Meeting Report

American Health Information Committee
March 7, 2006

The American Health Information Community (AHIC), a federally chartered commission formed to help advance President Bush's call for most Americans to have electronic health records within 10 years, held its fourth meeting on March 7, 2006, at the Department of Health and Human Services (DHHS), 200 Independence Avenue, SW, Washington, DC, 20201.

The purpose of the meeting was to bring together the Community's 17 members to continue discussion of steps toward ways to achieve its mission of providing input and recommendations to the DHHS on how to make health records digital and interoperable, and assure that the privacy and security of those records are protected in a smooth, market-led way. The meeting focused on an update from the Office of the National Coordinator, a presentation on the Gulf Coast Information Task Force, and presentations from each of the four Workgroups chartered by the Community (Chronic Care, Consumer Empowerment, Electronic Health Records, and Biosurveillance).

DHHS Secretary Michael O. Leavitt chairs the Community. The remaining 16 members, selected by Secretary Leavitt, are key leaders in the public and private sectors who represent stakeholder interests in advancing the mission of the Community and who have strong peer support. Members will serve 2-year terms.

The meeting was chaired by Secretary Leavitt; however, Secretary Leavitt was unable to attend certain portions of the meeting. David Brailer, MD, PhD, National Coordinator for Health Information Technology, chaired the meeting in Secretary Leavitt's absence.

A summary of the discussion and events of the meeting follow.

Call to Order

Dr. Brailer reminded Community members that at the last meeting, four workgroups were chartered and charged with achieving certain consensus recommendations. Toward that end, the workgroups have held several meetings and have made measurable progress towards fulfilling their charges. He thanked Community members serving as workgroup co-chairs for their work. In addition, he recognized staff from his office and from other federal agencies, thanking them for their efforts. Dr. Brailer also reminded Community members that in considering the recommendations of the workgroups, AHIC's charter limits Community members' involvement in making recommendations about fiscal policies.

Dr. Brailer informed Community members that the next AHIC meeting, previously scheduled for April 25, 2006, has been moved to May 16, 2006. Future Community meetings are planned on the following dates:

- May 16, 2006
- June 13, 2006
- August 1, 2006
- September 12, 2006

- October 31, 2006
- December 5, 2006

Before continuing the meeting, Dr. Brailer took a moment to recognize and thank Dana Haza for her hard work and outstanding efforts in support of the AHIC. Ms. Haza is moving to accept the position of Senior Director for the National Changing Diabetes Program at Novo Nordisk. Dr. Brailer again thanked Ms. Hauser and wished her the best in her future endeavors on behalf of the Community.

Joining Dr. Brailer counterclockwise around the table were:

Linda Springer, Director of the Office of Personnel Management (during part of the meeting, Ms. Springer was represented by Dan Green, Deputy Associate Director, Center for Employee and Family Support Policy, Office of Personnel Management)

Douglas Henley, MD, Executive Vice President, American Academy of Family Physicians

Jonathan Perlin, MD, Under Secretary for Health, Department of Veterans Affairs and Veterans Health Administration

Michelle O'Neill, Acting Under Secretary for Technology, U.S. Department of Commerce

Kevin Hutchinson, CEO of SureScripts

William Winkenwerder, Jr., MD, Assistant Secretary of Defense for Health Affairs (Dr. Winkenwerder was represented by Carl Hendricks, CIO of the Military Health System, for part of the meeting)

Craig Barrett, PhD, Chairman of the Board, Intel

E. Mitchell (Mitch) Roob, Secretary of the Indiana Family and Social Services Administration

Howard Isenstein, Vice President, Public Affairs and Quality, Federation of American Hospitals (Mr. Isenstein represented Charles N. Kahn III, President of the Federation of American Hospitals—Mr. Kahn also was represented by Chantal Worzala, Senior Associate Director for Policy, Federation of American Hospitals, for part of the meeting)

Mark McClellan, MD, PhD, Administrator of the Centers for Medicare and Medicaid Services (Dr. McClellan was unable to attend part of the meeting and was represented by Tony Trenkle, Director of E-Health Standards and Services, Centers for Medicare and Medicaid Services)

Gail McGrath, President and National Director of Government Affairs, National Patient Advocate Foundation (Ms. McGrath represented Nancy Davenport-Ennis, founder of both the National Patient Advocate Foundation and the Patient Advocate Foundation, who was unable to attend)

David Ayre, Senior Vice President, Compensation and Benefits, Pepsico, Inc. (Mr. Ayre was representing Steven Reinemund, CEO and Chairman of Pepsico, Inc.)

