

0805EHEALTHTRANSCRIPT09 3.30PM Next Steps Discussion.txt  
21 GOVERNOR DOUGLAS: We can go on to our  
22 next agenda item then, which is a discussion of our

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1 next steps as an alliance.

2 (Slide)

3 GOVERNOR DOUGLAS: I think it's going to  
4 take a few minutes to take stock of where we are, our  
5 direction and get a sense from members of the  
6 Alliance as to where we ought to be going as we  
7 continue our work.

8 (Slide)

9 GOVERNOR DOUGLAS: A couple of priorities  
10 we're working on, as you'll recall, one is privacy  
11 and security of consumer information in an electronic  
12 environment. One topic under this category is  
13 accountability, how state governments can exercise  
14 their oversight to assure accountability in  
15 electronic health information exchange.

16 At our August meeting, we'll get an update  
17 from the Privacy and Security Taskforce. They've  
18 been looking at possible models for HIE and looking  
19 at models for state privacy laws. We expressed an  
20 understandable concern about privacy and  
21 confidentiality of information and a variety of  
22 different laws that we consider to reconcile these as

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1 this process goes forward. We'll get a report from  
2 them in August.

3 Another topic is the broader role of state  
4 governments in electronic health information  
5 exchange. The Public Programs Implementation  
6 Taskforce developed a lot of recommendations that we  
7 agreed to and they're going to examine issues related  
8 to what they call bi-directional communication,  
9 public health and clinical care as ways for states to  
10 finance HIT. That will be very important as well.  
11 We adopted it earlier; of course, some  
12 recommendations on what states might do to provide  
13 leadership through the NGA. That was a very  
14 important step for the Alliance as well. Any other  
15 thoughts now on what the taskforces might recommend  
16 or pursue? Any additional roles that you want to see  
17 them concentrate on? I'm thinking of the two items  
18 under the first big bullet there--the privacy and  
19 security and the states' roles in health IT.

20 MR. DeVORE: I want revisit a topic we've  
21 probably talked about in the past. I want to go back  
22 to my day job. People actually ask me what have you

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1 accomplished here? I'm being held accountable, not  
2 so much for the change of the health care delivery

3 system in the U.S. as I am asked to report what is  
4 moving forward in this group. If you look at this  
5 group, we have about a year left, I think--give or  
6 take how much time we actually signed up for. Two  
7 things that we ultimately prioritized, which one of  
8 which was privacy, security and licensure and they're  
9 still the two things that I'm still not sure we've  
10 crossed the goal line on yet. We've gotten kind of  
11 keyed up in the right direction, but one of the  
12 things--I was talking to Cara during the break. It's  
13 unclear to me, the process through which those  
14 recommendations--we've got a white paper out. We've  
15 got the guardrail set up. I'm trying to figure out  
16 how to keep moving that truck down the road.

17           A lot of things we're talking about doing  
18 today the market's ready to go do. The system is  
19 primed to go and help move. I'm just concerned that  
20 we didn't add more things to the truck, things that  
21 look interesting. I would encourage this group to  
22 look to what the states can do, to look at what our

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1 core strengths are, to play to those core strengths  
2 and not be enticed to go and work on things that I  
3 think, especially on the HIE, the market is ready to  
4 go do. It doesn't mean the state doesn't have a role  
5 in it, but I guess I'm trying to figure out where are  
6 those recommendations going? Where are they at the  
7 licensure piece, taking those things that are

8 governors stepping up to go do is this being pushed  
9 up through the summer meeting and what can we do as a  
10 group to help move those things through? Does that I  
11 mean I need to get on the phone and call my governor  
12 in Oregon and tell him you should be seeing this?  
13 Get ready for it. This is important. I guess I'm  
14 kind of unclear as to what we're doing other than  
15 adding more activity. I'm trying to get back to  
16 Governor Geringer's point, which is one of the major  
17 goals, not just actions we're taking, but also one of  
18 those things I can actually sign up for.

19 I didn't mean to give a diatribe here  
20 against any one thing. I would love to be able to  
21 say we moved this ball over the goal line. I don't  
22 really care what the rest of the world says or

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1 whether it makes the front page of the Washington  
2 Post, but it's key to moving health care toward a  
3 more efficient system where there's licensure,  
4 privacy and security harmonization and those kinds of  
5 things. I think that would be something we could  
6 definitely hang our hats on. With that, I'll get off  
7 my soapbox.

