American Health Information Community

Secretary Michael O. Leavitt:
Well, this will call to order the first meeting of the American Health Information community, and I am delighted to be here with all of you. I think you've been well initiated this morning into the rights of the federal system, had your pulse checked, and received all of the various initiations that you need. I must tell you, personally, how appreciative I am of your willingness to do this service. My guess is over the next couple of years or more, we'll get well acquainted with one another, but I think it would be quite productive today if we could take a few minutes at the beginning and just spend some time with introductions, and maybe learn a little bit about each other personally. We'll get those chances at different times, but why don't we take a few minutes, and I'd like to introduce someone to all of you who most of you will know, David Brailer, and David, why don't you take just a minute, and just tell the group a little bit about yourself.

David Brailer:
Only a few minutes? [laughter] Thank you, and let me also both thank all of you for coming and investing so much of your time in this effort, but also to thank the secretary for what I consider to be remarkable leadership, given all the things that are calling on his time, the amount of investment that he's made personally and in the department in health information technology, and quality that it stands for, I think is just remarkable, so thank you sir. As some of you know, I'm basically a physician. I'm an internist, and have been involved in clinical practice throughout most of my career, although I was steered off in the direction of economics at the Wharton School of Business, where I spent a great deal of time trying to understand the economics of quality and was drawn into the private sector as an entrepreneur and learning methods of getting things done sometimes that are quite innovative, and I'm happy to say that we're both putting these practices together through the federal government, and I've been in this role now here for about a year and a half, and we've had a great time really trying to move this forward, and it's been a wonderful experience from the perspective of just how resonant health information technology is with people in the United States. So I'm very happy to see this happen.

Secretary Michael O. Leavitt:
And my guess is that at some point, David's going to write a book about the differences between entrepreneurship and government work. [laughter]

David Brailer:
Or entrepreneurship and the government. [laughter] And other oxymorons. So thank you.

Secretary Michael O. Leavitt:
He's made a great contribution to the world of health IT all of you know. I go out all over the country, and David's often referenced as a good example, not only of innovation, but his willingness to come into government service, and to do some heavy

lifting on a tough subject, and he's done an exceptional job, and been able to move it forward. Kelly?

Kelly Carmen:
Kelly Carmen, I'm a senior advisor to Dr. McClellan, who could unfortunately not be with us this morning. I've been with HHS for the last four years. I've worked with David Brailer closely. As with Carolyn Clancy too, with the first council that Secretary Thompson set up to coordinate a lot of internal activities on HIT, so I'm happy to be here in his place, and he'll be joining us in a little bit.

Secretary Michael O. Leavitt:
Dr. McClellan, as you know, heads the center for Medicare and Medicaid Services, which is the largest operating division in the Department of Health and Human Services, and obviously one of the largest payers of healthcare in the world, and so having him and his colleagues at this table periodically will be of great importance in this venture.

Lillee Smith Gelinas:
Good Morning, I'm Lillie Gelinas, I'm a Vice President VHA, Inc. We're the other VA. VHA is a cooperative of 2,200 Healthcare organizations across the country. It will be quite an honor to get to know the members of the community as we proceed with this enormously important work. I was enormously honored to be the consensus nominee for the nursing profession and hope that I can represent nursing to this work in the way to profession needs it to be. I went to school at the University of Southwestern Louisiana for my bachelor's degree in nursing, and my master's degree in nursing is from the University of Pennsylvania. When Dr. Brailer and I were talking, we were talking about two things we had in common, Penn being one, and the other being New Orleans. I think the most important role I'm playing right now is helping my immediate family, who are from New Orleans, and thank goodness they got out, but there's lots of work to be done, and as I said to Dr. Brailer, if we had had healthcare IT in place prior to that disaster, things would be very, very different for a whole lot of people, so I'm committed both personally and professionally to the work of the group.

Secretary Michael O. Leavitt:
Lillie, would it be imposing on you personally to tell us a little bit about you and your family's experience, briefly?

Lillee Smith Gelinas:
You know, I'm really proud of the fact that we are surviving and not going to funerals. They all got out. When Katrina went to a cat 5, they got out. I grew up with hurricanes all my life. At the peak, I had about 22 that had evacuated to Dallas, Texas, where we live now. I have, right now, two sisters, my 83-year-old mother, their extended family members. Some have gone back to New Orleans, because we will go back. We're part of the group that wants to build Louisiana back. But it does take a lot. Trust me, my -- I'll just tell you something funny. I'm standing at my kitchen counter, and I open my electric bill and it's $750 for the month of September, and everyone looks and says, "Well, I guess, yes, the washing machine goes constantly, the TV's on constantly, the

stove is going constantly, so some little things like that that you have to adapt to. We don't eat out a lot anymore. [laughter]

Secretary Michael O. Leavitt:
Comments like that, though, stock prices of Texas utilities will go through the roof. [laughter] Insider trading for all of us.

Doug Henley:
Doug Henley, I'm the executive vice president of the American Academy of Family Physicians, and again, Mr. Secretary, I was honored to serve on this group. I've been doing this job for this job for the last five years, and my home now is in Kansas City, Missouri, or Leewood, Kansas, right across the state line. My accent, however, people tell me I do have an accent. It's not Midwest. It's from the south. I spent 49 years of my life there, in North Carolina. I did all my training at UNC Chapel Hill, 11 years of my life spent there, so if you cut me I'll bleed Carolina blue, and it's a different color than Duke blue. [laughter] It's important to understand. And then I went back and practiced for 20 years in my hometown in southeastern North Carolina, and was fortunate five years ago to be appointed as EVP of the Academy, and our organization, in representing the physician community, we're here to make sure that healthcare in this country is of improved quality, of greater safety and greater efficiency on behalf of our patients.

Secretary Michael O. Leavitt:
Is most of your family still in North Carolina?

Douglas E. Henley:
They are. My mom and dad and two brothers. My older brother's an ENT physician, my middle brother is running our hometown pharmacy still.

Secretary Michael O. Leavitt:
Really?

Douglas E. Henley:
Despite all the competition. [laughter] He's an independent pharmacist.

Secretary Michael O. Leavitt:
No question of what the Thanksgiving conversation is around your table.

Douglas E. Henley:
Indeed, indeed.

Secretary Michael O. Leavitt:
Well, glad you're here, doctor.

Douglas E. Henley:
Thank you very much.

William Winkenwerder Jr.:
Secretary Leavitt, I'm Dr. Bill Winkenwerder, I'm the Assistant Secretary of Defense for Health Affairs, and am a physician by background, but have been in management for a decade and a half or so. Lots of similarities here, or connections. North Carolina -- I'm from North Carolina and Pennsylvania. David and I know each other from way back. New Orleans -- Department of Defense has been in the middle of that, but a little bit about the Military Health System, for which I have the responsibility to lead since just after 9/11, four years ago, came on to take that position. We take care [unintelligible] as beneficiaries, about 9.2 million people, active duty, family members, retirees, all over the United States, and of course overseas as well. And we operate that system through our direct care systems of hospitals and clinics, about 70 hospitals and about 800 medical and dental clinics, and then we work very extensively with the private sector, with networks, and so we're in connection with about 200,000 physicians in the private sector, and a lot of private sector hospitals deliver -- to deliver our benefits, so we have appreciated our working relationship on so many fronts. I feel like I work for two cabinet secretaries. [laughter] The ways in which we've been --

Secretary Michael O. Leavitt:
Battlefront is sort of what it would be well described as.

William Winkenwerder Jr.:
I'll tell you, yeah. But we look forward to this participation, glad to join you in this as well as the VA and the Department of Commerce and others, and we are implementing electronic health record -- we'll have an opportunity to talk more about that, but we're really committed to the new age of digitizing health care, and the delivery of health services.

Secretary Michael O. Leavitt:
Tricare is what, about 80 some-odd billion dollars now?

William Winkenwerder Jr.:
Well, I hope not. [laughter] We're growing fast, but not that fast. We'll probably hit $40 billion next year. I think the figure probably is between we and the VA, we're over $80 billion, pushing 90, so a lot of money is going into healthcare delivery for the military and then veterans, so we're -- you know, there's an opportunity here to do it better, more efficiently and with higher quality.

Secretary Michael O. Leavitt:
Well, Bill, we're glad you're part of this. Thank you.

William Winkenwerder Jr.:
Thank you.

David Ayre [spelled phonetically]:
Thank you. Hello, I'm David Ayre from PepsiCo, representing our CEO Steve Reinman, who unfortunately was not able to be here today but sends his regards and looks forward

to participating in the future. Myself, I'm the senior VP of compensation and benefits. I've been with PepsiCo for 15 years, and I'm like a number of the people here, I can't relate to a lot of these things because I come from Canada, and have spent, you know, time living in five other countries around the world, so I've seen healthcare and IT from a number of different perspectives. PepsiCo is very pleased to be here. We also are implementing electronic health records, and you know, it's a journey, it's a beginning, but we've found very much that by putting our employees as consumers at the center of that, we've had a lot of success and look forward to contributing.

Secretary Michael O. Leavitt:
Thank you. David will be here representing his principal today but also representative of private payers, of which they are a very good example. How many employees would be under your healthcare?

David Ayre:
We have about 80,000 US-based employees under healthcare spending and about 155,000 worldwide, which has various degrees of healthcare.

Secretary Michael O. Leavitt:
We welcome your perspective.

David Ayre:
Thank you.

Secretary Michael O. Leavitt:
Thank you.

Kevin D. Hutchinson:
Mr. Secretary, I'm Kevin Hutchinson. I'm the CEO of SureScripts. We're an organization that's pharmacy-owned. We have around 90% of the pharmacies in the United States that certified on the network for allowing electronic prescribing to take place, the infrastructure between physicians and pharmacies. I grew up in Oklahoma in the Midwest, and so for those Texans that are in the room, this might be a rebuilding year for the Sooners, but this weekend -- [laughter] this weekend you're in trouble. I have spent most of my career in healthcare information technology, years at IBM, VHA, as well as Medicologic Medscape, focused on electronic health records, both at VHA, and at Medicologic Medscape, and I represent the ancillary services, and I'm honored to accept a nomination to represent the pharmacies and labs and other ancillary services to healthcare. This is a work in progress. It has been for a number of years. It can be frustrating at times, but I have to say that one of the reasons that -- if you stay in this particular space, focused on healthcare information technology, it's because you see the real benefits to patients and to the United States, and the real opportunity for change in this particular industry.

Secretary Michael O. Leavitt:
Thank you. Tell us just a little bit more about SureScipts.

Kevin D. Hutchinson:
SureScripts is an organization that was founded by the National Association of Chain Drug Stores, and the National Community Pharmacists Association, representing both the chain drug stores, as well as the independent pharmacies. We're focused on building out the infrastructure within the industry to allow electronic health records and electronic prescribing applications to connect to pharmacies, be that independent pharmacies, mail order pharmacies, or chain pharmacies to allow patients to send the electronic prescriptions to their pharmacy of choice. We've been around -- around four years. We have about 50 technology companies on the physician side that have signed agreements and are certifying on the network. Most of those are electronic health record companies, as well as stand-alone prescribing applications, and as I said before, we have around 90% of the pharmacies in the United States that are now certified on the network.

Secretary Michael O. Leavitt:
Good. Thank you.

Dan Green:
Good morning. I'm Dan Green. I represent Linda Springer with the Director of the Office of Personal Management. On a personal note, I'm glad to be here. I hope, with so many physicians in the room, at the break, I've got this stiff elbow I'd like to [laughter] talk to you about. OPM serves as the employer for federal employees, and provides health insurance for our employees, retirees and their families. That's 8 million covered lives. We do it through the Federal Employee Heath Benefits Program. There are some 250 health plan choices that are offered to federal employees of all kinds, from high-deductible health plans to HMOs and [unintelligible] service plans. We spend $31.5 billion a year on this program, and so that puts us, with VA and DOD, over $100 billion in healthcare spending, so obviously move to provide efficient, safe and prompt service and medical attention to our constituents together is extremely important to us at OPM and throughout the federal government.

Secretary Michael O. Leavitt:
Thank you. That's -- I'm pleased that you're here and look forward to Linda's participation as well.

Dan Green:
Yes.

Michelle O'Neill:
Good Morning, I'm Michelle O'Neill, I'm the acting Undersecretary for Technology at the Commerce Department, and on behalf of Secretary Gutierez and the Department, I'd like to thank you for this opportunity to participate in this endeavor. The Technology Administration includes the National Institute of Standards and Technology, winner of another Nobel Prize in physics, just recently announced, and we have a long history of cooperation both with HHS and a number of the healthcare industry organizations that are in the room. The goal is to improve the standards and measurements of -- related to

the healthcare industry, and to help to advance that area through standards and measurements.

Secretary Michael O. Leavitt:
Tell us about you personally.

Michelle O'Neill:
On a personal note, I was born in a military hospital, I am a participant in the Federal Employee Health Benefit Plan. [laughter] I have three immediate family members that are doctors, and having had a child in the last year, I'm very much a consumer of healthcare services, so -- and originally from upstate New York, Rome, New York.

Secretary Michael O. Leavitt:
You'll have a particularly good perspective on immunization records. [laughter]

Michelle O'Neill:
That's correct. It happened to be on my priority list, in fact. [laughter] Thank you.

Nancy Davenport-Ennis:
Mr. Secretary, I'd like to thank you sincerely for the opportunity to represent patients and consumers in the United States. I'm Nancy Davenport-Ennis, and the organizations that I represent were founded by my husband and I almost ten years ago. We have The Patient Advocate Foundation; that's a direct patient services group. We served 3.2 million Americans last year who were in some form of access to care issue when they contacted us. The patients that we serve have chronic, life-threatening, and debilitating issues. 83% of them are cancer patients. For every patient that we serve in our seven offices throughout the United States, we maintain electronic records of that experience, and we use the data and the records that [unintelligible] identified in order to be able to talk with regulators and policymakers to help them understand what we are seeing day-in and day-out through the consumer experience of trying to access healthcare, whether they're fully insured, or whether they're uninsured, or whether they're a member of the underinsured population in the country. As we built the corporation, we have certainly tried to look at what our relationship is to the health plans in America, to the employers in America. We formed coalitions and relationships with the nonprofit patient groups, with the regulatory agencies at the state and the federal level, and [unintelligible] through the years, our role has been to mediate and arbitrate positive resolutions to the health care matters. And what we find is that often, if we can establish a precedent that the health plans are joining with us in trying to correct the problem at a more global level. On a personal note, I think probably two things I'd like to say. I, too, am from North Carolina, had relatives that lived in the small town that Mr. Henley served in as a doctor for a number of years, would also like to share that Hurricane Katrina has impacted our corporation. We are now serving displaces patients who have been relocated to other areas and are trying to put together a fabric of healthcare, and we're doing that, in some instances, with other nonprofit corporations. I am a survivor of breast cancer, which is not important to the discussion, only to say it does sensitize one to the issues. Today, my husband is actually at Duke University Medical Center, waging his own battle with the same illness, and so I

bring to you a very personal perspective as well as a global perspective of health care in the United States today.

Secretary Michael O. Leavitt:
Thank you Nancy, and from my reading of your background, your battle with cancer was a turning point in your professional life.

Nancy Davenport-Ennis:
It was, indeed. I was an English teacher and had actually spent a fair amount of time writing books and working in the real estate and home-building industries as a professional educator throughout the United States, and the first diagnosis that I had really didn't get my attention. Six months later, I met a young woman. The second time I was diagnosed, she was 31, divorced, the mother a 12-year-old son, given no options, and we introduced her to Duke, we got her into a clinical trial, and after three and a half years of helping her work through that experience, we knew that we did not want to see another American deal with some of the issues that we indeed felt that we could make a difference in. And fortunately, many of the businesses in the United States and many federal and state agencies have joined to support what we do, so that we can serve the Americans that we serve today.

Secretary Michael O. Leavitt:
Well thank you. I believe you're in a place where you can make a big difference here.

Nancy Davenport-Ennis:
Thank you.

Secretary Michael O. Leavitt:
Thank you.

Nancy Davenport-Ennis:
We appreciate the opportunity.