Scott Serota, President and CEO of the Blue Cross Blue Shield Association

Julie Gerberding, MD, Director of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (Dr. Gerberding was represented by Ed Sondik, MD, Director of the National Center for Health Statistics, for part of the meeting)

Mark Warshawsky, PhD, Assistant Secretary for Economic Policy, U.S. Department of the Treasury (Dr. Warshawsky was represented by Adele Morris, Senior Economist, U.S. Department of the Treasury, for part of the meeting)

Lillee Gelinas, RN, MSN, Vice President of VHA, Inc.

Office of the National Coordinator Update

Dr. Brailer discussed four major efforts currently underway: (1) Office of the National Coordinator activities, including contracts, infrastructure, and other work; (2) partners that are developing certification, developing architectures, privacy, and security; (3) the work of this Community; and (4) the new work AHIC has charged each of the four workgroups with. Significant progress has been made in each of these four areas. Dr. Brailer noted that this meeting will present an opportunity for developing recommendations to DHHS, other federal agencies, and constituents in the private sector. The workgroups have been challenged with making specific recommendations around the four specific charge areas; the Community in turn will be making recommendations to Secretary Leavitt. Dr. Brailer commented that to have meaningful action within the Department this calendar year, those recommendations need to be made at the next AHIC meeting (to be held on May 16, 2006). Once this first round of recommendations has been made, the workgroups will focus on their efforts on developing recommendations on longer-term broad charges.

The Office of the National Coordinator is continuing its efforts, including the development of a strategic plan that builds on the strategic framework that was released in July 2005, and will be made publicly available this year. These efforts concentrate on the ultimate goal of incorporating an interoperable electronic health record and other health information technologies, tools, and services.

Approval of January 17, 2006, Meeting Minutes

Minutes from the January 17, 2006, AHIC meeting were distributed, reviewed by Community members, and approved unanimously with no changes.

Gulf Coast Health Information Technology Task Force Presentation

Lee Stevens, Federal Policy Director for the Southern Governors' Association (SGA), reminded Community members that the catastrophic hurricanes of 2005 revealed how vulnerable medical record data are in the United States today. For the first time in U.S. history, medical professionals were faced with tens of thousands of evacuees who had little or no knowledge of their existing medical conditions or treatment regimen. In many cases, their health history has been lost forever. Hurricanes Katrina and Rita revealed to Gulf State Governors the difference between localized emergencies and unprecedented regional catastrophes for which the health care delivery system was unprepared. Today, Governors seek to rebuild the system to respond to a catastrophe and the mass evacuation of hundreds of thousands of citizens.

Dr. Brailer approached the SGA to convene a task force to define principles for an interoperable health information exchange network. Governors immediately recognized the opportunity to prepare the health care delivery system for a catastrophe. The task force will consist of providers, payers, consumer advocates, IT professionals, business leaders, and first responders who provided medical care to victims of Hurricanes Katrina and Rita.

The SGA Gulf Coast Health Information Task Force will:

- Conduct return-on-investment studies and review current state health information technology efforts.

- Develop a set of goals to guide the work of the Task Force.

- Prepare a review of emerging national principles to guide state implementation.

- Define a set of principles for the mobilization of health records.

- Produce a communications plan to encourage support for adoption.

Dr. Roxanne Townsend, Medicaid Medical Director for the State of Louisiana, described her experiences in New Orleans in the days and nights immediately following Hurricane Katrina, noting that she saw firsthand what not having electronic information and the history of patients' medical records does to a patient and to the clinicians who are trying to take care of them. For example, many nursing home residents moved to the Superdome in New Orleans had medical records with them that consisted of handwritten pieces of paper taped to their gowns with incomplete information in many cases and often did not stay with the patient for the duration of their stay in the Superdome.

Dr. Townsend thanked Dr. Brailer, the Markel Foundation, and others involved in developing Katrinahealth.org, which was up and running shortly after the hurricane. Currently, Dr. Townsend's office has a contract with the Office of the National Coordinator to create a level of interoperability and recover and recreate many of the Katrina evacuees' medical records. She concluded her remarks by noting that the SGA has a unique perspective and can reproduce what is being done at a local level and employ it across states.

Stephen Palmer, Policy Analyst for the Texas Health Care Policy Council, noted that the Council is a new entity in the office of the Texas Governor that was established through legislation in 2005. One of the charges given to the Texas Health Care Policy Council is to coordinate and facilitate all of the mission technology initiatives throughout the state. Texas was among the states affected by Hurricanes Katrina and Rita, and its population saw firsthand the consequences of a paper-based health information system. Although the recent hurricanes drove home the importance of health information technology, Texas had already started down that path with health IT initiatives at both the state and regional levels. The Texas Health Care Policy Council will seek to coordinate and align these various health IT initiatives. The Council also will be working closely with the Texas Health IT Advisory Committee to serve as a health IT resource. In addition, the Council will be participating with the SGA on the Gulf Coast Health IT Task Force, charting a digital recovery for the health Information infrastructure of the Gulf Coast Region.