8 GOVERNOR DOUGLAS: That's very helpful to  
9 keep us focused on the goal, which is obviously to  
10 make some demonstrable progress and provide some  
11 greater consistency in both statutes and

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12 interoperability around the country. As Kathleen  
13 noted, we had a discussion at the NGA meeting in late  
14 February where Governor Bredesen on our behalf raised  
15 the issue with all our colleagues. In a very  
16 preliminary way, there seemed to be some real  
17 positive response and enthusiasm for pursuing this as  
18 a general concept. The devil is always in the  
19 details, but at least conceptually there seemed to be  
20 a lot of interest in it, so certainly we can do that.  
21 But what I was going to mention we're  
22 going to develop our first report to the states and

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1 to the NGA. A copy of that should be in your offices  
2 now. We're going to ask that you look it over in the  
3 next week and a half. I suggested the deadline be  
4 the 23rd to get back to Kathleen and her team with  
5 any comments. It is important to put it in writing  
6 or electronic form and get it out and get some  
7 specific ideas out to the members. We'll look for a  
8 June publication timeframe for some of these ideas.  
9 Obviously, that includes the topics you mentioned,  
10 Brian, moving forward. Governor?

11 MR. VILSACK: To Brian's point, one of the  
12 things that will happen when this report is finished  
13 and provided to the governors and their staff in the  
14 summer months usually, in Iowa at least and I'll  
15 suspect it's true of most every other state, that's  
16 when the planning process begins for legislative

17 proposals for the fall. So the report will become  
18 quite timely as governors begin to prepare for next  
19 year's agenda. As they take a look at what they're  
20 currently doing in the state and what needs to be  
21 done and what legislation needs to be passed, you  
22 will have a much better sense about what you've been

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1 able to accomplish probably by the end of this year,  
2 the first part of next year. You'll see governors  
3 making specific proposals and make specific mention  
4 of it in their state-of-the-state addresses and so  
5 forth. I think that's when you'll see some progress.

6 GOVERNOR DOUGLAS: Senator?

7 SENATOR MOORE: One thing on a process  
8 thing and then a couple of comments that I want to  
9 focus on as well. From a process viewpoint, I think  
10 it would be helpful to have the report condensed into  
11 kind of a PowerPoint presentation. I don't know if  
12 governors are anything like legislators. They don't  
13 read the lengthy reports.

14 GOVERNOR DOUGLAS: We're not anything like  
15 legislators.

16 (Laughter)

17 SENATOR MOORE: And something impressive  
18 may lend itself to the website as well, but highlight  
19 that so people can see some things that might trigger  
20 them into wanting to read the whole report. On a

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21 more substantive level, there are two areas. One I  
22 think is missing and one that probably needs to be

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1 more developed. I think we need to a lot more on  
2 medical education. The governors usually have some  
3 role on the appointment of their boards of trustees  
4 of the state universities and it seems to me that a  
5 lot of the medical schools need to make sure they're  
6 teaching things that are turned in. Some probably  
7 are but I don't know that there's any great  
8 uniformity to the attention that should be given to  
9 health information technology and also working also  
10 with medical societies or other groups on continuing  
11 medical education. I would hate to think that  
12 doctors and other prescribers will get their  
13 education on health IT from the technology companies  
14 themselves as has happened with communications  
15 because it tends to be a bit one-sided.

16 I think that we need to look at the  
17 broader training and really looking at one of the  
18 groups in my area, working with docs on the redesign  
19 of their practice so it accommodates health IT rather  
20 than becoming a burden on them. I think that whole  
21 issue of how we condition the workforce into seeing  
22 the advantages and being trained to utilize health IT

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1 more integrally than looking at it as another add-on  
2 to their duties that they're not getting paid for  
3 would be an area to probably flush out a little bit  
4 more under a workforce development chapter.

5           The other that we don't say much about--  
6 we're talking about state goals, but it is a state  
7 goal and that is define ways that the federal  
8 government becomes a partner in cost sharing, not  
9 just in developing standard, but there are several  
10 bills in Congress in the e-Prescribing area. Senator  
11 Enzi and some others are sponsoring a bill. It  
12 actually looks at Medicare and Medicaid some add-on  
13 financial incentives to using health IT and actually  
14 some disincentives after a certain period of time if  
15 they're not using it. So there's some legislation  
16 that I think NGA might want to look at that we ought  
17 to focusing our observations, where we do our  
18 lobbying to support legislation and funding that will  
19 help to work with us on development of health IT, but  
20 to really be a partner.