Scott P. Serota:
Mr. Secretary, thank you also for the appointment. I'm Scott Serota, the president and CEO of the Blue Cross Blue Shield Association. We serve 93 million Americans across the country and in every state of the Union and also have some people nationwide. We're the largest participant in the Federal Employee Health Benefit Plan. We do a lot of work with Tricare, so we touch virtually every program that is out there. We also administer part A benefits and part B benefits for Medicare, and we are very committed to leadership and health information technology. It is essential to help realize our vision of quality access and affordability, and we want to be sure that we can provide leadership and expertise. We connect with 90-plus percent of the physicians in America, 90-plus percent of the hospitals in America and believe that information will be the cornerstone of making our system more efficient and effective, and that's why we're here. I'm also obviously representing the payer community, and we, on behalf of the payers, are also committed to be an active and engaging participant. On a personal level, I was a -- I

started my career as a hospital administrator, so I've been on that side of the equation for a while. I was an entrepreneur, started my own HMO, and the rock bought it, the Prudential, back when they were in this business. Bill and I worked together in that environment, joined the Blues in 1996 and was appointed CEO in 2000, and I am looking forward to working with everyone in the room to make a difference.

Secretary Michael O. Leavitt:
What was your first job out of college?

Scott P. Serota:
I was an administrative fellow at Hillcrest Medical Center at -- in Tulsa, Oklahoma, and got the opportunity to watch Tulsa expand rapidly in an oil boom, and crash rapidly in an oil bust, and that drove me out of Tulsa, Oklahoma and into St. Louis.

Secretary Michael O. Leavitt:
Did you go into hospital administration as a passion, or did your passion come after you became a hospital administrator?

Scott P. Serota:
It's hard to remember back then, but I -- it was always my -- it was my intent when I graduated college to go into hospital administration, so I guess the passion for being in that business was there before I started. It is -- it's an extremely rewarding profession, a very complicated business, a great way to learn principles of management, because you deal with people at all levels in management and in operations, and it's a 24-7 business, so it -- high pressure, high stakes, and it was a great way to get oriented to the profession.

Secretary Michael O. Leavitt:
Well, we're going to mine all of that experience in this endeavor.

Scott P. Serota:
I'll do my best to contribute. Thank you, Mr. Secretary.

Secretary Michael O. Leavitt:
Thank you.

Mark Warshawsky:
Mr. Secretary, I'm Mark Warshawsky, Assistant Secretary for Economic Policy at the Treasury Department, and on Behalf of Secretary Snow, we have a great interest in the success of this endeavor. Our -- at the Treasury Department, our interest in healthcare is maybe not specific to the various programs, because of course we don't have jurisdiction on that, but it's more of an economic perspective, in terms of concern and interest of getting high value healthcare, efficient healthcare, given that healthcare represents one out of every seven dollars of the gross national product of the United States, represents a very major expenditure of the US government, both directly and indirectly, and the Secretary is the managing trustee of the Medicare Trust Fund, and therefore the Department has an interest in an evolvement in many healthcare issues. Speaking

personally, my background is an economist with a specialty in research on employee benefits, particularly pensions, but also have done research in the past on health benefits and healthcare more broadly, and even more personally, as opposed to professionally -- been with the federal government now for four years, and before that, I worked at a nonprofit pension provider, T.I Crepp in New York City, and before that had worked in other jobs in the federal government. I'm the father of four children, and like you, I have an interest in all the forms that we fill out, seemingly innumerable forms every summer, when the kids go to summer camp, every fall when they go to school, every new doctor, etc., etc., so we have a personal interest in efficiency here.

Secretary Michael O. Leavitt:
Good. Mark, answer the same question Scott did -- first job out of college.

Mark Warshawsky:
My first job out of college was to work for a small insurance company in Chicago as an actuary. It was a both life and health insurer, so I have that perspective.

Secretary Michael O. Leavitt:
That's good. Mark -- I've read some things he's written, and he'll be a very thoughtful contributor here, and his principle Secretary Snow has expressed an ongoing interest in this subject for the reasons he enumerated. His view, and I think is shared by many, that an economy that has one sector going as rapidly as this has to be considered a significant factor in our capacity to continue, so we're glad you're here.

Charles N. Kahn III:
Mr. Secretary, thanks for the invitation to participate in this process. I believe that it is one of the most important, if not the most important effort right now in the development of the healthcare system and healthcare for Americans. I'm Chip Kahn, president of the Federation of American Hospitals. We represent approximately 15% of the hospitals, but we work very closely with the entire hospital community, so I'm happy to be here this morning representing hospitals. I've been in Washington 25 years, spent many years working on the hill, and was very involved with the development of HIPAA, which in some ways foreshadows this groups, in other ways may shadow this group, [laughter] depending on your attitude. But I think at least in terms of its thinking, both in terms of trying to do something about electronics, as well as get the conversation started about privacy, which anticipated electronic medical record, a lot started with HIPPA, and that was a good experience for me. Today, obviously I represent hospitals, but at different points in my life, I've dealt with hospitals from the standpoint as a parent, and I guess the thing that's most chilling to me, and I didn't think about it until earlier this -- in some of the earlier comments, that I had a very sick child in the 80's, and during his hospitalization, which lasted between eight and ten weeks, I cant remember low long -- soon after, I got a call from the insurance company and they said, "We're not going to pay for the hospitalization," and I said, "Why?" He said, "Because the records are gone." So this was ten weeks of records for a kid with leukemia, gone. It's a local hospital, go unnamed, and I went back to the hospital, and so we fought over the money for a short time. Fortunately I won that battle, but more importantly than that, within a few weeks

we were back in the hospital, and nothing untoward happened, but many questions arose which could not be answered, because there were no records. And fortunately, the anesthesiologist and the surgeon who had done initial work were still there, so they could sort of reconstruct it in their minds, but they were very smart guys, and it all worked out. But it might not have, and hopefully, the work here will lead to that kind of thing never happening again for anyone, and that was in a closed system in a hospital, so anyway --

Secretary Michael O. Leavitt:
So bring us up to date on your son.

Charles N. Kahn III:
Oh, well he passed in '89, so --

Secretary Michael O. Leavitt:
Oh, I'm sorry to hear that.

Charles N. Kahn III:
So that was a -- but he struggled with Leukemia for -- I guess it was six years, and I was -
-

Secretary Michael O. Leavitt:
That must have a profound experience for your, in terms of healthcare and your family, and --

Charles N. Kahn III:
It really was, it really was, and he also had down syndrome, so he had a lot of -- a lot of issues, but I was on the hill at the same time, so it was sort of difficult working on health policy, and then sort of spending the night every few weeks at Children's Hospital, was really very difficult.

Secretary Michael O. Leavitt:
I can't imagine how much -- that must have been a very difficult period in your life --

Charles N. Kahn III:
Yes, it really was.

Secretary Michael O. Leavitt:
-- in your life. Well, thank you for sharing all of that. That's a very helpful perspective, I think for each of us to have.

Jonathan Perlin:
Good morning, I'm Dr. Jonathan Perlin, and I'm the Undersecretary for Health for the Department of Veteran's Affairs Veteran's Health Administration. Secretary Leavitt, Dr. Brailer, thank you very much for your leadership in this tremendously important area. I'm feeling that I'm representing VA and of course Secretary Nicholson, but coming from an environment with a fully implemented electronic health record, I also hope I'm

representing a point of optimism that this isn't unachievable. In fact, it's not only possible but possible rapidly. I'm not proud of the fact that I can tell you -- I have to tell you, to confess that ten years ago, our medical records were available in the VA 60% of the time. Four out of every ten patients, ten years ago, did not have a health record available at the time of their appointment. I just published an article recently, and our records are available virtually 100% of the time, available to 62,000 patients who evacuated from New Orleans in the wake of Katrina, immediately available wherever they went across the United States and around the world. Pleased to be able to refill prescriptions, and in fact, follow up on their health histories with all of that information, and it really drives home to me how tremendously important and empowering the electronic health record is in providing what is my aspiration for healthcare in the VA, safe, effective, efficient, compassionate healthcare. I really believe it's the fundamental tool to help achieve these things. As I mentioned, the electronic health record is pervasive across our 1,300 sites of care. It's used by the 75,000 physicians, 58,000 nurses, the other 33,000 allied health professionals that are part of the VA clinical community. We have over 200,000 direct employees. In addition, each year, over 250,000 other people come through VA in the service of veterans. 70 million Americans are touched by VA's benefits, commemoration and health services. 7.6 million are enrolled for healthcare. We serve them across 1,300 sites. Every one of those sites has electronic health records available. That is really quite an amazing statistic, when I think back on how much has been accomplished with that. We now have a library, having executed over 1.4 billion order sets, and we're approaching one billion notes, adding three quarters of a million new notes every day, and that those notes, I'm proud to say, don't get lost. My own background is that I'm an internist; I'm not from North Carolina, [laughter] [unintelligible] of the country --

Secretary Michael O. Leavitt:
Which version of blue are you, then? [laughter]

Jonathan Perlin:
I'm blue and orange, from UVA. In fact, I'm interested -- as I mentioned, background also in science, I'm actually in neurophysiology but retread as a health services researcher. I kept asking questions about why certain things didn't work, and that led me into administration, and I got an MHA, and went through administrative channels. So I really discovered, over the course of my entire career, that they electronic health record, as it was emerging, and I came from an environment where we've had direct provider order entry for over 20 years, was really the tool to help shape and support quality and garner improvements. So, again, I hope that you'll have a chance to see electronic health records at some point in VA as an example, and I look forward to learning from all of you. [unintelligible] if I didn't introduce my collage, Dr. Rob Coladner, who's really been a visionary in the development of our electronic health record. I thank you so very much for the opportunity to participate on this commission.

Secretary Michael O. Leavitt:
Was there a moment in your life when you decided public health was the avenue of medicine you wanted to -- was there a pivotal moment?

Dr. Jonathan Perlin:
I think there -- it's keeps being reinforced. I love to take care of patients. In fact, I still occasionally get over to Washington VA Medical Center to see patients, but as proud as I am of moving a patient's blood pressure from 140 down to 120, using the electronic health record shows you what you can do on a population base. We moved from 29% of patients appropriately vaccinated, to a national benchmark of 94%, and that, I can tell you, just for patients with emphysema saved 6,000 lives, and halved the number of unnecessary hospitalizations. So it's those moments that really are pivotal in terms of focusing from patient to population and then back.

Secretary Michael O. Leavitt:
Thank you.

Dr. Jonathan Perlin:
Thanks.

Julie Gerberding:
I'm Julie Gerberding, and I'm absolutely happy to be here. I'm -- I've been asked by the Secretary to represent not just CDC, but the public health perspective on the electronic health record, and I do that with great enthusiasm, having learned firsthand through my experiences at CDC how difficult it is to get integrated information, and get that information in the hands of people who can use it to make effective decisions. It's important, however, that I disclose my conflict of interest, because I, too, am a clinician, and I've experienced the long frustration of not having access to information when you need it and where you need it in my many years at San Francisco General Hospital, and the incredible opportunities that this experience provides is just -- I think it's a -- the whole experience is a breakthrough in healthcare. I also have to acknowledge that I met and fell in love with my husband while he was working on developing an electronic health record in the city and county of San Francisco, so we have a kind of a family interest in this issue as well.

Secretary Michael O. Leavitt:
Now Julie, overseas, one of the remarkable treasures in American medicine, I think you could say global medicine, we've been spending a lot of time working on the issues related to flu pandemics. In fact, we're off tomorrow to Asia for a number of countries in several days, and we're going to be moving deep into the rural parts of Vietnam and Thailand and others to see where that very frightening virus often finds haven, and I'm looking forward to learning from her. She's been a great teacher for me over the course of the last several months. Julie I'm glad you're here.

E. Mitchell Roob:
Mr. Secretary, my name is Mitch Roob, and I'm the Secretary of the Family and Social Service Administration in Indiana. We are responsible for Medicaid, childcare, TANF, mental health, long term care, really all the social service agencies wrapped into one. Last year we served, of the 6.1 million Hoosiers, we served -- we provided services to 1.1

million of those people. So, before I did this, I used to run Wishard Hospital in the Marion County Health Department, which is in the Indiana Health Department -- or Indianapolis Health Department. I spent a lot of time on public health issues there, at the local level, and running a public hospital, and Wishard is the place where the Regan [spelled phonetically] Street Institute was started, and I brought my health record. I brought my health record, you can see my broken -- various and sundry broken bones here, over the last several years from my poor balance, so, it's helped me -- personally, the electronic medical records help me when I used to run the department of public health, it helped us identify early on problems in the city and address them more cost effectively. So I'm very excited to be on this committee. Thank you for the opportunity. I went to DePauw University, a small school in Indiana, and then went to business school at Notre Dame, so thank you very much.

Secretary Michael O. Leavitt:
Mitch, I grew up in a family of all boys, there were six of us, no girls, and -- in a small rural town, and we spent most of our lives in an emergency with stitches and broken arms [laughter] and various things. I just have one question for you. Can you explain to me what a Hoosier is? [laughter]

E. Mitchell Roob:
There's a story that a Hoosier is allegedly from the southern part of the state of Indiana. Indiana's a southern state in this place in the Midwest, actually, [laughter] and it's supposed to be from the fights that used to occur before we were a state, and they picked up off [unintelligible] whose ear, and that's what -- that's allegedly where it comes from.

Secretary Michael O. Leavitt:
Oh, that's a great piece of lore. [laughter]

E. Mitchell Roob:
That was before the electronic medical record. [laughter]

Secretary Michael O. Leavitt:
Anybody got a better story than that? [laughter] Very good. Craig?

Craig Barrett:
My name is Craig Barrett, I am -- work for a small electronics company called Intel. I've worked there for 31 years, currently chairman of the board. Before that, I was an engineering professor at Stanford University for ten years, and listening to the -- all the other members of AHIC, I think one of the two groups I represent is the West Coast of the United States. [laughter] It's a long way away; it's over them mountains, and perhaps we don't get our voice heard very often. The other group that I really represent is the high-tech community, and computer and software organizations around the world, and my interest in this organization and heath care and IT and healthcare is really twofold. One -- as it's the largest industry in the United States unless it's a competitive industry, it's hard for me to see how the US economy is competitive long term, and secondly, having just had my annual checkup at a large, to be unnamed clinic and having to fill out

the same seven pages three times in two days, it seems to me that IT can be more usefully spread throughout the healthcare industry. Ultimately, I would like my doctor or any doctor I go to know as much about me as amazon.com knows about me. [laughter]

Secretary Michael O. Leavitt:
Well, good. Craig and I are fellow westerners, and it's nice to have you here. My first recollection of our meeting was at a -- he was opening a new manufacturing plant, I think in the state of Arizona, about the size of the state of Utah. [laughter] It was quite a place. You know, I -- your story, I have to confess that not long ago I went to a hospital for one of those over 50 tests that you have to get [laughter] and I counted seven times, exactly the same number, and a rather profound thing happened to me. I went into the final phase, and I was sitting on the table ready to start, and the doctor came in and said, "I need to go through a checklist," and he went through a checklist of questions, and he said, "Do you have any serious medical conditions?" And I said, "No." And he continued on through, and in walked an anesthesiologist, and I said, "Maybe I ought to mention to you that I have sleep apnea," he said, "Maybe you should." [laughter]

That was a medical mistake, and it was mine. I made a mistake by not telling the physician when he asked, but it occurred to me that that's a very poignant example. Not only did I fill out seven times my information, but what could have been a very serious mistake was made that could have been, should have been, would have been avoided if one of the other times I went to the doctor, it had been noted, and so I think that's a -- every one of us around this table, really, have had our own experience, and we come with a different perspective, but they're all valuable, and I think will bear heavily on our deliberations. I'd like to acknowledge the Deputy Secretary of the Department of Health and Human Service, Alex Azar, my Chief of Staff Rich McKeown and a number of other members of my most senior team. I'd like to invite David to introduce members of his staff, because you'll be interacting with them on an ongoing basis.