Discussion Highlights

"KatrinaHealth [captures] the low hanging fruit, the things that were easiest to get and that was the medications…The piece we did not always have in there consistently, and it's a harder piece to capture, is allergy information…The other piece we would love to have if we're talking about just the basics is a brief problem list so anything that is not being medicated is under control." – Dr. Townsend

"Thinking about the adoption issue for those who can't use computers, the elderly…There is a segment of the population that we have to be ever-cognizant of as we move towards an electronic system, how are we going to deal with their issues and their needs? When we make recommendations we're certainly going to have to address it." – Ms. Gelinas

"It [adoption of electronic health records] is going to be an issue, but the initial adopters really need to be the provider sector and it's going to be our responsibility as providers to make that information available to other providers." – Dr. Townsend

"Have you had an opportunity to tangibalize the financial cost savings that would have accrued [if electronic health records were used]? How much money would you have saved, how many lives would you have saved? Can you tangibalize what that cost, what the return on this investment is?" – Mr. Roob

"Specific to Katrina, I really can't tell you…one of the things that we don't know because we don't capture it electronically right now is how many errors were made in people's care based on not having the information at hand…If you look at a lot of the studies and the return on investment, things that have been looked at for health information technology, the estimate is somewhere around 30% you may save by saving redundancy." – Dr. Townsend

"I think the issue here from your perspective is you can prove the worth of this financially. I think that may be helpful to tangibalize the financial cost of not having the system. Because ultimately, it will be about the allocation of scarce resources." – Mr. Roob

"To this comment that Mitch raised, we will follow up with SGA about making sure that some evaluation can be at least considered in the work that we're doing…We've worked very closely with the Markel Foundation on an after-action evaluation of KatrinaHealth and the other health IT responses, and those should be made public soon, so that will give us all more to debate about how do we make sure that the Health Information Community is part of the solution in the future." – Dr. Brailer

Chronic Care Workgroup Presentation

Workgroup Co-Chair Dr. Craig Barrett reviewed the membership of the Chronic Care Workgroup and noted that this presentation was focused on the following specific charge:

- Make recommendations to the Community so that within 1 year, widespread use of secure messaging, as appropriate, is fostered as a means of communication between clinicians and patients about care delivery.

Enablers to accomplish the specific charge include: (1) geography, which can leverage existing infrastructures (existing business models, multistakeholder collaborations, high awareness of HIT value); (2) clinicians who care for a high percentage of patients with chronic illnesses; (3) the availability of secure messaging (excluding open e-mail) between patients and their clinicians in physician offices with care management supports; (4) decreased malpractice risk from better documentation; and (5) reimbursement of clinician time and expertise for less costly care than that provided in office or emergency room settings.

Workgroup Co-Chair Dr. Mark McClellan presented the Workgroup's recommendations to support the enablers described by Dr. Barrett. First, the Office of the National Coordinator, through existing contracts, could define optimal solutions to address technical barriers related to interoperability, identification of users, and security. Second, the CMS can identify opportunities in existing programs and projects to evaluate the value of secure messaging. Third, AHIC should receive input regarding licensure reciprocity across state lines for purposes of secure messaging to address this legal barrier.

The following open issues face the Chronic Care Workgroup and AHIC in general:

- How can effectiveness best be defined?

- What infrastructures and programs could be leveraged, and where?

- How can secure messages that could be considered reimbursable best be defined?

- What is the most effective way to address workflow issues in the office setting?

The following next steps were identified: (1) review existing information on secure messaging—receptive environments, business infrastructures, evaluations—to support potential reimbursement policies; (2) research outcomes associated with secure messaging; (3) identify local, state, and federal entities, national organizations, and private entities that could support the recommendations; and (4) develop a conceptual framework for the transition to the Workgroup's broad charge (make recommendations to the Community to deploy widely available, secure technology solutions for remote monitoring and assessment of patients and for communication between clinicians about patients).