21           My concern is that if it really comes down  
22 that might be the end of it. The federal government

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1 in the past has tried to dump Medicaid into our laps  
2 as a block grant and I would hate to see this as one

3 of these block grants that ever grows and it gets  
4 smaller and gets regulated into smaller and smaller.  
5 We need to focus on what's our relationship between  
6 state and federal about the funding as well as the  
7 policy side of activities.

8 GOVERNOR DOUGLAS: All good ideas,  
9 Richard. Senator Enzi has been in on IT grants as  
10 well. David?

11 DR. SUNDWALL: Thank you. You mentioned  
12 licensure and last week I had an opportunity to  
13 present on behalf of the Alliance to the Federation  
14 of State Medical Boards at their annual meeting of  
15 the licensure of physicians in this area. It has a  
16 high, high level of interest. Generally, the  
17 presentation we have, subcommittee or our taskforce  
18 on practice had about five recommendations for their  
19 consideration--how to facilitate telemedicine across  
20 state lines. How do you recognize the professionals  
21 who are not in state? How do you discipline them if  
22 you do something bad in their state for a patient in

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1 your state? It's very provocative.

2 The intent of where we're head was well  
3 received, but there was a fair amount of push back.  
4 Part of it worried about government. Part of it  
5 wondering if what we're commending is at all  
6 feasible, but there's one thing we came to a  
7 consensus was that was one of the recommendations of  
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8 the taskforce's that the NGA convene a meeting of  
9 state medical board representatives to talk about  
10 these issues because they're absolutely critical.  
11 They're also very intimate with the legal issues  
12 because they're wondering how on earth their  
13 substandard care would there be discipline in another  
14 state, but it gets to be tricky. I'm not sure that  
15 you were referencing licensure of physicians or  
16 providers, but they're very concerned about this.

17           And the other consensus was they agreed we  
18 ought to have a uniform application online for  
19 medical license and that ought to be across states.  
20 That would be great. It would save a lot of  
21 paperwork and headaches. That's something the NGA  
22 could put high on their priorities if you want to get

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1 buy-in from a very important group and that is the  
2 state medical boards.

3           GOVERNOR DOUGLAS: Reed?

4           DR. TUCKSON: A couple of quick comments.  
5 The AHIC 1.0 documentation is extraordinary. The  
6 recommendations go down to like five or six. I'm  
7 already on page 6. The amount of work is incredible.  
8 I think a strong editorial hand would be useful. I  
9 don't think we should be slaves to our own wonderful  
10 recommendations. Putting them together in a coherent  
11 way might be useful.



17 saying I've got this incidence of infectious disease,  
18 colds, gastrointestinal and you can start to give  
19 that to the public health department to see if they  
20 can make some sense out of all that.

21                   Lastly, I would very much underscore Dr.  
22 Sundwall's point around the Federation of State

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1    Medical Boards. I did also have a chance to make a  
2    presentation at that same meeting. I will tell you  
3    they need to be challenged by their governors and I  
4    think they're willing and able to do that, but  
5    there's a lot more they should be doing. I think the  
6    governors need to really get with them to push this a  
7    little bit more forward in the context of our  
8    discussion.

9                   Lastly, education was very important.  
10   Senator Moore, for the professional community, but  
11   you know the group that is not educated and did not  
12   appear to use all the powers we're talking about is  
13   the consumer. The school system doesn't teach this.  
14   It is interesting to me that with every child that  
15   you see walking down the street with an iPod, every  
16   child that is connected to computer system and  
17   they're very facile with video and audio  
18   entertainment through the Internet, but they're not  
19   facile with using this data to make more informed  
20   choices. The whole presumption of what we're doing

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21 is left to the devices of an education system that  
22 has never explicitly addressed it. I would urge that

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1 we think carefully about making a recommendation to  
2 get immediately with the people that control the  
3 science curriculum in the states, of the school  
4 districts and see if they might start to explore how  
5 they can prepare our children to use all these  
6 devices.