David Brailer:
Sure, thank you Mr. Secretary. I'd like to actually introduce five people who will now be leading the Office of the National Coordinator. I'm working very closely, not only with the various leaders of Health and Human Services, VA, DOD, Commerce, Treasury, but also with many of you. First, I'd like to introduce Captain Robert Wa [spelled phonetically], who is the acting deputy of the National Coordinator's Office. Robert? Secondly, Dana Hasa [spelled phonetically], who many of you have met. Dana is the acting director for programs and collaboration, which will include the AHIC and numerous other of our outreach activities. Third, John Loonsk, who is acting director of interoperability and standards, and who is on detail to us from the CDC. Karen Bell, who is acting director of information technology adoption is not with us this morning, she's on detail from CMS, and then Jody Daniel, where's Jody? Jody, who is our director of policy and research on detail from the Office of the General Counsel. We're trying to detrain Jody as a lawyer. [laughter] Sorry Alex. So I'd like to thank them, you'll see them very much.

Secondly, I'd like to just recognize and have stand the staff who work with the Office of the National Coordinator, in -- either directly in the office, or as affiliates in other agencies. There are a lot of people out in the hallways that you've seen, but I would like to say that besides our core staff, who many of you have known, we have staff working with us in close relationships with the Assistant Secretary for Budget Technology and Finance, CMS, the Assistant Secretary for Planning and Evaluation, ARC, and Carolyn Clancy's here today, CDC, Department of Defense, VA, Commerce [unintelligible] Treasury, it's been a very close working relationship with many of the different people. And finally, sir, I'd like to just introduce two people who are here with us today, first is Fran Schader [spelled phonetically], who is the Senior Vice President for ANCE, who is our new contractor to coordinate the Health Information Technology Standards Panel as one of our new contractors, and secondly, Mark Leavitt, who is the Chairman of the Certification Commission for Health Information Technology, our contractor in that space, we do --

Secretary Michael O. Leavitt:
And it's spelled exactly the same, and we can't figure out for the life of us how we got connected [inaudible] same name. [laughter] We're going to work on that a little longer. Good.

David Brailer:
Thank you very much.

Secretary Michael O. Leavitt:
Thank you. Well we have about 40 minutes between now and the time we intend to take a break, and I'd like to use that, if I could, to just lay a foundation for our work together, here in the community. While I'm on that phrase, let me just say I -- Craig and I are from the West, and a lot of times out west people are referred to as a hick, it's not a very complimentary term, and I've been using the term AHIC occasionally, and others have to. You'll hear me refer to it most often as that community. There's a Washington tradition of assigning acronyms to just about everything. Someone told me -- I'm trying to remember the phrase they used. Someone expressed it, and they said, "Well, it's TMA," and I said, "What's that?" And it's too many acronyms. [laughter] So you'll hear me refer to this gathering as the community, for reasons I think are embodied in its name, and I'll explain in a minute. I don't think there is a person who sits at this table who has not given speeches about the promise of health IT. Probably dozens of them, many of you hundreds of them. I wish today to make -- not to spend any time on the promise of health IT. The work of the community needs to be about actual progress, about serious, measurable, urgent progress toward a goal that I think we all share, and that's a goal the President's laid out for health information technology.

We all have spent time on a number of different organizations. There are hundreds of organizations, all of them work in serious ways to try to move us toward progress. I'd like to talk about why I see this group being different. What are the distinguishing differences that make this group worthy of our investment and time, and what will -- how will we change the world? I think we're different -- our difference can be expressed

really in two words, and that's market power. That's a blunt way to put it, but let me just acknowledge that sitting at this table, as we have gone around between the Department of Health and Human Services and the Veteran's Administration and the VA and all of the public health community and various private employers who just sit at this table, let alone private employers generally represent a huge segment of the health care system, but in particular, let me just focus on the federal players who are at this table. We represent, by my calculation, north of 40% of the dollars that are paid in a $1.8 trillion segment of our economy.

Now, when I became Secretary of Health and Human Services, and it became evident that this was going to be part of my task, I consulted with a lot of people about, and there are -- you know, there's this very active discussion of what the federal role ought to be. Some would say, "Look, you know, you represent 40% plus of the market, you ought to just move. You have the ability, just go out and get it done. There's a lot of agreement. There's just been -- we've been decades now, waiting for something to happen. It's happening in places, it's not lining up, people are using different standards, the federal government is the only place where there's a concentration enough of power to make this happen in the market, so you need to vote with your feet and get this done." Others would say, "If the government takes this on, we won't do it right, and we've got to be very careful not to interfere with the innovation of the marketplace." It's become very clear, I think, to me and to everyone else that there does need to be a federal role here. we do need to lead with our feet, because we do represent a substantial amount of the market, and unless the federal government, unless government generally acts to create the momentum, the forward-leaning momentum, it' going to be difficult to bring this quite diverse market together.

On the other hand, we need to move in the right direction, and without being able to have consultation and direction and help and the full involvement of those who are the innovators in the market, who actually create the innovation, we might move the wrong way. This is really, then, a marriage between the market power of the national and local and state government, and the innovation power of the marketplace. Now, that's one of the things that makes this very different, I think, from other opportunities we have. What this represents is a collaboration. I'd like to just give you a sense of my thoughts about this. I see the world beginning to intuitively organize itself into networks, not just in the technology sector, but in every sector. Nations are beginning to weave themselves into networks. The EU, for example, is a group of countries who were operating as mainframes, who all decided to operate like a group of networked PC's, and we're seeing it in business, we're seeing it in medicine, we're seeing it science, we're seeing it in war, we're seeing it in virtually every aspect of society. Intuitively, we're beginning to organize ourselves into networks. A collaboration, in my judgment, is simply the sociology of a network and learning to bring diverse portions of a society together to work together in networks is the new frontier of human productivity. I believe what we represent here is the emergence of a new set of skills that society is having to develop. How do we organize ourselves to create momentum in networks, and what we see represented at this table is an opportunity to begin that process.

Good collaboration is a lot more than just compromise. It's just -- it's more than sitting down and splitting the difference. They're problem solving expeditions. They create tireless momentum toward a defined end goal. I need to confess, and all of you know it, they're sometimes -- they're messy, they're difficult, sometimes they're complicated, but in markets this complicated, they're absolutely indispensable, and that's what the community is about, is creating a network to begin moving forward. I'd like to speak frankly about how the influence of this group actually converts to action. The community is a federal advisory committee. I want to make the distinction that we chose not to call this a committee. We chose not to have the title of this be commission. We chose to have it community, and we'll talk a little bit about that in a minute, but the charter empowers the community to serve as an advisor to the secretary of HHS. That is the form of collaboration that was available to us. It may not be ideal, but it nevertheless is quite workable. I will, of course, need to maintain the autonomy of the office that I have sworn to uphold. But I'd like to make clear that it's my intention to weigh very heavily the advice that I receive here. It will, of course, need to be converted to action, and I want to make clear to you that intend, as secretary, to act. And by act, I mean to imply that there are certain regulatory authorities and capacities that as Secretary of Health and Human Services, I have to be able to implement in a broad sector of the healthcare industry, because of my relationship with the payers, meaning Medicare and Medicaid and the Indian Health Service and FDA and others, certain directions. There are others at this table who have similar capacities. The Department of Defense, the Department of -- Veteran's Administration, at the Department of Commerce, in the form of NIST.

So sitting at this table is the capacity to take the best advice, and to begin to implement it in a place where it can, in fact, effect a profoundly important part of the healthcare market. Also sitting at this table are others who have influence in the -- among private payers. So, what we're talking about here is organizing the capacity of a collaboration to move into action. Once we have made decisions on a path forward, I intend to take those decisions and to implement them in the form of whatever regulatory action or rule is necessary for us to implement them, and it's my expectation from our conversations that the same will be done at the Department of Defense and the Department of Veteran's Administration and other departments represented in the public health sector that are here. It's my hope and belief that the same will be being to occur in other sectors, because when you move 40% of the market, it's going to move the market. Our objective here, with having this blend of market innovation and market capacity is to bring a marriage together of those two, so that we can, in fact, move forward. That is what I believe makes this a unique moment in the -- on the pathway of health IT. Now, it's clear that in some of -- in some cases, for us to implement as a federal government, we'll need to work through the Department of Commerce at NIST, and there will be certain occasions where that will be -- occur, and that's why it's so important that Michelle and her colleagues are a part of this. I mention the word "Community." I want to emphasize it again because, there are seventeen people who sit at this table, and seventeen people do not a community make. There are thousands of people who have been working on this for a long time. Most of you mentioned, as you introduced yourselves, that this is -- you're here representing some, not just group of interest, but some perspective. That's a

very important thing for all of us to remember. We are all here representing different perspectives, not different constituents, but different perspectives. And in terms of being able to provide advice and then being able to hook it to the gear of progress, will require all of those. There are hundreds of groups that continue to meet and make great contribution to our effort. This community, the American Health Information Community, needs to be the hub around which all of those other activities operate, and the place where advice can best be consolidated and then implemented. I want to give you a couple of examples.

The National Committee on Vital and Health Statistics has a significant expertise. I'm delighted that Dr. Simon Cohen is here. Where is Simon? Oh, he is not here. But, I've had extensive conversations with him and they've indicated a desire to continue their important work but to make it accessible to us to be an important part of this community. The same thing would be true of the President's Information Technology Advisory Committee and many others. Dr. Brailer mentioned that we have been laying a foundation for this work over the course of many months. Yesterday, as a matter of fact, we announced there's a signing of some agreements on the development of a Standards organization. The Health Information Technology Standards Panel has been engaged. Why is that important, and why is that significant? A good share of our work, in order to move forward, will require a conclusion on what the standard should be. There are dozens of Standards organizations. I've heard David say the great thing about Standards is there's so many to choose from. That doesn't work in its totality. Ultimately, there has to be a harmonization of those Standards. Therefore, it will be very important that we incorporate into this, the work of the Health Information Technology Standards Panel.

If any kind of a system's going to work, there has to be a certification process. There has to be some means of creating an independent group that is outside of government that can look at products and independently say, "We're going to certify that as compliant with the Harmonized Standards". Not to tell people how to write their software; not to tell people how to solve their problems; but to make certain that there is a harmony about what we're doing to move forward and to create a sense of certainty in the marketplace. The bottom line here is that if you're a Standards Development organization, I'm talking to you. You're part of this community. We need your help. If you're concerned about privacy and confidentiality, I'm talking to you. If you're involved in groups and organizations, we need to have their assistance and their help. And we need to have this community serve as a hub to be able to bring that together. I will be bringing public dialogue in as part of this. We'll have meetings; we'll have workshops, forums, symposiums, mini-summits and maybe some major summits. The point is, we're working as a community.

Now I'm going to be asking all of you, as part of your work in the community, to lead working groups, because we will quite clearly identify tasks that I'll refer to today as Breakthrough Tasks. I'm a big believer that to get things done, you need a task, and in the context of that task, you're able to break through different obstacles that were there to begin with, but it needs a context. I'll talk a little more about that in a second. I'd like to talk a little bit about how we operate as a community, as a collaboration. I mentioned the

fact that the way this vehicle of a FACA is established, our role is to advise the Secretary. I want to operate in a collaborative way, and I want to move with a Model of Consensus. Let's talk about what consensus is. To me, consensus is not unanimous agreement. We likely won't reach unanimous agreement on everything. I intend to manage our group, as Chairman, in a way that will determine when we are, for the most part, in agreement. Because this is advice to the Secretary, we're able to do that. The measure of our success will be that, at certain points along the way, we're going to reach Milestones of Conclusion. And when we reach those Milestones of Conclusion, if as the Chairman, I have bypassed dissent too many times, it's going to manifest itself because the majority of this group isn't going to agree. And if that's the case, then it will be clear to me that I have not managed that part of the process adequately and will have to recalibrate. But my purpose isn't to sit around and have a lot of votes. We will vote when I need to have a point validated and to understand with certainty whether or not we're on track. But for the most part, I intend to try to keep us moving forward in a very constructive way so that we're not bogged down in details that might not be as weighty as the conclusions otherwise would be.

Now let's talk for a minute about our agenda. I think it's important to acknowledge that there's a significant number of crosscurrents that we're dealing with environmentally here. One of them is the tension between the adoption gap which exists, the clear manifestation that a lot of small practitioners don't have access and that there's a disconnect between those who have to ultimately pay for the technology and those who get the benefits of it. So it manifests itself in a crosscurrent of pressure between adoption and interoperability. I want to be clear that I believe we have to deal with both problems. Unless we're able to create adequate adoption, interoperability is a hollow victory. On the other hand, it's my belief that adoption will never adequately occur until there's a level of certainty about the market. I was out at Stanford, Craig, a couple of months ago and I stepped up to the bench of a new Pathologist who was just about ready to leave the University and go to practice law in another western state. And he said, "I've heard your talk about Health IT and I want you to know I agree with it; I just need to know what to buy. I can't afford to do this more than one time and I've got to be right. Just tell me what to buy." Well I couldn't tell him what to buy with exactness. But it pointed out very clearly to me that a small practitioner needs certainty if they're to have adoption. And we could spend a trillion dollars on creating adoption and if it didn't connect with other people, it would do a lot less good than, I think, what we aspire to do.

So here's the point I want to make: We'll take on adoption, both as a department and as a government, but our efforts here need to be more about how to create connectivity and interoperability. There'll be lots of opportunities for what we do to contribute to that, but this is primarily -- needs to be about achieving interoperability. Second point: there is a cross pressure between, what I'll refer to as, the pure vision of interoperability and immediately available progress. There are -- I think all of us have in our mind, some version of the pure vision, where everything goes into the right block, and everything is uniform, and everyone used the same term for everything else, and information is electronically exchangeable. And I think we all have some version of that vision. And that vision changes over time. It also changes with the perspective of the person who is

viewing it. But there is, in all of our minds, a pure vision. That pure vision will take a decade or more to achieve. And it will only continue to get better over time; it will never be finished. On the other hand, we cannot just look for the immediate progress that's available unless it somehow connects up to a pathway that will lead toward that pure vision. So part of our job here is to balance the immediate available progress with the long-term pure vision. And I believe that can happen. We have seen it manifest here in our discussions already. There's another rather significant cross pressure and that is: What should the emphasis of our effort be? Now we've talked a little bit today about immunization records. That's a very clear consumer or retail manifestation of the benefit. We've talked a little bit about the Avian Flu; I'm going to talk more about that in just a few minutes, and the need for electronic health records to be at the heart of our biosurveillance. We've talked about the need for hospitals to more efficient. Those represent, in some ways, three different constituencies of benefit. While all benefit from all three, some benefit more from others. Part of our work together has to be finding a way to merge those communities of benefit and to find the balance.

I'd like to talk just for a minute again about the importance, in terms of our agenda, of action. I indicate I thought the most significant part of our capacity to implement was our market power that's represented in the federal expenditures. There's another one. And that is the belief on the part of the marketplace that we are going to act. I believe that World of Health IT watches our progress carefully. And if they see us bogged down into an intransigence that looks like many other groups that have occurred over time or what they might otherwise expect of something that's sponsored by the government, we will not have succeeded. However, if we can choose a series of early breakthroughs and accomplish them, the combination of that action and our ability to move the market with our expenditures, will signal great progress. I want to give you just an example of how I believe, or why I believe, we can act quickly and we can act in ways that will profoundly change the health IT community. Lillee mentioned her personal experience with her family in New Orleans. I experienced it. I went to seventeen different -- Bill Winkenwerder did as well; Julie Gerberding was with me -- we saw -- I went to seventeen different cities and saw in seven different states. It became evident to me that there is somewhere around a million people, maybe more, who are now functioning in the world without healthcare records.

I sat at the side of a cot with a woman who told me about watching her purse and her false teeth walk out, wash out, the back door from the top step of her landing. And she said, "I'm sitting here without any clothes to change into. I don't have my Medicare card. I don't have a clue what my prescriptions are. I know I'm supposed to take a yellow pill everyday about noon. Don't know the exact name of it; don't know the dosage of it." Well, by my estimation, there's something we can all agree to and implement. And I believe that's what brings this group together with such potential -- I said I wasn't going to talk about potential -- so wouldn't make such progress.