Discussion Highlights

"What is your [Mr. Serota's] sense about the prospects for re-emergence of payment mechanisms that move away from fee-for-service and more to group payment and prepayment?" – Dr. Winkenwerder

"I don't think the marketplace is ready to be in a risk-assumption business. The greatest difficulty we ever had in capitation was with chronically ill patients anyway. This would not be the first place I would start trying to reintroduce capitation. I am very supportive of the goal of developing reimbursable mechanisms of communication so long as…[it is] improving the outcomes. The question is how you measure that." – Mr. Serota

"The ultimate result is some kind of packaged reimbursement for service. It may not be the pure capitation model that we used before but it may be a disease-specific payment, it may be some kind of more global payment…My discussions with providers across the country would say a move back to capitation and risk assumption by the providers is not high on their list of objectives." – Mr. Serota

"There will be obviously some security features built in there and messages related to the patient's chronic conditions status and updates being included in this in those limited electronic or personal health records. We've seen some providers as part of these programs using secure e-mail to exchange information among each other to improve the coordination of care for chronically ill beneficiaries." – Dr. McClellan

"[In terms of] the use of Web-based portals for transmitting information securely...a program run by Humana called Green Ribbon Health has this secure messaging via Web portal built in they're starting to use and we're really in the phase of gathering information about how well it's working…It does open up the possibility for a lot of different participants in this process of care coordination to share information effectively…The main thing we have been focusing on now is making sure they are secure and evaluating which ones seem to work best in which circumstances." – Dr. McClellan

"Let us not forget at the end of the day if we can get the whole system electronic with full medical records everywhere, that will fully allow all of this process to occur in a seamless fashion and will allow each clinician and the patient and the consumer to deal with issues of accountability and cost and quality, et cetera…But the enabler of payment as it relates to the provider of the service as everybody here has said

it will be critical. The physician community I doubt would want to go back to the days of pure capitation. – Dr. Henley

"Many physicians aren't ready to take on full capitated risk especially for their most chronically ill high-risk patients but the proposals the physician groups have developed would allow for our reimbursement systems in Medicare or health plans to provide better support for the kind of care coordination in a more manageable risk environment. That's where these kind of blended payment systems come in. So we're looking for all the opportunities we can find to get these ideas into practice and get them tested to see what kind of impact they can have." – Dr. McClellan

"You can't separate the advancement of technology from the issues of payment, but the payment issue becomes enabling to adopt the technology and to implement the technology, which is what we are about here in the Community." – Dr. Barrett

"There are approaches based on claims data reporting that physicians can use now. We started, for example, a voluntary reporting pilot program where for a set of validated clinical quality measures, physicians are essentially adding additional code reporting into the current billing systems in Medicare." – Dr. McClellan

"I think we're in a phase where we need to support both the claims-based reporting on quality measures as well as the transition to a broader use of electronic reporting because so many physicians don't have electronic records fully in place yet. We need to view this as a transitional period for both types of reporting are supported." – Dr. McClellan

"We have got to get people enough financial support to get the care they need. For many people in the health care system and for people with limited means, a health account or other types of consumer-driven care approaches that give people an opportunity to save while still giving them adequate financial support to give them the care they need is a great way, I think, to encourage the use of these kinds of services." – Dr. McClellan

"We have to focus very strongly on the small number of people who are eating up the bulk of the health care cost—that is the chronically ill." – Dr. Barrett

"There is some information that consumers can use now to help find where they can get the best care for their needs at the lowest cost…There needs to be a lot more support for consumers along those lines and it should include process measures like whether or not best medical practices are being followed, whether or not electronic records are being used." – Mr. Ayre

"I fully recognize the reimbursement issues and the incentive issues involved with payments to providers but I want to be sure that the group does not lose sight of in a very tangible way…of one of the ultimate goals which is to not only get better quality but also to lower costs for the ultimate payers for these services, which has been the great experience of the application of information technology." – Dr. McClellan

"In terms of competitive approaches, there are a number of health plans or a number of disease management groups that are available and competing for the beneficiaries to take advantage of the services that are going to tend to drive down the cost of delivering services. People choose providers that save them the most money as well as get them the best help." – Dr. Henley

"My suggestion is to focus on the implementation of these messaging systems within the existing chronic disease management, care management programs that already exist, that already have a payment structure

in place, that have some measures for quality…I would suggest using that as your starting point and working out the methodology and the technology and then that can be spread to other sources."
– Mr. Green

"There is a firm belief that secure electronic communication…has to make the system better and make care better." – Dr. Barrett

"Our whole focus is to leverage off existing infrastructure capabilities that demonstrate the results and then to use that as the leapfrog to get other people to do it, not to start from scratch…" – Dr. Barrett

"I think consumers would like to have one provider in charge of their health care, [but] that's just not the reality. The reality is that consumers typically are going from specialist to specialist and we just don't see that many family practitioners anymore. That's what makes it more important that consumers have input on their care, that they had the ability to access information on their care."– Ms. McGrath