7 GOVERNOR DOUGLAS: Good thoughts Reed.  
8 Thank you very much. Quickly taking notes--Governor.

9 GOVERNOR GERINGER: Mr. Chairman, a couple  
10 of comments. One would be possible next  
11 presentations or reports I think we should somehow  
12 come up with a list of recommendations on how we  
13 should track the results of this. For instance, most  
14 of the presentations talked about, at least  
15 antidotally saying now this will benefit us because.  
16 It will eliminate over medication. It will reduce  
17 errors. It will enhance health. Our internal  
18 investment ought to at least be in the enumerated so  
19 as governance is considered we can start to track.  
20 And I think another part of the recommendations would  
21 be here's something you can track or at least  
22 accumulate information. There's a correlation, not

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1 necessarily a cause. It gives you insights into  
2 what's going on. I can't imagine having something  
3 like that in front of the governor or legislator who  
4 would go out and say why should I do this? Well,  
5 here are the reasons why. Here are the mechanisms.  
6 There needs to be a road map. There needs to be  
7 something like Smart Cards or other things that  
8 becomes part of a person's health records that they  
9 feel comfortable using so they're willing to  
10 participate because they receive something back in  
11 terms of either better health or greater convenience.

12           And as I sat through our vote on the 19  
13 recommendations in 5 categories, I thought how many  
14 governors sitting down here would include that in  
15 their state to the state. We need something with a  
16 little more sizzle.

17           (Laughter)

18           GOVERNOR GERINGER: We're plodding through  
19 a lot of process here and we're not really packaging  
20 it in the nuggets that would actually make an impact  
21 so we can carry it to the state-of-the-state or our  
22 legislator can help on it as far as they're intended

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1 for a committee--something like that that catches on.  
2           The draft report I think is a good start.

3 It needs to push things out there. I think it really  
4 needs to emphasize the state initiative--the ONC has  
5 been good about fostering this. The federal  
6 perspective is important, but it's not number one.  
7 The states are number one. If you look at Secretary  
8 Leavitt who commissioned the group to try to get and  
9 find \$10 billion worth of savings in Medicaid over  
10 five years there are numbers being bandied about that  
11 there's \$3 billion in fraud each year, but what are  
12 the tracking mechanisms on health information  
13 exchange and other tracking mechanism to even detect  
14 fraud? The recommendations are lacking and that's  
15 one of the things we can recommend as we consider  
16 governance or centralized, decentralized--whatever--  
17 here are the types of things you would put in place  
18 so that those things are demonstrated in terms of  
19 their effectiveness.

20 So as far as next steps, I'd like us to  
21 clarify and make it newsworthy, if you will, putting  
22 it in terms where we can measure the effect of what's

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1 going on. General public health is changing. At the  
2 same time Massachusetts instituted e-Prescribing, we  
3 started noticing these changes in public health  
4 indicators. If we don't know there's cause and  
5 effect or if there's at least a correlation, that a  
6 beginning level. Those are the kinds of things I  
7 think the policymakers would like to see happen right

8 away.

9 GOVERNOR DOUGLAS: Thank you very much.

10 Gail?

11 REPRESENTATIVE HARRLEL: Thank you very  
12 much, Governor. One of the things I would very much  
13 like to see, and I know the NGA has been doing the  
14 State Alliance, but as a legislator I think there are  
15 many other legislators across the state--there are  
16 what, three of us that are a part of this group. But  
17 the legislators are, indeed, the ones who pass the  
18 laws and the governors only get to sign them. We are  
19 the ones that appropriate the money, so I think there  
20 needs to be some outreach in this. And when we get  
21 this finished, and I agree it's a little bit wordy,  
22 and 19 recommendations need to be consolidated down

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1 into something that is a bit more concise and easier  
2 to sell. That's what I do as a legislator. I'm  
3 going out there selling something--a program, a  
4 vision and I think putting this in a format that we  
5 can go out and market it to other legislators so that  
6 we get a buy-in across the spectrum is absolutely  
7 essential.

8 Without the legislative support for this  
9 very, very important issue, you can't implement it.  
10 You can't make it happen. There's only so much you  
11 can do through executive order. You have to have the

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12 money and you have to have the legislative buy-in.