Now with that, let's talk some about the way we're going to go about assembling a decision on how we will proceed. My grandparents lived in a little town called Bunkerville, Nevada, my father's parents. Almost always when I would go to their house

as a young kid, there would be, on a table in their living room, a large jigsaw puzzle, one of those several thousand piece versions. My grandmother was quite a puzzle solver, and she had a quite deliberate way of going about it. She would lay all the pieces out on the table. And then over the course of time, she would begin to sort them by creating the border pieces. She'd look for all the pieces that had a straight edge and then she'd line them up so that there was a border. Then she'd start looking for the corner pieces. Now once it had taken that much shape, then they would begin to sort them into piles that had different colors. And then she'd call the family together, and every member of the family was assigned a different sector on the puzzle to work on. And over time, every piece would, one at a time, be put into place, and over time, it'd just get a little easier because you could see what piece you were hooking to. Now I believe that we are, here in this community, essentially, solving a puzzle.

I would also suggest that to a large extent, we have aligned the border pieces, and we've begun to put in the corners in the form of a Standards Organization, in the form of a Certification Organization. Soon we'll put into place an architecture…we're in the… very soon we'll put out a -- announce the results of an RFP that will begin to allow us some alternative architectures that we can choose from. But the next step will be for us to begin to divide up the pieces of the puzzle we want to solve first. Now the logical thing to do is to divide them into some categories. And so I'd like to suggest today that we divide our tasks, or potential undertakings, into three general categories. One would be consumer related endeavors, or what I'll call, consumer empowerment breakthroughs. Now what am I talking about here? One of the things I would say about our movement of Health IT is that it has not yet fully engaged the imagination of the consumer. It has primarily been about making hospitals' and doctors' work more efficient. Or it's been about being able to create large public health benefits. All those are important and crucial to the economic equation, but they have not yet captured the imagination of the American people.

As we talked today, there were a few things that did. Very clearly, Michelle talked about, "It's a priority for me to have an immunization record." You talk to about any mother with preschool children, and that'd be a good thing. If they could go to the Internet, despite how imperfect it might be, and have a record of when their children were immunized, that's a winner. There would have been a lot of people in New Orleans and Mississippi and Louisiana and Alabama who would've been delighted to have the capacity to go to the internet and be able to pull down a record that may not have been interoperable in its entirety, but if it had just… if they had a PDF of a lab report, or a doctor's diagnosis record, it would've been terrific. And while that is not exactly the pure vision we're after, the technology exists for that to occur and to occur soon. And I believe that's what we're talking about when we say, "Let's begin to work toward the pure vision." But let's not let perfection -- in every case I know of, incremental progress toward a pure vision trumps perpetually deferred perfection. And that is what we're dealing with here: is finding ways to move toward the pure vision but, at the same time, take the available opportunities for progress. So the way I would like to pursue our agenda: we have identified in advance of your coming, and I think they've been reviewed with all of you, fourteen potential puzzle parts. Now I want to be clear that this

is not an exhaustive inventory of puzzle parts. This is where the community aspect of this comes to play. There will be lots of ideas. And what I am hopeful of is that, over time, you will put those ideas, either by talking with interests that you…points of view that you have, or if you have ideas, or if the public would like to come in with a puzzle part that they'd like to have us consider in putting this puzzle together. That will become an inventory of, quote, "Breakthrough Projects". In our work, we will then begin to look at those and conclude which ones we want to undertake. And then, just like my grandmother, we'll organize some workgroups. And I'll ask one of you, or two of you, or more, to Chair that workgroup. Then we intend to go into the broader community and identify the best people we can, the people who would need to be at the table if we were to use existing technologies, etc., who can make it happen. Just like the Katrina Pharmacy Project: if we identify the task, and then send them out to figure out how they can do it, we'll ask them to bring it back, we'll want to filter their product through our Standards Harmonizing effort, we'll want to make sure that whatever they come up with is consistent in terms of certification, and we'll begin to build this puzzle. Now over time, the same thing will occur that will happen in a puzzle. The picture will become perpetually clearer, the parts will become easier to connect, and the momentum of our progress will accelerate.

Now I'd like to, when we have had a break, I'd like to begin looking at potential puzzle parts. I would like to tell you about one puzzle part that I believe is a compelling national interest. It does not fall into the consumer category. It does not fall into the category of Personal Health. It falls into the area of public health. I mentioned earlier, in casual comments that Dr. Gerberding and I are going to be going to Asia. We'll be visiting a number of different countries over the course of a week. We're there to deal with the potential of a Pandemic Influenza. It is of vital importance that, in this country, we have the capacity to identify when such a virus begins to present itself in the United States, if it occurs or when it occurs. Our capacity currently exists because we have devoted people, in emergency rooms and clinics and other places, who can identify the symptoms and begin to report them through public health channels. Regrettably, that often takes two and three weeks for the dots to begin to connect when it happens more than once. That's unacceptable. It needs to be two or three hours. Because our capacity to respond, in either a pandemic situation or in a bioterrorism event, absolutely depends on our capacity to define the area in which it's occurring. So I would like to ask that we put forward, as one of our first breakthrough projects, a system of biosurveillance that would allow us, in the most sophisticated form possible today, given what we have, the capacity to accelerate dramatically reporting of public health incidents related to bioterrorism or pandemic flu or other public health threats. Now that's the only puzzle part I have absolute certainty about. It's one on which I believe we have a responsibility to act.

Well, in summary, I do believe this is a unique opportunity. We're connecting market power with market innovation with a commitment on the part of 40% of the medical market to move. It will require us to balance between the various competing priorities. But we'll do it like a puzzle. We'll break it down into small parts, and we'll begin to build it into, what I believe will become, an increasingly clear picture. I intend to devote substantial time to this personally as I have asked all of you to. We'll be meeting

somewhere between every month or every six weeks. But in addition to that, I'm going to be asking you to deploy on a lot of these workgroups. This is going to be an active group. I've indicated as well, that I think our success is dependent upon our ability to deliver serious momentum and action.

That means that when we have active, I have to act as Secretary. It means that the Department of Defense has to act. It means the Department of Veteran Affairs needs to act. It means that the Department of Commerce has got to be prepared to act if we're to use this market power in a productive way. I'm very hopeful that a significant group of private sector employers will come forward and that they will also commit themselves to adopting in the same timeframes or faster than what we do. It's my fundamental belief that if we don't lead the market, we'll be a drag on the market. And if we're a drag on the market, we will have failed. And I have no intention of failing, and I know that's not the reason you're here either. With that, we have time for a break and we'll come back and if you have any comments about what I've suggested, we'll take a few minutes to do that, and then we'll get right down to dividing up puzzle parts. Thank you.

[break in audio]

Secretary Michael O. Leavitt:
-- or comments about them that would be appropriate. So, Dr. Brailer.

David Brailer:
Okay, thank you Mr. Secretary. We have assembled fourteen potential breakthroughs and I'd like to describe the concept of a breakthrough. These are health information technology applications and uses that could produce a specific and tangible value to healthcare consumers that could be realized within a two to three year period. There are three categories: consumer empowerment, things that are aimed at bringing consumers more directly into healthcare, health improvement, which is how doctors, nurses and other clinicians do their work, and then public health protection. These breakthroughs are not an exhaustive list as the Secretary described. This list is a compilation of archetypes, of categories, of types of breakthroughs. And we will be asking, after you do your prioritization discussion, for these to then be staffed over the course of the next month to develop specificity around the particular goal, charge, timetables, barriers, etc. So this is not, again, exhaustive and there are many others that we'll be adding.

The first category is consumer empowerment. In this category, the primary example is the personal health record. The personal health record is something that an individual can use to access their information: prescription, lab, test results, claims data, allergies, etc., that an individual can use to access information about their children, perhaps, if they're ill, or about their parent, if it's an ill parent. These tools are used to communicate with clinicians and to be able to track health status and to integrate personal health information with advice and other treatment options. Any questions or comments about what is intended by the concept of the personal health record?

Secretary Michael O. Leavitt:

Let me just speak and say that, obviously, this can take a lot of different forms. It could take what's available at any a number of large hospital groups or software where there's an individual, but I think what we're looking for here is the ability to create something that's more universally accessible. I've had conversations over the last little while with a number of different people who've made the point to me that, if I had the ability to even have access to something that's available on an already commercially available format. I used the term earlier -- the example earlier of a PDF. If I could go to a website and, say, assemble my health records. I want to request, from the provider, access to my records that I own and have availability of, and I'd like you to put them into a PDF format so that they could be assembled on my behalf. I'm prepared to take the responsibility for the privacy; they're my records. I'm not asking to have access to your system; I simply want to have access to my records. And I'd like them to be able to be sent to me electronically in a form that I could have them assembled somewhere else. Now, in a very simple way, what I would then have is -- I would have my, potentially, have my immunizations, I'd potentially have my lab results, I'd potentially have the information I needed. So I think we're talking about a large range of potential options here, from something quite basic like that that could then begin to lead us toward the more pure vision to, what Dr. Perlin described as available at the VA where -- and actually, what Mitch had carried in with him.

E. Mitchell Roob:
Yeah, I brought that up.

Secretary Michael O. Leavitt:
Yeah.

E. Mitchell Roob:
Exactly what you said is right here.

Secretary Michael O. Leavitt:
That's exactly right. Now the problem with what Mitch has is he got that, I assume, from one hospital system.

E. Mitchell Roob:
No, actually…

Secretary Michael O. Leavitt:
Did you not?

E. Mitchell Roob:
These are three different, all Indianapolis hospitals.

Secretary Michael O. Leavitt:
Okay, so that's an example of the kind of a thing that we're talking about, where through some available formats, a person could assemble, on their own or through the help of some commercially available service, information and data that I have a right to and

would like to have. Now I want to acknowledge that having my health records available on an Internet site that might be secure does bear some risk. But I'm not speaking here in terms of my public policy half. I'm just saying that Mike Leavitt would really like to have that, on me. And so that's one idea that would have, I think, some consumer appeal to it, and would begin to connect consumers to this idea of having access to their own information. And if it were available, we would begin to migrate toward the pure vision. So, any other comments or thoughts about it?

Male Speaker:
If I could add to that. And that's sort of along the vision that we have with the consumer based company where we'd like to pull information and create accountability with the consumer. And I think that right along creates an accountability model for the patient or the consumer or the employer, whoever it is, and they're responsible for owning their information. And that will help them begin to make better decisions and to use that information. That, to us, is scalable because you could do that worldwide in addition to the U.S. So the concept of creating that power and accountability and the responsibility for the patient to fill the gaps. And if you cannot have everything electronically available, meaning, to take your idea that it may take us ten years, while in the beginning, if they can go and assemble it. And if they get a piece of paper, but they can actually input it themselves, that will get them along in engaging in these situations. So, I think that's the right thing to do.

Secretary Michael O. Leavitt:
Good comment. Chip.

Charles N. Kahn III:
I think there are just a host of issues here though, and I won't go over all of them obviously, that you immediately get into here, but at the very face of it, that we have the problem of the interface between paper and anything else, that, and then, there's also one of time. How time sensitive is this? And second, I don't know whether if I called my Internist today, he would be willing to give me my record. Obviously, that's always an issue. But if he was, he's going to say okay, but if he had to give the record to every patient and he only has paper, and most of those files are this thick, then the question is: Who's going to make the copies to make the PDF? So I -- oh, who's going to do the scanning? So I think that we're immediately getting in -- one of the problems with, actually, each of these items is that, even though in itself, at the surface, it seems like a baby step towards, you immediately get into all of the issues of infrastructure and the underlying issues of problems because there's going to be an interaction of paper with anything that is futuristic and electronic with most people. So I just thought I'd bring that up.

Secretary Michael O. Leavitt:
And this is a really important point, and it's natural that it would come up in the context of the first one, because I'm guessing it could be said of any of them. But it's a good way for us to illustrate, in my mind the way I believe we ought to work together. Everything you say, Chip, I think is true and ultimately will be true of all of these. What I would see

us as a group doing is we're defining the "Where," where do we go, and we would then organize a workgroup who would have people with the right expertise to identify the issues and to flesh them out, but more importantly, to come back with what are potential solutions that could be harmonized with other solutions and move us toward a good puzzle piece. And then we'll come back and have a conversation. And we may conclude that the steps necessary to get to that vision may be more than what are prudent to undertake at this moment. On the other hand, we may say maybe only one or two or three percent will avail themselves of it in the initial stages, because there isn't a clear business model about who's going to pay for the conversion of the scanning and so forth. But if we create the technology, the Harmonized Technology Pattern, where it could happen, then the market will begin to drive it, and people will figure out the business model. They'll figure out whether they want to offer it, and the market will begin to allow those things to unfold. And so I would like to just say, what you're asking: exactly the right kind of questions. And I want to -- we need to do that but that's where I see this heading: as a question of what do we take on and as a matter of problem solving. Nancy.

Nancy Davenport-Ennis:
My comment, I think, from the perspective of the consumer and the patient community, is that indeed, I concur with all that you said Chip, but I think that the consumer community and the patient community has demonstrated to us over and over again that, if they are taught, if they're instructed, what their responsibility is in the new process, they will engage on it. And it may take ten years before all consumers would have access to their personal health records or electronic medical records. I think, from the consumer perspective, it's a fair statement to say that in moving forward on this particular item, we would have to spend a fair amount of time addressing concerns around privacy and security. Because that is absolutely been expressed to us in the conversations we've had with groups across the country as one of the major concerns. And while patients see huge benefit in having access to this record, and they want to have access to it, they know two things: it's going to take the cooperation of every medical provider for them to have that, and number two, it's going to take assuredness that their privacy and security as it relates to job discrimination, future health insurance discrimination, life insurance discrimination, ability to borrow money and that type of financial discrimination, they're protected against. But to me and for those that I'm here to represent, I think this is one of the very important breakthroughs that we would like to see as a result of the work.

Secretary Michael O. Leavitt:
Doug.

Douglas E. Henley:
Well, two comments and then an observation. I totally agree with Nancy. This is important work that we're about, and you have stated that very well, Mr. Secretary. And at the end of the day, it's not about doctors, it's not about hospitals, it's not about vendors, it's about patients and improving the quality of care, improving the safety of the care they receive and making the system more efficient. At the same time, there is unique value now manifested significantly in the literature about the value of each person having a personal medical home. And when that usual source of care relationship exists,

quality goes up and cost efficiency is improved. Revealing a bias as a family physician, there's also significant literature that shows when that personal medical home is with a family physician or another primary care doctor, that quality equation increases even better, and the cost efficiency improves even better. It's important, then, as we talk about personal health records, electronically, that the technologies, the architecture, the standards, whatever we may be talking about, that they are integrated so that patient-physician relationship is enhanced in that process. So that the patient can get their information when they need it and want it, so it's not site specific, but yet, that the flow can go back and forth between the personal medical home and where the patient is.

And even in a paper-based system today, there are those technologies that can do that. And they are innovative, they are simple, and we can make that happen. We need to continue to push the healthcare System to become fully electronic. But even in today's world, the electronic solution to this issue is there. And we can make it happen but, again, it has to be integrated so it flows across the back and forths of that patient-physician relationship, patient-provider relationship, is further enhanced.

Secretary Michael O. Leavitt:
I want to go to Kevin and then I'd like to -- I want to go to the next one, and we'll come back to these as we go. Kevin.

Kevin D. Hutchinson:
Just some brief comments echoing what Chip said and also what Nancy was speaking of as well. One of the things we have to consider, and they also represent [inaudible] ancillary services [inaudible] the sources of the data. There is a lot of information in healthcare that is electronic at one stage in the process but is turned back into a paper environment -- whether that be lab results, whether that be medication information -- that at one point is in an electronic state. And we need to consider, as we're looking at all of these different elements, where're those sources of information, at those points that they are electronic, and how we can gain access to that, whether it's in a personal health record, electronic health record, or other means. One of the things that we learned during the Katrina Health Project was around authentication. So privacy and security as well, but authenticating that the individual is who they say they are, whether it be a physician - in this case we were very fortunate to have the AMA involved in the project to help us authenticate physicians and physician access to that. But that's a big piece of a lot of these different elements, is around authentication.

Secretary Michael O. Leavitt:
Very good. Now the next two or three begin to look like subparts of what we just talked about. So I think it's a question of what we've just looked at as the whole pie. Now let's take a look at small pieces and see if they're incremental. David.