"As a workgroup focused on chronic care improvement, one of the things we need to look at is the data elements that are needed both on the provider's side as well as the patient's side to really drive an incentive for them to use it…One element we have not touched on today is medication adherence and compliance, which these tools could actually help track especially for the chronically ill, the ability to make sure patients are taking their medications and taking them as prescribed." – Mr. Hutchinson

"As the workgroups go off and deliberate and discuss, it is our expectation that they will be able to come back with very specific recommendations that will help this group decide if they will pass that forward to the Department, other agencies in the federal government, to other entities in the private sector."
– Dr. Brailer

Consumer Empowerment Workgroup Presentation

Workgroup Co-Chair Linda Springer reviewed the membership of the Consumer Empowerment Workgroup and noted that this presentation was focused on the following specific charge:

- Make recommendations to the Community so that within 1 year, a pre-populated, consumer-directed, and secure electronic registration summary is available to targeted populations. Make additional recommendations to the Community so that within 1 year, a widely available pre-populated medication history linked to the registration summary is deployed.

The Workgroup is reviewing the following draft principles for consensus:

- Individuals should be guaranteed the right to access their own health information.

- Individuals should be able to access their personally identifiable health information conveniently and affordably.

- Individuals should know how their personally identifiable health information may be used and who has access to it.

- Individuals should have control over whether and how their personally identifiable health information is shared.

- Systems for electronic health data exchange must protect the integrity, security, privacy, and confidentiality of an individual's information.

- The governance and administration of electronic health information networks should be transparent and publicly accountable.

The Workgroup is exploring barriers and policy implications for breakthrough models. Issues to be considered include the following: (1) the need to raise consumer awareness of personal health records (PHRs), (2) confidentiality of PHRs, (3) need for patient proxies, (4) liability of providers, (5) state laws that act as barriers, (6) data standards that are not yet consistent, and (7) a lack of interoperability when sharing information. Potential breakthrough models include the use of existing regional health information exchange with a consumer interface, PHR vendor(s) linked to one or more intermediaries to get updated registration and medication information, and payer- or employer-based portals that supply information to PHRs. Possible target populations include patients who frequently utilize the system, such as those with chronic conditions. The following populations also are under consideration: (1) pediatric population, (2) older (45+) population with high drug usage, and (3) possible local/regional geographic locations with plans/providers.

There are a number of open issues that need to be addressed. For example, policies are needed to ensure that patients are in control of their health information and trust the network. Patients must be guaranteed the right to access their own personal health information. Policies also are needed to enable authorized caregivers and family members to access a patient's record. PHRs, EHRs, and relevant data sources (claims, pharmacy data) are not interoperable. In addition, mechanisms are needed to prohibit inappropriate or unauthorized secondary uses of data. Clarification is needed on how, under current laws, personal health information in PHRs is protected. Inaccurate information from PHRs could lead to medical decisions associated with bad health outcomes. A standardized approach to matching and authenticating patients to their health records is needed.

The following three next steps were identified: (1) refine and streamline principles for the specific breakthrough models; (2) refine the scope of the breakthrough models; and (3) analyze the policy, technical, and other barriers through additional research and public input.

Workgroup Co-Chair Gail McGrath noted that when this process first started, Secretary Leavitt directed Community members to reach out to as many groups and as many people as possible to obtain input from the consumer prospective. The Consumer Empowerment Workgroup has taken this direction to heart, and has included 30-40 consumer groups in its deliberations. She also noted that the Workgroup has been collaborating with the Markel Foundation. Ms. McGrath read a portion of a letter from the Markel Foundation: "The health information technology agenda will be slowed and put at risk unless the AHIC establishes a public process to develop and disseminate policies to guide the work of federal agencies and contractors and provide voluntary guidance to health information exchange efforts in the private sector."

Discussion Highlights

"You may want to consider what the accountability of the individual should be…[similar to] the concept that consumers need to be accountable for their own health record and updating it…This concept of targeting populations, like pediatrics, is a very good idea. And I think that where health care will go is eventually a changed behavior and building the behaviors in from day 1 of an individual's life…Eventually, having an electronic health record will be like a birthright." – Mr. Ayre

"In our targeted populations, the pediatric group might be a good place to target because you do have a starting point that will lead over time." – Ms. McGrath

"It's going to be critical to maintain interoperability between personal health records and EHRs…Personal health records must operate with certified EHRs. The certification process should accept those standards by which PHRs can plug and play. The vendors for PHRs in some fashion should…pay attention to the EHR certification process…If we miss that opportunity, we miss a huge opportunity in terms of the portability of data from one part of the system to the other and the accuracy of the data would be at risk." – Dr. Henley