13 So I would encourage us, as a group here in CSO,  
14 other groups out there to make sure we have within  
15 this component something we can take to legislative  
16 groups to inform them that's part of what we need to  
17 be doing is selling the consumer, selling the other  
18 governors, selling the legislators so they can pass  
19 the laws and most importantly, appropriate the money.  
20 Measure it so we can say this is going to save you.  
21 As we know in Florida, 3000 PEAs out there among  
22 physicians is saving us \$2 million a month. That is

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1 a return on investment. It is saving a huge number  
2 of adverse incidents. That is a return on investment  
3 in lives as well as money that we're doing. So we  
4 need to package this appropriately with our selling  
5 point in it so every one of us can go back--you can  
6 go back to the Governors Association. We can go back  
7 to our legislative groups and sell it there as well.

8 GOVERNOR DOUGLAS: All good points. That  
9 leads into the next and final section on that slide,  
10 which is supporting implementation in the states,  
11 providing some tools, recommendations, packaging, as  
12 you said Gail, so that they're useful and in the  
13 facile bytes as several others have noted. I guess  
14 the key question now is how exactly do you do that?  
15 We've thought about a few states being chosen to  
16 develop specific statewide innovations that would

17 include our recommendations, sharing best practices.  
18 Somehow we do have to deliver, as Brian said a few  
19 minutes ago opening this discussion. Any thoughts on  
20 how--we'll have the report. We'll make that  
21 available.  
22 Clearly, we want to talk with all the

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1 other organizations. You know you're right the  
2 legislatures and the executive branch organizations  
3 that are represented on the Alliance, too. Brian?  
4 MR. DeVORE: Just a question, other states  
5 would they follow a white paper more than they would  
6 follow the results of a 12-month pilot? What's more  
7 appealing to a state legislature and executive branch  
8 is to see that four or five states have done it.  
9 They've seen the savings or how do we go about doing  
10 that? I guess I'm trying to figure out a set of  
11 tools. Those go back to my nicety versus necessity.  
12 I'm trying to figure out necessity versus that's  
13 interesting, but I don't have time or the budget.  
14 How do we do that? Maybe if it's focused enough  
15 maybe it's three or four months. I don't know. What  
16 are you thinking to show benefits? Maybe you need to  
17 get an online form for licensure and kind of focus on  
18 how to deliver it with measurable results. You call  
19 that good enough. You may only have 80 percent of  
20 the information, but if you don't have the other 20

22 percent. That was a great question. What's the best

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1 way of thrusting forward to Representative Harrell's  
2 point so you can get the buy-in, so you can look at  
3 this data from Georgia or they can look at this data  
4 wherever you're at and say I'm having a hard time  
5 defending what we're currently doing because they're  
6 doing something which is selling much easier versus  
7 maybe a white paper.

8 GOVERNOR DOUGLAS: I tend to think it's  
9 correct if some other state has implemented an idea  
10 that's working. If measurable results, cost savings-  
11 -whatever it is--maybe you could persuade  
12 policymakers in my state that it's worth pursuing as  
13 opposed to something that's completely theoretically.  
14 Yes?

15 REPRESENTATIVE HARRELL: What I would  
16 suggest, perhaps, is that we take those good examples  
17 and we have referred a variety of very good examples  
18 of cost-saving programs. We take an example of Rhode  
19 Island. We take some of the things in Florida. We  
20 take some of the things they've done in  
21 Massachusetts, in Michigan and you make a list of  
22 those and you do a little package of success examples

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1 with the cost savings that come from them so you have  
2 your measurability. You say this is a successful  
3 program. It's the good news of the day. Let me give  
4 you 10 reasons why, 10 good examples why you need to  
5 do this. You pick those out and say this program is  
6 going to save you \$2 million a month. This program  
7 is going to save so many adverse incidents. This  
8 program is going to do whatever. And you make that  
9 part of the white paper.

10 Leave the details for the policy  
11 wonks like me who will sit there and read the white  
12 paper. You need the executive summary for people who  
13 want to do the state-of-the-state address. They can  
14 do the bullet points. You need a variety in that  
15 package so there's something there for everybody no  
16 matter what level of interest you might have. But  
17 the specific example that proves a point makes it  
18 really good. Also, for a state legislator, my  
19 legislation I like to come back from the various  
20 meetings I go to with a bill. Okay, this is going to  
21 solve a problem I see in the State of Florida. If  
22 I've got model legislation that I can take back and

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1 give to my agency for health care administration or I  
2 can give it to my staff director of my committee and

3 say, you know, this is the model legislation. Staff  
4 do the research and let's do that in Florida. That  
5 sells.