David Brailer:
Sure, the next is medication history, which would be a compilation of someone's prescriptions, potentially over-the-counter products, but certainly prescriptions, as was evidenced in Katrina Health. The purpose of this, as many of you know, is to have that

information available both to the consumer, to their clinicians and to other people that need it, either because of episodic care or events like an evacuation or many other things. And this is directly linked into the advances that are happening with the prescribing and other components of healthcare electronic advances today. There probably are other, if you would, silos of information, could be lab, etc., but the sense in this evaluation was that the highest value, easiest accessible sub piece of the personal health record, is the medication history.

Secretary Michael O. Leavitt:
Why don't we go to the next picture --

David Brailer:
Okay sure.

Secretary Michael O. Leavitt:
-- the balance of the consumer empowerment and then come back and talk with them about them as a group.

David Brailer:
Sure.

Secretary Michael O. Leavitt:
I think that makes more sense.

David Brailer:
Good. The next is even more scaled back from the personal health record, which is health record locator, which is simply an index of where data exists for that person. It's a set of pointers, if you would, that could, perhaps, either show electronic data or even paper data that has faxable access, or telephone numbers to call for the information, or perhaps other ways to say at least, "Here's who has my data, and here's how to find it." This is at the core, as many of you know, of the centralized personal health record to start with, and either could be a stepping stone or it could have its own intrinsic value, but in itself would not be the data, it would be the indices or the ways to find the data, if you would, their tags or pointers. And then finally a piece that is, I know, talked about often by many people here today, is a central set of registration information, demographic related, insurance pair information, information that could be used whenever one arrives at a doctor's hospital or handling the components of explanation of benefits on the aftercare side. But this would be, essentially, a single, centralized, updateable database for each person that any person that wants to get access to that, and then an insurer and a provider, a lab, could access this to make it easier for the patient to not fill out those forms. So this is the electronic clipboard, if you would, in terms of signing on. These are four categories, four types of things, and as many of you know, there are many other variations of this. But we've tried to summarize both from the high to the low, the types of ways that personal tools for consumers could come together.

Secretary Michael O. Leavitt:

Could you take some time, David, and just elaborate on the range of sophistication or the ways in which -- how elaborate these could be, what's the range -- I said elaboration but, what's the range of operation these could take, for example, there's a lot of different ways a registration system could be configured from, that would require some kind of electronic connection between all systems which is much harder to reach or some internet based system. Can you…?

David Brailer:
Sure. Maybe starting there and working up, clearly, there could be, for example, a web portal that someone could go to and manually enter in updates of their home address, other things, that could then be accessible, simply as a web portal by any doctor, hospital, Lab, who wanted to access that. It'd become more, if you would, automated to be able to be tied into practice management systems or billing systems, etc. And so the question here is how integrated is, to Doug's point, into the systems of those who access it. The health record locator has various ways it can be constructed but in its essence, it's quite simple. It is an identity of a person, either that is provided by a data holder and some information about a URL web address or access codes or a phone number or a fax number for that data holder. And the question again becomes how much tie-in this has to other systems. Is it a web accessible system that identifies how you key into it, or is it simply the phone number to call? And most of these projects that are happening in regions around the US, they're quite diverse. The system is online; it does have a web access tool. If it's not, it simply does have that phone number. And so it's quite, if you would, flexible in terms of the various types of data. The medication history, to Kevin's point, would be aggregated from the electronic data holders at this point. The reason Katrina Health was able to make rapid progress is because that data -- a large share of the data was held by a very small number of entities, because prescription data has become so concentrated in electronic ubiquitously throughout the industry. The question here, again, is not, "How do we put the data together?" but, "How do we automate the access tools to electronic health records or to other things?" And there's a great degree of variability, each with more value, each with requisitely more barriers to cross. So I think that's a question of how far we want to go. Does that answer your question?

Secretary Michael O. Leavitt:
It does.

David Brailer:
Good. Thank you

Secretary Michael O. Leavitt:
Let's just have some discussion now. Craig.

Craig R. Barrett, Ph.D.:
Just back to my earlier comment which is, the internet as an entity allows one access to essentially all of the world's information except for medical records, today, and if I typed Michael Leavitt into a Google or Yahoo or an MSN search engine, I would get hundreds of thousands of entries and probably could find out all sorts of information about you.

I'm not interested in knowing your health record but the fact that it contains so much information with standard technology, it's just inconceivable to me that you can't engineer this system with the existing technology to also provide a personal health record to allow you, in cryptic fashion or password protected or biosensor protected, something, that you could have your record inputted, and not being in the medical community and recognizing that 80% or more of the records are paper based, as you point out very clearly, you can scan those in in a metadata format and be able to search them as well as you can search electronic input. So I just want to encourage the community to recognize that this vehicle already exists, to search and sort information, with existing technology. We are just not using it, in this particular case.

Secretary Michael O. Leavitt:
Thank you. Yes.

Female Speaker:
I wanted to weigh in on the side of this part of the breakthroughs really represents personal accountability. And I think more accountability that we push to the consumer, the better. I'm personally accountable to pay my taxes. I'm personally accountable to stay healthy. I'm personally accountable for my social network that's my family. I don't depend on anyone else to be accountable for me, and when I was talking to Dana [spelled phonetically] when we were doing our download in preparation for her meeting with you around these breakthroughs, it just struck me with what I see happening in Louisiana, Mississippi, and Alabama right now. Who knows how many medical records are already underwater and irretrievable? We'll never be able to scan them. It's an imperative that really has been heightened by this national disaster. But it does put accountability back where accountability should be, and that's to the consumer.

And I honestly think consumers would be very excited to be a part of the process to make it happen. Because as we went around the table, I was really struck with the individual stories of frustration around, I couldn't get this, or I couldn't get that, or if pushing the accountability to the consumer is the right thing to do, and the sooner we do it the better we all off will be. This is a matter of, not debate; it's a matter of a place where we've really got to act quickly.

Secretary Michael O. Leavitt:
Yes, Scott.

Scott P. Serota:
I'll make a couple of comments. I think, conceptually, I don't think there's any way to dispute the fact that this is the direction that we need to go. And I support the notion that the technology already exists. The issue of personal accountability is also one that, from the payer's side, we believe is essential if we're going to keep healthcare affordable, as to begin to get people more accountable. My concern relates to health literacy and the fact that we're going to begin to ask people to do things that in most instances, they're ill prepared to do. And I think it's important that if we move along this path of personal accountability and personal health records, it's got to be coupled with some mechanism

to improve the health literacy of folks, because you can't ask people to be accountable for things they don't understand. And we have a large portion of the population (I don't know, somebody probably knows the statistics, I don't) that either don't have access to computers, or are not computer literate. I'm worried that we may exacerbate the uninsured issue and create even greater spreads between the haves and the have-nots in the industry and in access to care.

So I think, as we look at this, we have to look at it in a broader context of, not just people sitting around this table who'll say, yeah, that'd be great for me because I understand it and I know how to do it. I think about my father, eighty plus years old, down in Florida, who doesn't know how to turn on a computer, and say, "Well now you're going to be responsible to make sure your records are okay." And he's going to say, "My what? My -- I don't know. I can't find it. I don't have a computer." So I think we have to look at it in the context of a transition. Of course, my kids and all of our kids, no problem. They'd go down there and take care of everybody's records for them. But I just think we need to be sure that we look at it from that broadest possible perspective, and when we give people accountability, we make sure we also give them the tools to accept that accountability.

Secretary Michael O. Leavitt:
Dr. Kolodner and then we'll go to Nancy. Do you want to comment?

Robert M. Kolodner:
Thank you Mr. Secretary. I think one of the things that we've heard is this issue of personal accountability. And since we're getting started and not trying to force it on anybody but have people choose and raise their hand to move forward, that making these available and possibly having people choose which parts they want to have, is really the way to move forward. And I think that what we've seen in VA is that the people who are, since 49% of our patients are over 65, and obviously that the Medicare population falls into that, the issue of privacy is less important than getting the information to their providers. So there'll be groups of people who will choose, either because their risk takers or because they trust the technology or because they don't have a job that's at risk or health insurance that they consider at risk, and their health is more important, they'll choose to join in. And I think the other part of it is, that even if a solution has a technology base, it doesn't mean that the person has to be technologically savvy; they can have somebody do it on their behalf. And there will be entities that will arise. Just like a bank takes care of my money – I don't need to know how to do the transfer. There will be trusted entities that people can turn to. Or even for older family members to the younger family members. So, again, it's important to, although there may be a technology base, it doesn't mean the person using it has to have the technology. They may have something mailed to them on a quarterly basis so that they have the information on paper.

Secretary Michael O. Leavitt:
As I move down to Nancy, I'll just say the last two months before Katrina, I went to 51 cities in 32 states to talk to seniors about the Medicare Prescription Drug Rollout. And

what it provided me was a one on one opportunity in a small group setting with literally thousands of different seniors. It really sensitized me to the difference in circumstances of different seniors. And how many of them are dependent upon their child as a caregiver, on the other hand, there are many who are quite engaged and just want to have control and what I hear all of you saying is that some people would benefit differently because of different circumstances. Nancy.

Nancy Davenport-Ennis:
I certainly concur with all of the comments that have been made around this particular subject, but I think that the community would have an opportunity as we are looking at how do we implement a Breakthrough in this area for consumers that we build a deployment vehicle and process that would be sensitive to the fact that some are going to have access to web-based information. We have others that due to geographic constraints still would not even if they had a second generation of people to help them with that. And so the community perhaps can be sensitive to developing a deployment prescriptive model that would say in different circumstances this is how you could still have access. And then moving back to the patient accountability and the cost that may be accrued to the system to make these records available. I think that's another area that we need to engage the consumer and the patient community. Because I think the experience will be that those who can indeed afford this at any level are going to want to participate. Those that cannot perhaps again we can address a system where they can get there in an alternative manner.

Secretary Michael O. Leavitt:
Thank you. Chip.

Charles N. Kahn III:
I think this is an important point. I hate to keep using the Katrina analogue, but if we look at Katrina, there were a million people who figured out how to get out of New Orleans and there were 200,000 that didn't. And if we sort of want to carry this, I think we need to be careful wherever we go, that there will be even maybe a majority of people who could figure out how to navigate. This issue of literacy is really critical. On the other hand, we sort of look at the dynamic of who's more likely to need this system and be sick versus who's not, probably that 200,000 uses a lot more healthcare proportionately than that million because of the nature of those populations. So I think whatever we do, accountability is critical, but I think we have to be realistic about accountability. And I don't know where that gets us, and I don't know where that gets us in terms of cost. But that's got to be there, because, as we were saying, my sisters can figure out, they're in their forties, they can figure this all out. I just know from dealing with my parents and dealing with the drug benefit of my parents in the next few months after trying to deal with the other card, we've got this great experiment now, this national experiment, and I think it's going to be about a 60% success. The trouble with it is, I think we just need to use that natural experiment and understand that we got to worry about the other 40% of people.

Secretary Michael O. Leavitt:

Craig.

Craig R. Barrett, Ph.D.:
I just wanted to point out was that with all of the discussion of access to computers and the internet, etc., I find it really interesting that we're here in the United States talking about this subject. If you go to a country like Brazil, which has far less than 10% of the PC or Internet Subscriber penetration. Over 95% income tax forms are put in online in Brazil. So it's entirely possible for countries with essentially no infrastructure to go 100% electronic in something like filing tax forms. We may be discounting the ability and the capability of the average citizen in the United States to use this capability. Discounting that substantially in this discussion.

Secretary Michael O. Leavitt:
Let's go to Mitch and David and then -- Kevin, did I see your hand?

E. Mitchell Roob:
Mr. Secretary, I'm a bit more optimistic in terms of where the Medical Records are today. In the case of Medicaid, we could probably reconstruct most of those systems out of claims data in Medicaid systems today, so for the least insured most at risk patients, we probably have somewhere in your databases that you guys fund, you probably have a lot of that information already. And in public health clinics that provide a great deal of the indigent care, those records likely exist electronically in more cases frankly than the folks who are privately insured. So I think frankly on the lower socioeconomic status, you may be farther ahead than people who don't deal regularly in that patient population might think.

Secretary Michael O. Leavitt:
You know, Mitch, your comment is a wonderful illustration, of I think, this tension we talked about earlier of pure vision versus immediate progress that begins to migrate toward the pure vision. Here's what I mean. It appears to me that there are two very difficult places to penetrate and you may not even want to go there in the long run. One is the sanctity of the database owned by a provider. If I'm a provider, I've got very serious worries about anybody going into my records. That's a bad place for anybody to be who is not authorized to be there for very specific purposes. And I think that's going to be a place that's going to become somewhat sacrosanct. The second area is the degree of risk aversion that every individual feels in their own situation. For society, I feel very protective of the capacity to protect their privacy. As an individual, a lot of this is convenience for me. I'd just like to have it, and I'm prepared to -- some people are willing to say, look, it wouldn't be the end of the world if that happened to me, but I ought not to give that up for anybody else.

And so what I see ultimately happening here is we continue to work toward the pure vision, and the pure vision in my mind is somehow the capacity for the data is resident in everyone's system is electronically interconnectable and the person that is not naturally capable or for whatever circumstance is not able, to use that data on a voluntary basis, it would be available to some caregiver who would want it. If I'm an emergency physician,

and I have someone present it to me, it would be very helpful. You hear people talk about -- and I'm not here in any way to promote this idea, but you hear people who talk about having a chip under your skin and a physician will be able to hit it, and they'll know where you live and your Medical Record. Well that would be a very helpful thing to an emergency physician. It obviously has lots of other concerns. So I think the two areas we've got to be very careful of not doing anything to, at least in the early stages of this to deal with, is access to people's systems and the violation of people's right to choose how their data is used. What I hear us talking about in my mind moves around both of those issues because people get to choose their level of risk and they are…no one is going inside anybody else's system. There may ultimately need to be either a market incentive or a reason for people to send data out to me, but it doesn't penetrate either one of those sensitive areas. Other comments. Yes, Michelle. And then back to…

Michelle O'Neill:
I'd like to just take a slightly different perspective on this issue. In looking at the overall architecture and thinking about, and I think this is characterized as, particularly with the "My Health Record Locator," as being a stepping stone if you will. We see enormous benefit in starting -- as that being a good starting point because it starts to answer critical questions about where is the data and how do we find it. And I think if you look at that as the underpinning of some of the other parts, subparts, and then the overall record, it'd be an interesting place to get started and I think, could launch into the other aspect of the --

Secretary Michael O. Leavitt:
What I hear you saying is that if I had the ability to walk into a clinic, and they handed me the clipboard, and I could at least say to them here is the way I identify myself and go on the internet, and it will pull up my name and address and my latest information on insurance and so forth, and it could go into some kind of standard format, that that would at least be a big step forward.

Michelle O'Neill:
Yes.

Secretary Michael O. Leavitt:
Yes. Bill. And then Doug.

William Winkenwerder Jr.:
You'd asked for, initially, our thoughts about these areas, the four areas, just to get back to some of the basic thoughts that I agree. I think from our perspective, from my personal perspective, these are the areas to focus on in terms of consumer involvement and empowerment. But secondly, I want to just comment that there have been some very good comments here and concerns, expressed objections, maybe, about certain things. But I think one of the things that the group might well turn its attention to, and I suppose we'll have to be careful about this, but is getting better educated about what is working. Craig gave an example about something that's already happening. There's lots of those examples. And I think it could help alleviate some of the concerns frankly about privacy,

confidentiality, about how this particular thing can work or not. And so there are many examples out there.

The final thing I want to say is just that sort of the principle that it's been our experience in looking at the progress we've made in the Department of Defense in the last four or five years in this issue, and we believe we've made huge progress, is that much of that has been born out of necessity and if there's a sense of necessity, for example, we had been promoted to really make a quantum leap on the health information that we collect on our service members on the battle field. Now that's probably about as difficult a place as you can imagine to try to collect health information. But we do it today. We do it electronically. We're able to move that information back to our Central Data Repository here in the United States. The reason, though, that we did that frankly or focused so much on it in 2001 and 2002, is there was a terrible track record from the 1990's, I think people knew from the first Gulf War, about all the illnesses that people came back with. Much of that couldn't be determined because there were no good records. It was kind of the Katrina situation, in essence. So we were really sort of on the hot seat to make something happen. Another example is we had an area of security break-in three years ago into one of our facilities and some records were…personal information was stolen. And it was a wake-up call about what we needed to do in the area of security, so we had a massive overhaul of our approach to security. Today we feel like that's something we've got tacked down pretty well. So I think we've all got examples to share of things that work, that address some of the biggest and most difficult problems, and I think that we ought to turn our attention, as we have the time, obviously time is short in these meetings, but it's a good thing to do.