"In the President's FY07 budget request for health information technology, there is a line item for personal health records. And as that goes through the process and comes out as an appropriation, we intend to use that to support exactly that effort of ensuring that there are standards and that there are linkages between personal health records and the rest of the health information infrastructure."
– Dr. Brailer

"We [DoD and VA] both have electronic health records systems…[and with the] need potentially for a portal with just registration information, medication history, allergies, that is something we collect in both of our systems…it is an extensive reach, about a third of the doctors in the country between our populations…I wonder about creating a portal that has this basic information in it as a starting point."
– Dr. Winkenwerder

"We do have not only an opportunity but a responsibility for a more public health approach." – Dr. Perlin

"I think we should take it to the workgroup. We are working towards interoperability of our systems and moving information and already doing that in a significant way, but what strikes me with this is it's a subset of all the data that we already have that then might be more easily available to our covered populations as well as to a broader community of medical care providers." – Dr. Winkenwerder

"I want to make sure that we are not going outside of the bounds of what HIPAA has already put in place in terms of access to records and ability for providers to share in information for clinical care, for health care operations." – Ms. Worzala

"I wanted to bring up some thought processes we had with regard to the portal. We followed a path that said it should be patient's choice of entry into this personal health record world and we think a portal is a great idea. That portal could either come from your physician's office, it could come from your payer, it could come from a number of different sources." – Dr. Hutchinson

"One of the major issues I think we're going to have in this area is the various state laws that exist out there around privacy…around the view of sensitive medications, for example…there's an argument in industry that we have to address [whether] partial information [is] more damaging than being able to view the entire record of information." – Dr. Hutchinson

"Looking over the principles, [the Workgroup] clearly articulated the patient's rights, if you will, to protecting their personally identifiable information with regard to access, use, collection, security…To build trust, I think being able to clearly articulate and intelligibly communicate to the consumer is important…That should be a part of going forward. It's good if they have these rights but being able to communicate those rights to the patient I think will build that trust." – Ms. O'Neill

"There is an issue here as to what the unscrupulous [person] might do with their PHR…There is a responsibility not only on the public side but also on the health care system side to address this."
– Mr. Trenkle

"We have been meeting over the past year with the leadership of the various pediatrics professional societies and children's hospitals in a group called the Pediatric Steering Committee, exploring their contribution to health information technology to the unique care environment in pediatrics." – Dr. Brailer

"The challenge is not a technical one, but the alignment of incentives, the value proposition of different players having to get involved to make this thing viable and…for this to get traction, I think we have to articulate how this helps the different entities." – Dr. Perlin

"As one moves to the concrete recommendations at the next step, I think it will be worthwhile to articulate what value accrues to whom by doing what…[For example, there may be] incentives with exercise and filling out this information so there is actual value in creating the information so that when that patient goes to someone else who has access to the information that is ultimately paid by this insurer that information leads to a more rational use of resources, ultimately achieving better health outcomes." – Dr. Perlin

"It's our hope that this meeting represents a key pivot point where the groups can go out and turn themselves to what needs to change to get this done and if they do that, refine who the populations are. Or what the delivery models would be that set that context." – Dr. Brailer

"We see [the Medicaid] population…changing primary care providers much more regularly than we do a privately insured population. So having that personal health record for that patient population, I think would add value from a health care standpoint and maybe be easier to implement than perhaps you might think." – Mr. Roob

"I'd like to raise the importance of [authenticating] patients and matching patients to their records. This will be a growing quality issue as health information flows through the system, making sure that you have the right records for the patient who is in front of you. If you don't have the right record, there could be pretty serious quality repercussions." – Ms. Worzala

"The Commission on Systemic Interoperability had a substantial discussion and set up recommendations on the question around patient authentication. It could be important input into this discussion."
– Dr. Brailer

"The notion or the need for consumer confidence and trust, openness, accountability, all of that is so important in this that having a sponsorship of broad sectors of American society…is really important…I'd lean towards something that was sponsored by bigger institutions that were accountable to the public." – Dr. Winkenwerder

"There are plenty of broad coalitions of practices that are using a single EHR." – Dr. Henley

"The whole issue of portability of PHRs is extremely important. As you see more and more employers using PHRs as a way to improve employee wellness and other types of outcomes, I think that as people move from employer to employer, or move from different plans, I think it's important that we establish portability not only the interoperability between EHRs and PHRs, but also between PHRs." – Mr. Trenkle

"The workgroups are not management bodies. They are not implementation bodies…The implementation tasks are left to the Office of the National Coordinator, federal agencies that are involved in federal efforts to support health IT, or to the contractors…We view the workgroups…as advisory bodies." – Dr. Brailer

"We are trying to support a process that allows these recommendations to be accelerated through the discussion not just to the federal government, but to private-sector entities or others. Again, we view this