6 GOVERNOR DOUGLAS: Thanks Gail. Steve?

7 MR. PALMER: I can second a number of  
8 folks interested in the idea of having some actual,  
9 tangible pilot programs and demonstrations of having  
10 these recommendations being put into practice. One  
11 thing I would say along those lines is the federal  
12 government has been putting out a number of different  
13 contracts, grant programs for regional initiatives a  
14 little bit for state levels, but mostly regional  
15 initiatives. They seem to go to the same grantees  
16 across multiple programs. I'm not sure if that would  
17 be the way to get most bang for our buck in terms of  
18 being able to demonstrate the ability to shift a  
19 state from a situation of being almost ready to see  
20 something happen to a certain critical momentum  
21 rather than throwing more money at a state that  
22 already that critical momentum.

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1 GOVERNOR DOUGLAS: Other thoughts?

2 Kathleen, do you have some directions from the  
3 Alliance on where we want you to move forward?

4 MS. NOLAN: Personally, I'm delighted with  
5 the direction of the conversation. I was a little  
6 worried that people wouldn't want to worry about what  
7 we were capable of doing. That didn't come up. But

8 I do think one of the things--I think there's a  
9 couple of categories of things that I heard and I  
10 think they're all in cases where we haven't seen a  
11 lot of work going on and I think that's ideal.

12           One of the things we've been talking about  
13 a lot with the taskforce is the question of whether  
14 we haven't crossed the finish line on some of this  
15 stuff, but if we run the course of our ability to  
16 pull out recommendations from that versus helping  
17 states think through some of these issues I think you  
18 saw that. The 19 recommendations that are really  
19 approaches that states could take versus or earlier  
20 ones, which were really national movement. I think  
21 it's very telling. But in thinking about what I  
22 heard just now there was the issue of how we interact

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1 with the provider community, both on the licensure  
2 side and the education side. That's something we  
3 don't have a tremendous amount of experience in--on  
4 thoughts about how to do that. We need to do some of  
5 that work and get into how we do the handholding and  
6 do some of the things that were mentioned earlier  
7 today. There was the private sector coordination  
8 component, which I think is really critical for us to  
9 think about what the strategies are for working with  
10 the private sector initiative in that area. I heard  
11 a lot about packaging and I think that's my point

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12 about these taskforces. There's been a lot of work  
13 and has generated what within that we need to move  
14 forward. E-Prescribing was a place where we saw  
15 right away opportunity, somewhere we could hand out,  
16 repackage, figure out different strategies for some  
17 players and however you wanted to see it.

18 We probably need to do some more of that,  
19 perhaps, trying to drill down and get more tight  
20 around the first reports; maybe we're going to see  
21 some of those. But it's also about doing some of  
22 that repackaging. Maybe it's time to step back and

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1 say of all the recommendations we have so far, which  
2 are the ones that this group feels the most  
3 comfortable with putting forward, either in a group  
4 session--this is about this kind of theme and we  
5 think this theme is the key area. Or is it really  
6 about five that are so critical that we think we need  
7 to move forward?

8 Those are two strategies we're going to  
9 need to go back and think a little bit about it and  
10 we're going to need to come back to you with  
11 something in writing to give you something to think  
12 about and see how we can do that. This is a  
13 refocusing. It's the perfect time for that. We  
14 talked before about implementation, of the idea of  
15 doing some pilots again, I think, if we have some  
16 clear direction about one of the five or six major

17 areas we want to get some movement in, we can begin  
18 to develop some piloting initiatives. We'll really  
19 be able to bring them forward. But also as you said,  
20 we need to bring them forward in the interest of  
21 what's already been there. That's akin to your point  
22 Governor about metrics. This is about a lot of

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1 issues and this is our tool to get there or a major  
2 tool to get there. We need to make those  
3 connections.

4 I heard a lot of different things, but it  
5 get us back our groups that are dealing with the  
6 dynamics internally like Medicaid, things like the  
7 state level health IEs. Those are all looking at  
8 some of the technical side. We have to take the  
9 broad picture with this group and support those  
10 strategically. I heard a lot of different ideas.  
11 Let us take this back a little bit, do some thinking  
12 and give you a strategic plan essentially talking  
13 about how we might move forward with some of these  
14 things. We're not losing the experience of this  
15 dialogue. Does that make sense?