Secretary Michael O. Leavitt:
Good. David. I'm sorry. Kevin.

Kevin D. Hutchinson:
I go back to your analogy of the puzzle and the pieces of the puzzle, and actually as you talk about personal health records, there's been a lot of work done in this area, specifically the Markle Foundation has a task force that they've looked at this in depth on personal health records that David Lansky has led. An area that's interesting is to do the analogy of the Personal Financial Record. And if we go back in time and back into the Quicken and Microsoft Money and when we all started using these things, we remember that we were writing checks but we were inputting information into these applications but had no connectivity to banks, originally to do this, so the value and the number of people that found value in those applications, I am an admitted Geek of technology, so I was one of the people entering in all of my checks only to print them, sign them and stick them in the mail and mail them to someone because I wanted the graphs and pictures of my Financial Record which I never used. But then there's the day that I could actually get electronic access to my bank and I was now able to do reconciliation of my statements. That was valuable. And now I have a lot of information in there to do some values estimates. And then we moved into the investment community where you could actually get your investments online. It became much more valuable for people to start using it. It goes back to the source of the data.

If you take the puzzles, actually, there are pieces within this that we have to focus on going back to the sources of information that is electronic today. And I hear time over again from physicians, I know this is about consumers on this particular piece, but if I could just get to labs and meds and some other key elements, I could learn a lot about a patient just having that information in front of me. Now it's not a complete record, but it's a start, and there's value in that and the same thing with allergy information. And as we look at these pieces under the personal health record, I think that's something that we actually have to breakdown. It's not the complete record day one, but what are the elements and the pieces that we can deliver that will bring the most value.

Secretary Michael O. Leavitt:
That is a terrific illustration of the pure vision and the integration of immediate progress moving toward the pure vision. Never thought of that. What I -- if I understand what you said is you started off as a very early adopter --

Kevin D. Hutchinson:
I said I was a Geek. Yes.

[laughter]

Secretary Michael O. Leavitt:
And over time, as that progressed and their ability to interconnect with data that you were manually putting in or that was electronically being placed there but not able to interact, ultimately, that came to have a lot of value, but if you hadn't gone through those early steps, the ability to get to the pure vision would not have existed.

Kevin D. Hutchinson:
And I don't think the major market will go through those early steps. But I think we're already at a point in healthcare where we can take advantage of some sources of information that is already in electronic form to leapfrog those manual entry steps. Now there will be some manual entry if they want to add to the record themselves. But we already have sources of data that could be electronic from whether it's pharmacies or payers or labs, that would be able to input and send this information electronically into these records.

Secretary Michael O. Leavitt:
I guess another thing I'm taking from your comment is that if only 10 or 15 or 20% of the population takes advantage of those early adopter steps, it does provide value. But it provides value to everybody, because as you get to the pure vision, then those who benefit in the last traunch of adopters have benefited from what has been learned in the capacity of society to move in steps toward the pure vision. Julie. And then…

Julie Louise Gerberding:
I was just -- I'm thinking about your analogy to the banking and recognizing that there's kind of a third step and that's when the bank begins to send you information or alert you

that there's an action that you need to take or a problem with your account or something that you need to do, and these elements of the personal health record would also lend themselves to that kind of alerting. You know, you're 50 years old, you need those 50 year old tests, or you need to seek medical attention for this, that, or the other thing. So there's a way to tie this into the second category here, of Health Improvement, without relying on the consumer, per se, to have the knowledge to make use of the information directly.

Secretary Michael O. Leavitt:
Mark.

Male Speaker:
This is a general point relevant to these four ideas as well as the others, and I'm wondering at what point do we bring this in, and that is what are the specific, not the general, but the specific policy levers that will bring this about? And that's important because as we prioritize, obviously, we want something that has a very high probability of achievement and in a quick framework, so we have to have some sense of how that's going to happen. We may not know all the details at this point, but we have to have a little bit of a sense as to what's doable and how it can be done, in particular, in the -- Mr. Secretary, as you indicated, that there's a lot of market power here around the table, but in a little more specificity, what are the policy levers that are going to be used in any of these projects?

Secretary Michael O. Leavitt:
It would seem to me that that clearly has to be part of this discussion and maybe one of the things that gets teased out by a workgroup to bring back to us. And that part of the assignment of a workgroup needs to be: what are the public policy implications of this? And then have a full discussion of it. Good point. Someone else raised their hand.

Female Speaker:
Yeah, just building off…

Secretary Michael O. Leavitt:
I'll go to you, Doug, after that.

Female Speaker:
Building off of that concept, CMS has recently requested for some public information through a request for information on what the agency's role should be in trying to encourage the use of personal health information and PHR adoption, so we're in the process of synthesizing through all that now and working with Office of Civil Rights and thinking through it and current law, what are some appropriate first steps we could be taking, not only in getting a lot of claims data out that could be both Medicare and Medicaid data but how do we actually think about, through our current authority, what we can do as an agency to push this forward. So I think that really will fit in nicely with any kind of workgroup that's formed around this.

Secretary Michael O. Leavitt:
Good. Thank you. Doug.

Douglas E. Henley:
I want to make two points. The first thing goes back, Mr. Secretary, to your exchange with Michelle about the demographic data of a patient, registration data, stored someplace, and they walk into the hospital, the physician's office, whatever, and they want to, rather than fill out the clipboard three different times, they say, my data's available on "www" whatever, or it may be on a memory stick, and here I give it to you or give you access to it. So to reinforce my comments earlier about integration or interoperability, it's one thing to have the patient, in this case, in control of that information, which is great, and for updating purposes, etc., but most places in the system now, forget EHRs for a moment, most places have, for want of a better term, Practice Management Systems in their electronic. What we don't want to have happen is for the patient to show up with a memory stick with that data or the website and somebody to have to go to it and have to re-key and re-enter that information. It has to be able to flow into that reception, into that other system, freely, interoperably, so that hands don't have to touch it anymore in terms of the mistakes that could be made. That could be a PHR, it could be allergy information, it could be medication information. And we don't want mistakes to be made so wherever the data is, it has to integrate across various sites of service and flow freely from Point A to Point B to Point C. So that's point number one. Point number two: I think Craig alluded to this, and I hope I interpreted his comments, and this may not be the right place to say it, but I've never been accused of being bashful, so I'll go ahead and say it, that it appears to me, and I'm not a Geek in this area at all, but it appears to me, that we always talk about technology in healthcare as somehow different than technology in the rest of the world, and it can't be that way. And my impression, at this point in time, having put some emphasis on this in the last couple of years, is that a lot of the technology in standards and healthcare are old, and they haven't kept up with the marketplace, the marketplace being the rest of the world, whether it's the banking industry or wherever it is. And somehow we've got to integrate that as well, and we've got to get over this idea that the technology has to be different for healthcare. Now there are different requirements perhaps in healthcare that it needs to meet and different reasons and so forth. But the technology needs to be seamless throughout the whole world, not just in healthcare.

Secretary Michael O. Leavitt:
You know, your comment about the integration of the data? I could tell you what I have in my head. I would like to have enough of a standard established, that the providers -- I guess there's some two hundred vendors that make practice software. It would seem to me that if we could, through this process, create enough of a standard, that the way information was recorded at a website or on a chip or whatever the medium of carriage is, that they could then begin to adapt over time, their software, so that when I gave it to them on a chip or it linked to the internet, or whatever it was, that it immediately populates the fields that require my insurance information for the seventh time. And if they want to have lots of different things, they can have it. But what we have is an opportunity to create that standard so that they can begin over time to adapt. And I think

the market does adapt to it if we create it. Now this has been a really helpful conversation. Oh, did you have a comment?

Steven S. Reinemund:
I just have -- I would like to make one comment to try to tie Kevin's and --

Secretary Michael O. Leavitt:
Okay.

Steven S. Reinemund:
-- Craig's comment together, and a lot of comments. Do not underestimate the power of the consumer to adapt, to accommodate, and to get where they need to go. And if I think about it from PepsiCo's standpoint, we decided to go into a Wellness Program a year and a bit ago, right. And we had 80,000 people that we wanted to make it available to, and we wanted to do it web-based, and we wanted to -- and we had every debate about privacy, and they won't be using the technology, and we have frontline people that don't have access to computers -- and we went through the whole thing. So we went out -- but we did it anyways. And 27,000 people of the 80,000 signed up. And 92% of those people gave us a personal health assessment, not us, but web-based. And as a result of that, 8000 people are in personal coaching right now for health-related issues to change their behavior. Now, it's not perfect; it's got all kinds of issues, but this year we hope to have 45,000 and then run those numbers through. So they got there and, you know what, they have personal health records, they're putting in by manual, they're doing it, they're printing it out like you do and come to the doctor, but that's way better than sitting around saying, you know what, until we got the perfect solution, we wouldn't get there. And I believe that the consumer will adapt, just like they started with Quicken, and they made their way to my mother who, at one time, I had to show her how to use the microwave, now calls me and blackberries me. That happens. And that's the progress that she's made in her lifetime. And that's what we need to -- and so if we just keep that positive vision moving forward, we'll get there. And you'll make mistakes; the consumer will reject some of it, but don't try to get it perfect before you go.

Douglas E. Henley:
Has your mom figured out how to use her VCR yet?

Steven S. Reinemund:
I can't figure that out yet.

Secretary Michael O. Leavitt:
You know, my mother discovered email. I mentioned I came from a family of five -- six boys. We all get what my brother calls low overhead lectures now on email from my mother. She used to call us. Now we just get it by email. If you're out there mother, I apologize. I came into this conversation with this thought in mind: I thought if there's a feeling among this group that, to go to the first step, which is My Registration Information, that might be a good place to start and test out one of workgroups. And I've got to confess to you I'm emboldened a little by what I'm hearing around this table. And

here's the conclusion I think I would draw, and let me just express it and see how the rest of you would respond to it. It would seem to me that a workgroup that could explore the boundaries of this some, to say: what is available? How could a system work? What would the public policy implications be? What would be the ramifications of registration, and what would be the ramifications of a health locator? What would be the implications of a medication history? What would be the implications of a more full-blown vision be? And to have them bring that back here for our discussion would be a very productive step. And I'd like to just get your reaction to that.

Secretary Michael O. Leavitt:
Bill.

William Winkenwerder Jr.:
Good idea. Good idea. I'd suggest, as well, if we have some examples of things that are working that can be shared and people could maybe read up on ahead of time would be additive so you're not learning when we come here.

Secretary Michael O. Leavitt:
Any other thoughts?

Male Speaker:
Totally agree. As we've all talked, I think the technology's there. I don't think there's anything unique in the healthcare Industry. I think privacy's just as important in financial transactions as it is in healthcare. I think a definitive model brought back to let the group look at something real as opposed to just a hypothetical would be great.

Secretary Michael O. Leavitt:
Other thoughts. Yes, Nancy.

Nancy Davenport-Ennis:
Well I think, Mr. Secretary, as has been pointed out by a number of people at this table, indeed it probably will be small steps. As long as we acknowledge that the small steps will ultimately lead to an inclusive program in the future and still go back and provide alternative ways for more people to be included, even initially. I think it's what the consumer and the patient community would want. I don't think this group can make a decision of how we are going to move forward with any of these without a thorough examination in bringing back a model that could work.

Secretary Michael O. Leavitt:
I saw another hand up.

Female voice:
Do it.

Secretary Michael O. Leavitt:
Scott.

Scott P. Serota:
I'm also supportive. I would encourage us to include the economics, though of -- great idea but how do we pay for it, who's going to pay for it, how the dollars flow in this? But I think further exploration is essential. This is a high priority item that I think would represent a true breakthrough.

Secretary Michael O. Leavitt:
Kevin.

Kevin D. Hutchinson:
I'm all for it as well. I think we also need to recognize that some of these elements, for example, the health record locator, if we limit it to the consumer side, this is an element that actually crosses over into other pieces of the electronic health record and physician connectivity, amongst physicians and to hospitals and other environments at a community level. So as we launch the group, we need to determine whether that's going to be focused on just the consumer side of that health record or is that something that takes on a broader approach?

Secretary Michael O. Leavitt:
Other thoughts. Scott.

Scott P. Serota:
Can I ask a clarification question? The Childhood immunization record: Is it in the right category, or should it be in this category?

Secretary Michael O. Leavitt:
That's a good question.

Scott P. Serota:
Maybe there's a reason that I don't understand.

Secretary Michael O. Leavitt:
Here is the way I think that's answered. I think the way we're talking about it is one step. I think the way it's being thought of in the consumer or in the public health arena is a much different -- is actually a part of the pure vision, where epidemiologists have the capacity to take nondescript data and scan -- have 50 million people and say X, Y, and Z, and we can draw these conclusions. Julie, is that a fair statement?

Julie Louise Gerberding:
Yeah, it kind of fits in all three categories. It has elements of each.

Secretary Michael O. Leavitt:
So we probably ought to look at it in the context of both. Chip.

Charles N. Kahn III:

Can I ask a question? First it says “childhood immunization record”. And it seems to me that, considering the challenges of the future, I’m confused as to why it just isn’t “immunization record”.

Secretary Michael O. Leavitt:
Very good point.

Charles N. Kahn III:
And second --

Secretary Michael O. Leavitt:
Very good point.

Charles N. Kahn III:
-- this becomes really problematic because the childhood immunization record, in general, is fairly easy to grab onto because it’s either going to be pediatrician’s office, a community health center or a public health department of some type, whereas as soon as we’re to adults and immunization for flu, it could be anyplace. It could be my office. It could be with, literally, we do at our office, or it could be at any pharmacy or a whole lot of different sites or a senior center. So all of a sudden, you’re into non-medical environments where the flu shot’s given. And the question is sort of: where is that communicated to? So I guess I’m a little bit -- I wonder do we want -- why are we just talking about kids, or am I missing something?

Secretary Michael O. Leavitt:
I think that’s a very valid point. My guess is, here’s the way it started: while I was Governor, we were the last in the country, I might add, in the immunization rates, and to my wife’s credit, she took the issue on with a sense of passion and brought a lot of people together, and they began developing a system that would remind people of their immunizations and so forth. And it was very complicated, but they made a lot of progress, and I’m very proud of her. And when I became Secretary, I found out that was happening in a lots of other states, too. And that there is maybe thirty, forty states that have a similar system. None of them are compatible. That makes Dr. Gerberding and her colleagues at the CDC crazy, because they’d like very much to be able to gather data from a lot of different places in an appropriate way.

So I think those records are primarily children’s records, but I think you have raised the vision here. That we’re going to Asia because we might need, at some point, to immunize every man, woman and child in a very rapid way. And if we know who that’s occurred for and who it hasn’t, it would be a very helpful process in being able to protect the country against a pandemic or a bioterrorism event, or whatever, so that’s an important contribution. Here’s where I think we are: I think the proposition is that we create a workgroup whose purpose would be to assemble a group of public and private members who could begin to frame in the world of what’s possible with existing technology, to take an incremental step toward the pure vision of interoperable health records. That they would explore the public policy ramifications, the economic

circumstances, the privacy implications, and bring back to the community, a discussion of what would need to be done to begin implementing, in the context of the entire personal health record, not simply the component parts. And I believe on that proposition, I would be prepared to declare a consensus. And I would like to propose that we bring back then, or I will ask the staff, to bring back to our next meeting, such a -- by that time, assemble a group, create a formalized charge and a timetable, a work plan and whatever budget requirements they would have, for discussion here. And if we can then -- if we can agree at that point, or if we can reach a consensus on it, I will then implement it as Secretary. Alright, with that, let's go on to the next category of which would be health improvement, and I'll ask Dr. Brailer to begin the discussion there.

David Brailer:
Okay, thank you. There are a number of things in the health improvement category. And again, these are illustrations, and they're somewhat all amorphous and overlapping. The first is one that many of you know well: the electronic health record, which is the primary tool that clinicians use, or would use, in their interactions with their patients, communications with each other, treatment decisions, collection of information and potentially communication with payers and other entities. This is an effort that's gotten a great deal of attention, and so I think I will let it stand at that. Secondly, is E-prescribing, that as many of you know, is the, if you would, the subset of that that involves the selection of medications, the transmission of information related to those, the checking for formulary, drug-drug interactions, drug allergy, other parts of the patient communication, etc. This is an effort that's already underway because of the Medicare Modernization Statute, but we felt that we should include it for completeness sake, because it does provide a mechanism to carry other efforts forward.