Health Information Community as a steering group for many entities even though it's technically legally chartered as an advisory group to the federal government." – Dr. Brailer

"If you want to treat something that VA and DoD does as something you'd like to see happen, you should recommend it. If you just treat it as a fact and the background that's part of your thinking but in the end is not a recommendation you make, that's still valid, but it's really up to the workgroup decide how to separate the difference between fact-finding and background information and forward-looking recommendations." – Dr. Brailer

Secretary Leavitt's Remarks

Secretary Leavitt, who was unable to attend the morning portion of the meeting, expressed his appreciation for the work being carried out by Community members. Secretary Leavitt noted that at the last AHIC meeting, he announced the creation of the Health IT Policy Council to help refine the federal government's action in responding to health IT issues as they develop. That Council is well underway and will focus on bringing the federal agencies together to find and facilitate recommendations generated within the Community.

Secretary Leavitt also informed the Community that it has been asked to undertake an additional assignment this year. The *Katrina After Action Report* called for the development, within 12 months, of an efficient and effectively deployed electronic medical record or health record that could be used by first responders in the case of an emergency. In the aftermath of Katrina, 1 million people were displaced without records, pointing out how crucial having a basic health record is for first responders. This would not be a full-featured hospital emergency or electronic health record, but rather a standardized set of a very limited number of crucial elements that would be needed in an emergency situation. Secretary Leavitt noted that this task falls within the Community's mission and fits well with the progress AHIC already has made. He also asked that the SGA's Digital Health Recovery Task Force continue its work in this regard. Dr. Brailer concluded his remarks by expressing appreciation for the work Ms. Haza has done in supporting the Community and wished her well in her future endeavors.

Electronic Health Records Workgroup Discussion

Lillee Gelinas, Electronic Health Records Workgroup Co-Chair, reviewed the Workgroup's membership and noted that this presentation was focused on the following specific charge:

- Make recommendations to the Community so that, within 1 year, standardized, widely available, and secure solutions for accessing current and historical laboratory results and interpretations are deployed for clinical care by authorized parties.

Ms. Gelinas commented that the laboratory is emphasized in the specific charge because the availability of electronic data and clinical relevance suggests uptake is quicker and clearly could be a catalyst for broader EHR adoption. The Workgroup recommends that initial efforts be aimed at a broader group than just clinicians with EHRs; a longer-term goal involves dovetailing with PHRs. Ms. Gelinas explained that if the patient or the consumer owns the data versus the lab or provider owning the data (which is the current system), the definition of how to proceed takes two different paths.

Dr. Perlin, Workgroup Co-Chair, described three potential models for accomplishing the group's specific charge:

- **Regional Health Information Exchanges (RHIOs).** RHIOs advance governance, primary financing, and sustainable business models while making comprehensive laboratory data from multiple sources available to authorized parties.

- **Standardized Peer-to-Peer Interfaces.** These interfaces fulfill the need for vocabulary, transmission, and implementation of technical standards, but limit access to results of tests ordered by any one provider (with an EHR).

- **Web-Based Portals.** These address market complexities and advance technical issues of patient identification, architecture, authentication, authorization, and policy issues relating to authorization (CLIA) and privacy, but may be limited to specific laboratory sources.

Dr. Perlin commented that the RHIOs model may be the optimal approach.

Ms. Gelinas discussed a number of enabling issues that need to be addressed. On the technical side, the Healthcare Information Standards Panel (HITSP) review of contending standards is needed and should be supplemented as necessary with laboratory data vocabulary, transmission, and implementation guidance. Private and federal consensus is needed in the following key areas: (1) identifiers linking patients to their clinical information, (2) identifying appropriate users of patient information, and (3) patient authorization for use of data. In terms of policy issues, authorization and authentication for data use must be clearly defined and established within parameters set by the Health Insurance Portability and Accountability Act (HIPAA) and Clinical Laboratory Improvement Amendments (CLIA) for authorized use of patient data. In terms of implementing models, where a RHIO exists, measures should be taken to provide access to laboratory results through RHIO architecture, using RHIO's governance and business models to address multiple sources of laboratory results, data flow issues, and HITSP standards. Where there is not a RHIO, access to laboratory results should be implemented using HITSP standardized technologies appropriate to the market context.

Dr. Perlin noted that there also are a number of open issues/questions to be considered. For example, which environments (mature RHIOs, hospital-based systems, others) best support the specific charge? Should implementation occur first in several small areas or more broadly (with greater risks) for future success? Portals may be expeditious, but also may disincentivize further uptake of person-centric solutions. Another issue to be addressed is whether initial provider access to EHR users should be limited, or whether laboratory information should be made available to all authorized parties. Consideration also must be given to how/when to include diverse laboratory data sources (e.g., national laboratories, federal systems, hospitals, local laboratories, physician offices).

