kelly may want
13 to add to that.

14 MS. CRONIN: This point has been brought
15 up as a potential point of confusing, even though
16 it's clarified in more detail in the purposes and
17 scope document that's on the website. Some of the
18 consumer advocates have raised this as a point of
19 confusion, so they're actually in the process of
20 redrafting this. So I think it will be moved forward
21 with recommendations. Any organization that stood up
22 this specific issue around what remains within the

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1 federal and state government on privacy and policy
2 development versus what will this new entity take on
3 in the way of advancing interoperability, how will
4 they relate? That will become clearer, but you're
5 not the only person to have raised this as a
6 question.

7 MR. CONAWAY: Mr. Palmer?

8 MR. PALMER: Just another question about
9 the state roles, in a AHIC 2.0 it seems like of a
10 number of federal initiatives have been shifting in
11 some ways from a focus on regional initiatives,
12 looking at things at the state level with this group
13 and the state level HIE, and generally, the direction
14 of the discussion at the federal level has been that
15 it leads to a greater level of state level
16 activities. With that shift in focus, I guess, it's
17 a presumption of mine. Is that an explicit and
18 intentional philosophical shift at the federal level?
19 With that shift in focus it seems that AHIC 2.0
20 should also have a greater focus on the state role,
21 inputs into the process in the state level role. To
22 what degree is that explicitly envisioned in the

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1 scope of work or the way you see this moving forward?
2 MS. CRONIN: It's sort of a work in
3 progress like the board composition might look like
4 and how we vote, procedures and membership categories
5 would ensure that explicit state interests would be
6 represented. But I think there's been so much
7 discussion around this issue that we are anticipating
8 that the recommendations that are advanced will very
9 much take into account how to cooperate and
10 coordinate with states. So I think the perception is
11 probably somewhat accurate that we've had more
12 emphasis on the state level activities and some of
13 it's just practical. We're a small office at the
14 federal level. We can't coordinate or collaborate
15 committees across the country in an effective way.
16 But I think there's also this emergence of
17 understanding of how we work with state government
18 and how working with other statewide constituencies.
19 They're able to actually organize, and in the right
20 way, actually advance regional activities. So I
21 don't think we downplay the importance of the
22 regional activities because so much of that helps our

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1 understanding of how things are really working in the
2 health care market. How you build trust. How do you
3 actually normalize data and how you normalize
4 standard? How do you develop practical policies that
5 oversee the data exchange? All of that is really

6 being played out on a regional and state level, so
7 these learning laboratories are really--I think
8 everyone will benefit from that.

9 But on a practical level, I think a lot of
10 our funding and orientation has probably been more
11 towards the state level. But I think some of it does
12 also relate to the fact that there are so many
13 existing authorities at the state level and
14 constituencies that really need to be incorporated in
15 our thinking.

16 MR. HAMERSCHLAG: Given the importance of
17 the state, I don't think anyone can envision a new
18 organization succeeding without a robust role for the
19 states. I think Kelly has articulated that--how that
20 plays out, but it's still being defined. It's still
21 a work in progress, but certainly the acknowledgement
22 of the importance of state roles is clearly there.

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1 No organization could succeed over time without a
2 robust role for the states.

3 MR. CONAWAY: I think that concludes this
4 session. Thank you very much. Thank you very much
5 Commissioner Hamerschlag and Ms. Cronin, and we'll be
6 following your progress.

7 GOVERNOR DOUGLAS: Thank you, Herb, very
8 much moderating our discussion and thanks to both of
9 our guests. We'll follow your progress with great

10 interest and look forward to working with AHIC during
11 and after the transition. Thank you so much.

12 It's now time to turn to a presentation by
13 the Health IT Now Coalition, which involves the
14 private sector in the deployment of health IT. I had
15 the privilege during the EPA meeting in late February
16 of participating in a press conference with some of
17 the leaders of Health IT Now. I appreciate their
18 contributions to this discussion.

19 MS. NOLAN: Maybe you want to save that
20 until they actually arrive. They're not here yet.