Third is quality monitoring and reporting, which is standardizing the means by which we are able to collect information from practices about quality and performance, so that it reduces the burden on those practices being able to report this information, makes it easier for a variety of different entities, public and private, to be able to collect, analyze and report that information, and to have enough cell size or volume of information to make meaningful interpretations. At the same time, there's a, if you would, an educational or disseminational component of how that information can be made available to the public, to payers, to other providers, other entities, to be able to make decisions based on that information. CMS has numerous activities going on with this, in the private sector, NCQA and other organizations do, but the sense is that there's a chance to have a much more streamlined and standardized architecture to make this easier, more complete, and more meaningful. Fourth is chronic disease monitoring, which is a very large collection of ways in which we can use electronic methods to monitor health status of people that have chronic illness; their self-medication, self-treatment, indicators of forthcoming acute illness or the capacity of them to manage their own illness to reduce their dependency on in-patient and other high intensity services. These could include home monitoring, personal device monitoring, automated weight monitoring, a variety of other solutions. So this is a large category that falls somewhat into the disease management category or into new methodologies for monitoring health Status. But this chronic disease monitoring area is one that is -- certainly has been highly discussed by

many people. We have talked about the immunization record, the childhood immunization record, being a subset. And certainly with a childhood immunization component would involve a very relatively narrow subset of providers and involve the parent as advocate on a broader basis, as we just discussed, as a very broad set of information collection. Employee empowerment tools are a collection of methods that allow those who are starting to manage their own financial risk under healthcare, to have tools to help them select providers, select treatments, being able to understand their own health status issues, etc. Again, these are in the context and could be overlapping with the consumer empowerment methodologies but we saw within the spectrum of how particularly people are managing their healthcare in the workplace. There are many other manifestations of this in other populations, but this is the one that had been identified as a key component.

Secretary Michael O. Leavitt:
An observation: as I have studied these, there are some that link back to that consumer discussion we just had but unlike that consumer discussion, these appear to me to be more freestanding, while linked like the puzzle, they are more freestanding as projects. And that doing what we did on the previous one, which was to say, "Let's look at the whole thing at once and then pick the component parts after we've had a chance to look at it", probably doesn't work as well here. It seems to me that in this group, we ought to pick, one, at the maximum two, to begin developing a workgroup on. I'll just tell you one that kind of -- this is revealing an early bias, but it will be instructive at least, this chronic disease monitoring. I am seeing a huge movement toward chronic disease monitoring of all kinds of the -- in wellness programs: diabetics being tested at home with the capacity to send information to their physician. A lot of chronic Heart -- the physicians here will be able to tell me more cases where I see it. But the device business and the ability to monitor at home and then have it link into an electronic record, looks to me to be a very big part of the future. And one of the things that inhibits it appears to be a lack of standards in terms of how that data is communicated technically and what the various metadata formats are. So that would be a place where, if we were to embark on that particular one, we'd need to bring a group together and I think bring it back, we'd drive the cause forward quite a bit if we had that, but it's likely a different proposition than what we were talking about before. So let's just have a discussion on the whole class of activities and talk about which ones. Chip and then Mitch.

Charles N. Kahn III:
Well, in terms of this class of activities, one that I sort of gravitate towards is the quality monitoring and reporting. And let me just say a couple of things about it. First, I see this as potentially a subset of all the activity you're going to have on the standards side, because in terms of creating sort of connections between what are being expected of records and put in records and then made standard so they can easily be transferred to CMS or to others collecting information with hospitals. That's where we sort of need to get it all together, because we're being asked through the hospital Quality Alliance, and there's an ambulatory side to this too, to collect information on measures, and right now, that's done in all different kinds of ways, and there's a system for collecting it but we have very few measures. As the number of measures increase, we've got to do it in a

way that's going to be seamless. And one of the things that the hospital Quality Alliance has hopefully undertaken, although I'm not very confident of that yet, is trying to get the Joint Commission on Accreditation as well as CMS to sort of merge their activities of collecting information from us. And I guess I would suggest, in terms of this piece, that there be some coordination or interface between the process where we have to sort of have one-stop shopping in terms of where we're sending the information, with what's implied here, in terms of sort of, the collection of the information. And that that effort sort of be brought, whatever kind of task force you set up, be sort of brought into the fold so that all that's being done together. And I think that if proper priority is set on it that we can, over the next couple years, sort of settle that and just have one repository of information, but then that has all kinds of implications for standards and everything else you want to accomplish.

Secretary Michael O. Leavitt:
I'm just sort of inclined to reply. This is a huge area of the future: Medicaid, Medicare. It's going to be a conversation that pressurizes very quickly on Capitol Hill because of the physician reimbursement rates and the connection that it has here. A step forward on this would be a remarkable contribution. I do see this as a highly complicated, difficult area that we need to take on. The question is going to be: is it the first one we take on or do we need to take it on with a longer term perspective because it's going to take a while? It looks to me.

Charles N. Kahn III:
I guess I'm arguing that one, other people are already thinking about it so that I think part of it is the question of the interface between this group and that. And second, I think going back to your whole point about visioning, if there isn't developed a specific plan, even if it's a three year plan, --

Secretary Michael O. Leavitt:
Right.

Charles N. Kahn III:
-- it's never going to happen. And there'll be pieces of it that happen, but it's never going to happen in a coherent way that's going to do anything but burden providers, frankly. So I guess my argument would be that I'm not sure that this group needs to play the key role, but it needs to play a role. And it could help energize the others if this group was looking over their shoulders as they were trying to set their agenda.

Secretary Michael O. Leavitt:
Well then the truth is, your point is well taken. If that vision is not possible unless it's part of some form of interoperable --

Charles N. Kahn III:
Right.

Secretary Michael O. Leavitt:

-- pure vision. It doesn't work to do performance, Pay for Performance, for example, unless you've got some way of measuring performance and doing it in a broadly accepted, automated way.

Charles N. Kahn III:
Right.

Secretary Michael O. Leavitt:
And so all of the public policy conversations in the world won't work unless we're able to get down to the -- so we may want to -- let's continue the conversation and come back to it.

Charles N. Kahn III:
Okay.

Secretary Michael O. Leavitt:
Julie and then we'll come right down the line.

Julie Louise Gerberding:
Yeah, I just wanted to mention a relatively small lane in this category of quality monitoring that is maybe a test bed for these ideas and that has to do with the reporting of hospital infection rates which, for more than twenty years, has been done using some standards for what's in the data elements and more recently, under John Lunke's [spelled phonetically] leadership, a standardized reporting format has been created, and now that hospitals are being to asked to report their infection rates at a state basis, many states are adopting this system as their method for reporting hospital infection rates. So it might serve as a useful test bed for exploring this idea on a broader scale.

Secretary Michael O. Leavitt:
Thank you. Good comment. Others had -- Lillee and then we'll go straight down the line.

Lillee Smith Gelinas:
Straight down the line. This is one that's not new. As you know, when we were talking on the phone, I said, "Gee, I'm only from Acute Care. How's that going to impact things?" But this is one, clearly, that we understand well. It frankly scares a lot of people, because what we will do in this whole quality monitoring and reporting piece that's being heightened by the Pay for Performance movement, or as we like to say at VHA, it really is "No Pay for Poor Performance," is this notion of making transparent bad care. There's a lot of bad care going on right now in America. And you read the Rand Corporation and all the evidence around, really Americans only get about 55% of the right care on any one given day. So this aspect is highly charged, scares a lot of people, because it's going to make transparent the bad care, which is actually the right thing to do.

A question that I wanted to pose is: How does the VA and the Department of Defense do this, because they are such a bright spot on the horizon to strive for, how does the Department of Defense and VA do this and do it in a meaningful way? And are there as many gaps in practice in the Department of Defense and the VA as we see in the public sector? Because I was sharing at break, when I went from the Navy Nurse Corp to Civilian Nursing, I thought we had just lost our minds in the civilian sector. There was no centralized area for healthcare information. All of a sudden, no one place had information. And it seemed extremely fragmented, which is exactly what it is. So if I could pose that question to those two colleagues, if that's possible.

Secretary Michael O. Leavitt:
Yes, please.

Male Speaker:
You want to talk? We're both interested in talk about this.

Robert D. Kolodner:
In VA, we have combined the information systems along with performance measures, and so we've used a performance measure where, when we started this eight, ten years ago, we had the starry, starry nights in terms of the scatter of total range of performance and each year, we raise the bar. So, I believe the next year's target is the fifteenth percentile so we know that 15% could do it, and that becomes the floor for the next year. And that's how we achieved the kinds of performance that we have where on these eighteen Performance Measures of Chronic Care and Prevention that we now set the benchmark in that. And that's taken time, but it's a matter of driving it forward and giving feedback, not only at the regional level, at a hospital level, but at the provider level.

In the DOD, because we are both a health plan and a healthcare delivery system, we use both sets of measures. We look at Health Plan Performance, and it's the same measures, HETAS, we benchmark and look at how we do, and we do pretty well. In healthcare delivery, we're looking at the same measures, and we do pretty well there. But I think it would be a mistake to suggest that that journey of continual improvement is an easy one. It's always difficult because you're talking about dealing with providers, changing behavior, actually doing something about the poor performer. And so that's always a challenge. But what I would say is that we have good visibility about the data that relates to performance and, of course, there's a bit more of an infrastructure to take action. On the other hand, we don't maybe have the same pressure that might exist in the private sector from the consumer, though our beneficiaries have every right to information and so forth that civilian consumers have. In fact, many of them are Civilians; they're retirees. But, I think the marketplace helps make things move, too. So it's a combination of activities, but the data is key.

Secretary Michael O. Leavitt:
Good. Thank you. Lillee, did that respond to your --

Lillee Smith Gelinas:
That was great, thanks.

Secretary Michael O. Leavitt:
David.

David Brailer:
Yeah. Thanks. I'm going to be known as the consumer maniac on this panel, but I'll start with that same premise again, that an informed consumer is better than an uninformed consumer. An informed consumer will effectively make good decisions for themselves and for the system overall. And if you get the vote on your -- I think you offered up -- I think you start the ball rolling down the track in this knowing it's going to take a longer time, but in the end when you bring information together to the consumer to decide where to purchase healthcare and where to make the decision, just like they do in any other decision, whether they buy healthy food or unhealthy food, that's where this is going to be powerful and will take a long time to get there. But if you don't start it today, you'll never get to that ten-year vision.

Secretary Michael O. Leavitt:
Good point. Dan, did you have a comment? I'm sorry, Kevin.

Kevin D. Hutchinson:
At the risk of losing my seat on the first day of the council meeting, I'm going to push back on the idea that these are silos, because in my mind, these are very much connected. In contrast to the first category of breakthroughs we talked about, to me, this category is about the feeder system or the infrastructure that's needed to feed data into the healthcare system in an automated fashion. Whether it be on quality monitoring, or chronic disease monitoring, or E-prescribing, or these other scenarios, it really is looking at what infrastructure is required to feed these systems. It's interesting as you get into E-prescribing and chronic disease monitoring, so many people think of E-prescribing as being new prescriptions and renewals going back and forth between a pharmacist, patient's choice of pharmacy and a physician. But the reality is there's a lot additional clinical exchange of information, allergy information to exchange between physicians and pharmacists as well as medication history information to be exchanged along with that, to provide a safer infrastructure for that. On chronic disease monitoring, it's very much related to E-prescribing, because one of the elements I didn't see in the paragraph, but I'm sure it's implied in here, is around medication adherence and compliance. Because given that the vast majority of care is in the outpatient environment, in those single-doc practices in those environments that one of the major tools is around Compliance. And I think there's been a number of studies that have shown the value of patients being in compliance with taking their medication and lowering the cost of care and improving the quality of care by staying on those medications. And I think as we look at chronic disease monitoring, we should consider the fact that 15% of the physicians in the United States write 50% of the prescriptions, and 30% of the physicians in the United States write 80% of the prescriptions. And so you have a unique population in that outpatient environment to really focus on improving chronic disease through

monitoring adherence and compliance. And the infrastructure that actually allows that to happen is the ability to exchange prescription information between these providers.

Secretary Michael O. Leavitt:
Dan.

Dan Green:
On the topic of chronic disease monitoring as a purchaser of health insurance and healthcare, it's been a frustration of mine for a number of years. Many of our insurance carriers come forward with perfect logic saying that what we need is to deal with the cost of healthcare and the suffering of healthcare, is ways to identify, not just monitor, but to identify people with chronic illnesses, and to help them monitor their illness, to seek appropriate solutions and care for that illness and be empowered to be responsible for their own chronic care. And given that the old 80-20 rule works where 20 or even, I've heard, 15% of the patients, the enrollees in a health plan account for 80% or more of the cost of that care for your insurance. It's of course been of particular interest to us, and so we have gone, and we have agreed to fund many efforts by Blue Cross, by all of our other carriers. What winds up though being frustrating is: did it work? And identifying -- having that feedback loop to evaluate the success of the programs. You get anecdotal information, a lot of anecdotal information, but whether to measure it in any substantive way, whether it's cost or healthcare Improvement or satisfaction from your consumers, those things aren't really there and any effort that we due it as a community should really focus, I think, have a big strong element in any case, on evaluation and what works.

Secretary Michael O. Leavitt:
That's a thoughtful comment. Doug, did you have a comment you wanted to make?

Douglas E. Henley:
Yes Sir. Building on Kevin's comments, I would totally agree. In this section, it gave me the most angst in terms of looking at this as pieces of a larger pie, and I think here we need to look at the whole pie. And David started out with his description. He described the electronic health record as the greater vision and then the pieces underneath that. I, again, picking up on Kevin's comments, I think the greater vision is where we need to be going here, and that's the electronic health record: functional, interoperable, connected, integrated. And at least speaking from the physician in me, there is movement there. There is significant movement in the last two years, moving that way. And I think the wave is building and moving rapidly now. And that's where we need to put our efforts.

Wearing another hat, I serve as a commissioner on the Certification Commission for Health Information Technology, [unintelligible] earlier, and on these issues, we have taken the tact that at the CCHIT to focus on certifying full electronic health record technologies. And to the extent that there are others in the market who wish to have an E-prescribing component or a chronic disease monitoring component, they will have to plug and play if the physician community and the others implement electronic health records in their practices and other parts of the healthcare system; if another vendor comes with an E-prescribing component that may not yet be part of their EHR, although

it probably will be, then they'll have to plug and play with the Certification standards from the CCHIT. So I think we need to focus on the big picture here, which is the fully integrated, interoperable electronic health record. And this part needs to be embedded in those systems. If they aren't, it will be inadequate. Just take quality monitoring and reporting. The whole effort will be inadequate and confusing if it's just a gazillion vendors out there just focusing on this one component versus focusing on the electronic health record in which this information, this technology, this capability is embedded already in that system including decision support, etc. And I think we need to take on the whole enchilada here.

Secretary Michael O. Leavitt:
This is really interesting and helpful conversation. Robert and then we'll go back down to Scott.

Robert M. Kolodner:
I think one of the things that's not clear to me yet is the relationship of the community to some of the major efforts that the Office of the National Coordinator is already taking on. So when we talk about HER, is that something that becomes a breakthrough or is that something where it's one of the major efforts, and what we're looking at is something to kind of boost while that's moving forward?