16 GOVERNOR DOUGLAS: Richard?

17 SENATOR MOORE: One thought might be also  
18 to build on the models. The programming has been  
19 going on for a while in the Ford Foundation and  
20 Kennedy School, the innovation program that states

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21 proposed, the programs generally. We took that model  
22 and they would give us some standards and we might

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1 even be using the recommendations and say the states  
2 have programs in the area. Do you think they're good  
3 and submit them for review and that may be helpful to  
4 encourage applications between the states. We've got  
5 some pretty good examples of good case studies and if  
6 we could get one of the foundations to perhaps to  
7 think of those and a little more monetary--that  
8 \$100,000, might be two grand, yes, but somebody could  
9 give out little awards to the states so that you're  
10 almost kind of like profiling. The governor might be  
11 interested in one of those, in making a future about  
12 this, publish each of those and the way to get the  
13 word out fast. If your state's the winner of one of  
14 these grants, it gets mentioned. That's a good model  
15 we can tailor to focus this and we'd be able to get  
16 solicited from the states some pretty good case  
17 studies and a panel that has some arm's length  
18 distance to be able to review and pick the two 3, 5,  
19 10--whatever they happen to be and tie it into the  
20 recommendations where you've got projects that are in  
21 these areas in these areas you're recommending,  
22 submit them for review and see if they make sense.

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1                   GOVERNOR DOUGLAS: Recognition of  
2 accomplishments. We're not going to give an award  
3 for the highest percentage of e-Prescribing though.

4                   (Laughter)

5                   GOVERNOR DOUGLAS: Maybe the most  
6 improved. Jim?

7                   GOVERNOR GERINGER: If we were to suggest  
8 maybe not just model legislation, having clicked on  
9 some data system in other areas, I know there are  
10 different preferences in the states. There could be  
11 options for executive orders. There could be options  
12 for things to be included in legislation and as we  
13 start to enumerate and list those things that ought  
14 to be legislated, let's say, all of a sudden we start  
15 to discover these are the kinds of examples we need  
16 to back this up that we're going to offer to the  
17 states the centralized model here, a federated model  
18 here are the things you need. In a federated model  
19 you can implement it more quickly through executive  
20 order. So things like that in terms of how to make,  
21 not just the leadership sell the notion, but it's one  
22 thing for implementation and it's another for

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1 execution and that's part of what Representative  
2 Harrell is talking about. I need something in front

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3 of me to see. So those things would be nice. We

4 could have a menu of options.

5 DR. SUNDWALL: One last quick comment on  
6 this. I started to read through this. I haven't  
7 read it in enough detail to know whether the  
8 criticism is valid, but I have heard in our  
9 discussion support for public health and embedding  
10 public health reporting in whatever we do with  
11 electronic medical records or promoting E-Health.  
12 But it's not apparent here. It's not clear to me  
13 from what I've read. So I would just ask that the  
14 support of the Alliance, if you don't mind, that I  
15 work with the NGA I'm sure there should be a section  
16 or some acknowledgement of as we promote exchange of  
17 electronic information we could build on public  
18 health reporting, mandatory reporting of diseases,  
19 disease clusters as Dr. Tuckson has talked about,  
20 immunization registries--things that really do have  
21 returns, big payoffs. I would just make sure I will  
22 be doing that unless you tell me I can't.

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1 MR. CONAWAY: As a corollary on that,  
2 there are systems that are better at getting the  
3 clinical and health data. That needs to be part of  
4 the discussion. In the federated model, it's more  
5 difficult to get this kind of public health data.

6 GOVERNOR DOUGLAS: That is the bottom  
7 line, obviously, to improve the health outcomes of

8 our population and hold down cost. We've got to keep  
9 that in mind. Ken?

10 REPRESENTATIVE SVEDJAN: One other  
11 thought. I'm just wondering the extent to which the  
12 work of this group should be coordinated somehow with  
13 the NCSL. Cory is sitting back here from NCSL. They  
14 have an effort that's focusing also on health IT.  
15 That's an organization that typically doesn't draft  
16 model legislation, but they do provide a lot of  
17 technical assistance to states and legislators on  
18 particular issues, on a whole variety of issues. The  
19 American Legislative Exchange Council is in the  
20 business of drafting model legislation and I don't  
21 know. Gail, maybe you know if Alex is working on  
22 this at all. I just don't happen to know. But then

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1 also the Council of State Governments, which has  
2 membership from the executive branch, the legislative  
3 branch and I believe also the judicial. Those three  
4 organizations they're all quite legislatively focused  
5 and they all play a little different role, but it  
6 might be very helpful to somehow coordinate the work  
7 that we're doing here with them.