Secretary Michael O. Leavitt:
That's where this begins to reconcile for me. This guy's been appointed to come up with an electronic medical record, or health record. There are component parts to that that are difficult to come up with but the whole effort is about coming up with the EHR. David, I'm going to ask you to speak to that. I will, before I do, just say that yesterday, day before yesterday rather, it's been a big week for Health IT, we put into play a final rule on E-prescribing, and we proposed a rule on some exceptions to the Stark Amendment which will allow hospitals and other medical providers to begin proliferating. And we did it in a very deliberate way. We said we're going to make that exception this wide until we've been able to create a pathway to the electronic medical record until we've got certified systems, and then we want it to be wider. That was a very deliberate decision. And I see the same thing happening for example with chronic disease monitoring. Medicaid, Medicare, Tricare, VA, we pay for a lot of monitoring devices. And at some point, I'm not talking about tomorrow, but at some point it ought to be said that we're going to be more interested in paying for chronic disease monitoring devices that fit into a standard that ultimately can fit into the overall vision. So I guess the reason I saw it fitting into component parts was because we're all about the electronic health record and that somehow we've got to begin to bring these together. Now we came up with independently -- Congress acted on the electronic -- on E-prescribing in the context of saying, "We've got the Medicare Modernization Act and directed the Secretary to come up with rules we've promulgated". I don't anticipate that's going to happen in other areas, and I don't think that's the best way for it to happen. So I've begun to see this -- the reason I've been seeing it as component part is because I see our whole effort being about creating the electronic health record. David, you want to comment on that?

David Brailer:
Sure. I agree with that. It's very clear that we have a charge, and many of you know the things that are under way. You know that we're triangulating a huge amount of federal and state and private sector resources on making the electronic health record come about, and not as a stand alone but part of a continuum in an interoperable infrastructure. And as some of you know, the original draft of this document, breakthroughs, did not have the electronic health record on it because, like the oxygen, we felt like we need not say it. But there was some discussion that I think just to make this discussion very practical, this group must deal with issues that we bring before it around the electronic health record. Our contractors will feed things to you, and your actions will determine things that this man will determine where we will go as a department and others will as well. The question is: do you want to form a workgroup that will take it on and carry it further, or do you believe that we have enough apparatus? Because I think the question of the breakthroughs is about charging groups to go off and do things on your behalf in addition to or in lieu of things that are happening out there. And so I think very practically this is a work management question, not a question of priority or vision or capacity. And I do recognize that these breakthroughs are like, if you'll -- I'll use your puzzle analogy, like a very old puzzle where you can kind of put the wrong piece in. They're hard to break up into discreetized pieces because they're so overlapping. But this is the challenge I think the Secretary's laid out: that we have to find things that we can punch through to create new flounce on this either through or around the electronic health record. So I view this clearly as a question as: Do you want a group of people working on this in addition to certification and standards and architecture groups and security groups, our staff groups, some of your private sector groups, others that are in the room, or do we have enough going there?

Secretary Michael O. Leavitt:
Scott. Excuse me. Robert and then Scott. Go ahead.

Robert D. Kolodner:
At least as one opinion, you've got enough going on and getting more in there in there might actually muck it up a little bit. But as we look across these choices within category, it's really an investment decision. And with that dollar that I invest, do I want something quick, because some of these are going to come quicker, or are there some that are so important that I need to start now even though they won't -- you know, getting the standards in place even though the real benefit of that may not come later? For example, the issue of the chronic disease monitoring, right now, VA has about 8000 patients on home Tele-Health Monitoring of some sort, and we're increasing that about 700 a month. And so we're beginning to get some experience with that and while that's useful, without the mechanism behind it to take the data in and to do the case management, it's an investment that doesn't begin to pay off. But getting the standards in place is important and will, in fact, address that sub-portion of patients who, in fact, disproportionately account for the cost. So there's a payback by getting that as well.

Secretary Michael O. Leavitt:
Thank you. I want to go to Scott and then I'll come to Craig.

Scott P. Serota:
Yeah, a couple kind of generic comments, I guess, and then I'll get a little more specific. We look at healthcare kind of as an integrated system when we're really a cottage industry, and we're really trying to bring this industry together, and that's part of what we're doing here. In that regard, I can't think of anything that we could invest in, in this category, more important than developing the monitoring process, the quality monitoring process. As I speak to our insureds and our customers and others around the country, the pushback I always get is: why can I find out more about a television set or a computer than I can about my doctor? I'm going to get healthcare, and I can't find out anything about that quality, but I can find out every component, where it's made and who's faster and what about virtually any other piece of equipment that I buy that has much less of an impact. And no individual, we insure 93 million people in the Blue system, and we don't have enough. We have 30% of the market; in most places we have 40% of the market. We don't have enough data, even within our database, to do this kind of a monitoring program, because when you break it down to the components of who's performing well in each individual's small category, nobody has enough data individually, so it has to be a collective effort in order for the physicians to believe it has any credibility and the hospitals to believe it has any credibility, because if I just extract my sample, as big as it is, it's still a sample. So we still need more data. So I think from a Macro perspective, we really have to, as a society, totally embrace this quality-monitoring program, for Pay for Performance and any of those things to have any meaning, to really get commitment from physicians and hospitals and other ancillary providers that commit to it. That being said, that's a long -term process. It's not something you're going to wake up tomorrow morning and have in place.

The low hanging fruit here clearly is E-prescribing. There's no question that it's mandated, we can do it, there are short term payouts to doing it, there are quality implications, there are safety implications, a whole host of issues. So I kind of think a balance here of the low hanging fruit is E-prescribing. I don't even know that you need a workgroup that would have to spend a whole lot of time on E-prescribing to get that moving forward. But I think the best investment of our time to put the vision together, I think, relates to quality and performance monitoring because I think that's a big piece that's missing in the system today.

Secretary Michael O. Leavitt:
[Craig? Greg? 6:50]

[Speaker Craig R. Barrett, Ph.D.? or Greg? 6:50]:
I think I want to second both of those comments and make a third. I had my first discussion on monitoring of healthcare and why doctors and hospitals didn't publish the success ratios of things only twenty-five years ago, so I think we've made a little bit of progress since then. But I think it's still a topic which basically covers the waterfront, and it's a huge topic. The charge, I believe you gave us, was to look for low hanging fruit, so I would totally second the E-Prescription issue for two reasons: one, I think there's a quality issue there and an interaction issue with allergies and drug interaction,

but it also drives everyone to become electronic in the system, and it's a simple way to do that. The other area that I would focus on in this collection would be the, I think it was the 85/15 rule that was posed earlier. The people who are chronically ill form a subset of the people who are most interested in their medical history and are most likely to take advantage of the data that are provided. So the topics listed here for short term ROI, I would vote for E-prescription and for chronic disease monitoring, just because of the dollars involved in the one and the subset of the population who are most interested in their medical history and using that information to help themselves. And the other just drives everybody into the electronic system, the electronic world anyway.

Secretary Michael O. Leavitt:
I'd like to hear Nancy's comment and then Julie's quickly and, Mitch, did you have something that you would like to say, too? Okay, if we could make those quick comments, and I would like to try to draw this to a conclusion.

Nancy Davenport-Ennis:
I concur with the comments that were made by both Scott and Greg completely. From the perspective of the consumer, the issue of quality monitoring and reporting becomes, for many, a life and death issue when they're making a decision about where to seek healthcare and the best quality of care that is available to them, and that applies across the board, whether it's a patient with a chronic life-threatening, debilitating illness, or whether it's a parent making a determination of where to go for the best service for a tonsillectomy for an eight year old child. The issue of quality monitoring is being addressed in some of our federal agencies today. We are in the middle of demonstration projects at CMS trying to collect data around the issue of quality monitoring. I fully concur with what Scott had to say about E-prescribing. Indeed, that program is almost essentially in place. It would almost be as though we just simply need to review it and determine if we have any further comment to make to it. With regard to chronic disease monitoring, again, we have demonstration projects going on now at the Centers of Medicare and Medicaid in the area of chronic disease management, and so we may be further down the road in that area than we think today. And if we can retain some of the specialist representatives from the chronic disease groups to work with us in a working group as we look at that particular issue, I think that would be a fairly quick turn around on what we can do in that regard. But from our perspective for patients and consumers, I think quality monitoring and reporting becomes the foundation of the whole discussion of electronic medical records and personal health histories.

Secretary Michael O. Leavitt:
Thank you. Julie.

Julie Louise Gerberding:
Just to identity a different frame on low hanging fruit, maybe this belongs in the public health thing, but I do think there's value of immunization records in this regard as well, and the one thing about the childhood immunization record is that it's probably the only category that has 100% inclusion, because all children are supposed to be, or almost all children, have immunizations, and so you would actually develop a cohort of the entire

population over a period of time as a base for the content of the health record. So it's probably easy, relatively easy, to do because pieces of it already exists, and it would have tremendous value for being able to have access to a population of people over time.

Secretary Michael O. Leavitt:
[inaudible]

Male Speaker:
This is truly a question, in terms of how you define chronic disease monitoring: Do you include the mentally ill and the developmentally disabled in that patient population to be examining or not?

Male Speaker:
Yes we do include people with psychosocial disabilities in that category, but again, this is a very large and amorphous group, and one of the tasks of a workgroup would be to find where are the northbound points? And so we didn't attempt to do that here.

Secretary Michael O. Leavitt:
I'd like to state, I think, a logical conclusion to our discussion and get your reaction to it. What I hear here saying is that there's a broad belief that because E-prescribing has moved so far in advance of our coming and we got proposed rules and final rules and a lot of discussion, that it would be valuable to have a briefing for this group at our next meeting on the progress that's been made and how it would inter-relate with other things. Chip, do you want --

Charles N. Kahn III:
I hate to break in but just on this one, there's no question, whether it's on the out-patient side or the in-patient side, that the technology's there, that you've moved forward with certain standards and regulations. But in some ways, and I'm not sure how the AHIC responds, this is one of the most problematic areas of all in terms of where the rubber hits the road. And I've got many members that are more than open -- they would do computerized prescription order entry tomorrow, which is the in-patient version of that, and the resistance from the physician community is so great that at best, they're on two or three year timelines to try to persuade doctors to do what could be done literally in six months, because the technologies are all there. And on the out-patient side, the exact same is true, is that all the people -- and I serve on the board of one company so I have some familiarity with this -- are still grappling for a business model regarding out-patient E-prescribing because it's just not -- because doctors are just not interested in buying retail, the instrumentation, which is not that expensive, to get into E-prescribing. So I that I think in terms of the reality of it is that the structure, the infrastructure, all that is a no-brainer in this area. The problem is here is the physician community, for whatever reasons, has not moved here.

And I don't know what we can do, because part of this is a business model issue on the out-patient side and on the in-patient side, part of it is just telling Docs they've got to wake up. But most of the hospitals in the country are voluntary medical staffs. So I think

somehow, whether it's moral suasion, or whatever, I think that there is something for us to do here beyond the obvious that's already being done.

Secretary Michael O. Leavitt:
Your comment and Julie's reminds me of an important discussion we need to have on how we order, in the long term, our agenda. If I could paint a picture, let's just assume we have this box of ideas: the puzzle. We've got all those puzzle pieces on the table. I see each meeting. We would analyze our capacity and conclude if we've got the capacity now to move to a different -- to an additional project. And then I would see this conversation taking place where we'll pick one of those up and we'll put it into another area of the puzzle, which is our active discussion area. And at some point, we will move from there either to say, "That's an idea we're going to put back in the idea area" or "We're going to move it forward to a workgroup". Immunizations, I'll use as an example. Clearly, we've got to do that. Question is: do we start today, or do we do it in October of next year, or do we do it in July? And when do we start that in terms of our capacity? I've indicated to you I want to keep our agenda fairly clean at the beginning, because I want to deliver some stuff fast.

So in some ways, Robert's suggestion of an investment decision is very real here. We've got to be investing -- I want to do some short term investments, produce some short term victories, make clear we've got a pattern that can be implemented, but at the same time, I want all of that to be headed toward a longer term vision. And so the natural conclusion, to me, comes to this point: that we recognize that this quality monitoring reporting we've clearly got to deal with. And I would propose that next meeting, we have a substantial portion of our meeting to talk about what this all looks like and how we would best break it up and look at it and split it --and it may be a puzzle of it's own. And we ought to have some sort of committee of the whole discussion of it. I'd like to suggest that, what I'm hearing is that the E-prescribing, that a briefing might reveal other things that can go in the idea box, and that that would be -- but there would be parts of it that would just keep going. And so a briefing on E-prescribing, an active discussion on a path forward with respect to quality monitoring and reporting, and then that we actually form up a group, a workgroup, on the chronic disease monitoring, that I can then bring back here and say, "Here's what the group looks like, here's the work plan, here's the timeframes, here's the budget," and then we can collectively deploy it. Could I get at reaction to that? Could we build a consensus around that proposition?

Male Speaker:
I would agree with that, and I feel compelled to comment on a lot of the discussion on E-prescribing being in the space [inaudible] in the center of all of this. I would absolutely concur with the comments made around the adoption with physicians. It's one thing to have all the pharmacies come to the table, connected and be able to utilize this. Now we have to remind ourselves, as I stated those numbers before, it would be great to get 100% of physicians to do E-prescribing but if you can get the 30% that are writing 80% of the prescriptions in the United States, it's those physician's that we really need to focus on if you're really going to make a short-term impact on the ability to do that. But the financing and the incentives of how to get physicians to adopt those technologies as we

move to that ultimate vision of electronic health records that I 100% agree with is a difficult one.

Secretary Michael O. Leavitt:
We have [inaudible] the perfect vehicle for that conversation in the form of a proposed rule that has now been put forward where we're going to talk about what are those incentives? What's the appropriate thing for a hospital or a clinic to do, with a doctor? How do we create the balance of adoption and interoperability? And so I think that'll be an appropriate space. Any other comments? Bill.

William Winkenwerder Jr.:
Include in the consideration and in the discussion, in terms of getting movement where there's resistance, that we not take off the table, explicit requirements. To be honest, that is what has helped us move forth, not because we're the military, but because we say -- literally, because we say this is what we're going to do. And I know that the VA has had the same experience. We're two large systems. But the leadership -- we're committed. We are going to do this. There will stragglers, yes. But once people know something's going to happen, most of them figure out a way of how to come onboard. And not to be punitive, this is not about being punitive; this is about getting to a better place.

Secretary Michael O. Leavitt:
This is about the marriage of market, power and market innovation. That's exactly the kind of conversation we need to come to. The Chair is going to declare a consensus around the proposition that was stated, and at our next meeting, be prepared to move forward as outlined. The final category I've spoke to earlier of what I believe is a compelling national need on biosurveillance. And given the nature of the time we have today, I'd just like to ask your forbearance in the acknowledgement that I do intend to form up a workgroup. I do intend to bring it back here. It was just something we need, and I think there's a -- you can add a great deal to this, because it will clearly have an integrated piece. It clearly fits into the entire vision we're talking about, but it's one I feel a need with my other responsibilities to move forward. And we'll be reporting to this group back and asking for your advice at the next meeting.

So here's the way I would summarize our conclusions on agenda. One is on the public health side, we will bring a workgroup back with agenda timeframes and so forth on biosurveillance. We will, at our next meeting here, an extensive discussion on quality monitoring and reporting. We'll have a workgroup formed on chronic disease monitoring, and we'll have a briefing for discussion on the E-prescribing. And we will have a discussion on -- we will form a workgroup and bring back a product and a path forward on the whole category of consumer driven electronic records that we'll merge into the pure vision. It's been a very productive morning. And if I read the agenda, we're right on time, and I'm pleased with that. I believe this afternoon, there are a couple of things that need to be accomplished. One is the opportunity for some public comment. And we're going swear you in at 1:00. And we'll have a, as I had mentioned, a public input. I have been asked to attend a meeting with the President in a little while, and so I am going to depart the meeting at this time, and I will ask Dr. Brailer if he will take my

place as Chair. And so I'll be departing, but I want to tell you that I think that this has been a very, very productive session.

I expect our future meetings will be longer than the five hours we've had today. But I think our conclusion was this is about what time it would take for us to tee-up what's necessary, and we'll get into the details of the subjects we've teed-up today and use the same pattern that we have. And your comments privately will be appreciated if you have suggestions as to the way we conduct this. And with that, Dr. Brailer, the Chair would call a break for fifteen minutes. And I believe -- do we have lunches being brought in or are we just going to drive on? [Inaudible] This is the military way.

[laughter]

It is nice to work with people who salute and say, "Yes Sir", I'm sure. We'll have a ten-minute break and convene back at 12:15.

[break in audio]

Female Speaker:
If I can have your attention just for a moment. If you are a member of the public in this room and you would like to participate in the public comment, we have a line forming outside downstairs, and so we look forward to hearing your comments. Thank you.

[end of transcript]