8 GOVERNOR DOUGLAS: That's good advice.  
9 Gail?

10 REPRESENTATIVE HARRELL: I would also add  
11 the National Foundation of Women Legislators, too,

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12 also does model legislation. Put them on the list as  
13 well. I know Alex has a Health and Human Services  
14 Taskforce and they do address IT. I would make sure  
15 that we reach out, perhaps, to all of those  
16 legislative groups, so the National Foundation of  
17 Women Legislators also.

18 GOVERNOR DOUGLAS: I know Kathleen and her  
19 colleagues have contacts in all these organizations,  
20 including the county and city representatives as  
21 well. Many of which are headquartered in all the  
22 states. Those are good ideas. Yes?

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1 REPRESENTATIVE HARRELL: May I make one  
2 more suggestion, and I hate to be a little negative,  
3 but you know sometimes you have to look at pitfalls  
4 as well. And having tried to pass legislation in the  
5 past that has not been able to pass or has been kind  
6 of circumvented, there are groups out there who may  
7 not be attuned as we to this. Certainly, when you  
8 get into the privacy and security issues, you meet  
9 those forces head on. I think we have not really  
10 discussed that. Maybe when we really get into  
11 privacy and security, we may discuss a little,  
12 perhaps, more in depth. But I know having tried to  
13 pass legislation that we wound up doing pretty much  
14 for e-Prescribing and dealing with substance abuse,  
15 especially prescription substance abuse.

16 With the number of deaths in Florida being  
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17 even more than you are having. I can tell you there  
18 are groups and there are people out there who don't  
19 view IT health information technology in the same  
20 vane that we do. I think maybe a little discussion  
21 on some of the pitfalls out there and groups that may  
22 be somewhat opposed to what you're trying to do

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1 should be part of our discussion on how you answer  
2 their concerns. How do we address those concerns?  
3 Whether it's big brother watching you or somebody's  
4 going to steal that laptop and get my health  
5 information. Who's going to give permission? Are  
6 you going to include sexually transmitted disease?  
7 Are you going to include psychotropic medications,  
8 psychiatry reports? Those kinds of things present  
9 issues. We've not really had this discussion.

10 MS. NOLAN: We normally call that lessons  
11 learned rather than pitfalls, but that's part of a  
12 case study as well as a new pilot program, the idea  
13 of how we learn from doing pilots. It's not just  
14 learning from your success. It's learning what isn't  
15 working and sharing that. So I think we can make  
16 that part of the study and approach as well as any  
17 implementation of pilots.

18 REPRESENTATIVE HARRELL: Fine.

19 MR. DeVORE: Maybe a note of caution. I'd  
20 like to point the finger at the federal government

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21 and AHIC, but where I think the biggest pitfall was,  
22 was we got wrapped into the thought that there's a

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1 legislative solution to this. There might be  
2 legislative components, but this is not all  
3 encompassing in legislation.  
4           Let's look for those low-hanging fruit  
5 that are potentially are private/public cooperation,  
6 things you can do by executive order, things you can  
7 do that don't require legislative solutions. Let's  
8 not forget that's a key component. If we think this  
9 has to be and only can be changed via passing a law,  
10 we're going to get into the same vicious circle that  
11 they ran into on the federal side and they're still  
12 struggling with. When that happens, the ugly side of  
13 all the people will sit around the table comes out,  
14 so the stuff we're working on lacks a lot of  
15 specificity to keep everybody at the table. When you  
16 begin to get specific, you start dipping into  
17 people's revenue streams and business models and  
18 privacy and security issues. I'm just cautioning  
19 that we look for those solutions that are  
20 legislative--if we can move the ball legislative  
21 that's fine. But if not, there are other things.  
22           GOVERNOR DOUGLAS: We're going to talk

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1 about the private sector involvement in a few minutes  
2 as well. I think what I heard Kathleen suggest is  
3 that for our next meeting she'll prepare a strategic  
4 plan for supporting implementation of our  
5 recommendations, a variety of activities, strategies,  
6 working with some states if that makes sense. We'll  
7 move in that direction. This has been a very  
8 important conversation.

9 Gail, let me turn it over to you for our  
10 next presentation. You've alluded to the role in the  
11 private sector a number of times in our conversations  
12 today. Now, we'll talk more about it.