Ms. Gelinas discussed the Workgroup's next steps, which involve defining environmental characteristics for successful deployment of recommended models. A rapid environmental scan will be conducted to explore: (1) RHIO- and hospital-based processes currently available; (2) governance, financing, and value proposition in successful RHIOs (using input from Agency for Healthcare Quality and Research studies); and (3) market contexts that drive specific solutions (RHIOs, Web portals, or direct linkage to laboratory results). The Workgroup also will identify key components of a patient-driven, easy-to-use, secure authorization process, from both technical and consumer perspectives. In addition, the group will consider both technical and consumer implications of opt-in versus opt-out patient choices. Finally, the Workgroup plans to provide further recommendations for the rapid deployment of models.

Discussion Highlights

"Let's assume I have a favorite portal company that I have my e-mail with and I have some music I buy and I tend to do some electronic shopping there and I have my instant messaging and I keep my photos

there and they have a window that says 'health record.' And I have registered and that's the portal that I would like. Is that part of this vision?" – Secretary Leavitt

"The idea is you would have a sort of generic viewer and be able to get the information. Someone used a good analogy earlier. Do you go online to bank with your favorite bank? You might have a different account with another bank and do transactions through their viewer or manage your money in one of these programs, [like] Quicken, that actually goes behind the scenes and reaches out to the same companies and gets that information and while not necessarily part of this specific vision, it's a sort of derivation that would allow one to get information that lives somewhere else." – Dr. Perlin

"Let's say that portal was 'Quicken for health care.' And I would assume it would use the AHIC standards and go off to the lab company and say…Mike Leavitt ordered a lab request there and send it to this place on my Quicken for health care record." – Secretary Leavitt

"Your 'Quicken for health care' is an absolutely fabulous vision. The challenge we have at the moment is that we need to set up the relationships…so we can transact online before we put the program, the 'Quicken for health care' in between. But it's a great vision." – Dr. Perlin

"We've proven that with KatrinaHealth…where we have labs highly stratified across national laboratory companies, local regional laboratory companies, and hospital/doctor office laboratories, the consolidation and unification is a massive challenge for the industry. So the focus here is how do we get the data to the doctor and thinking that the next step to achieve this is then to take it out to the patient to follow that medication solution once we can consolidate it." – Dr. Brailer

"You can have the Web portal in a regional model, where you can get one access, one view of all the lab data for one patient regardless of who originated it, or you can have it in an enterprise model where each lab, each hospital, can have a portal and you have to figure out which portal they have. Same thing from peer to peer." – Dr. Brailer

"Could you use the fact that the health care ultimately is paid for, attach it to the paying function and then and create a mechanism for bringing the information together? In practical terms, it would be somewhat difficult to operationalize…we don't typically share the basic lab data with the payer." – Dr. Perlin

"In a portal model…any physician providing care to that patient could ultimately do a query and…see the results of those tests that have been performed, to prevent multiple tests from being performed and ordered by multiple physicians because they are unaware the test was performed the day before by another physician." – Dr. Hutchinson

"Let's just roll this forward for 5 or 10 years and assume we have made lots of progress we haven't yet made, and we live in a world where electronic health records are much more common. [Assume that] we've got all the standards we need and the question now is, how do we initiate and determine who keeps our electronic health record?" – Secretary Leavitt

"The pivotal question in our presentation is whether the data is lab-centric. That is, does it reside in the number of sites because it's a lab element produced by a particular lab or does it in some way follow the person so that when the person moves, the person goes to different doctors, that it follows them…The value of the electronic health record from our experience is that if I have chest pain and I show up at the Washington VA and I'm giving a talk in Baltimore tomorrow and I have chest pain, they can actually know my past record and so they don't have to know which doctor I went through." – Dr. Perlin

"I think the elephant in the room here is that we are talking about data that has already been vetted and now is 'part of the past history.' What is of concern…is what do we do with the data that was just ordered, has been completed in the lab, and hasn't yet been vetted in terms of an abnormal value? Should the patient have free and open access to that positive HIV test that I ordered, and yet there hasn't been a conversation between the patient and the physician or other clinician as to what that test means because it's abnormal?" – Dr. Henley

"I see a difference between the record and the information. I don't see why there needs to be any change from today as far as who owns or creates and owns the information. I think we're asking for another level of complexity we don't need to get into. Your doctor has information. The electronic health record is the thing that makes that information useable outside of the doctor's office. And then there can be competition as to who has the best or most useful, efficient health record for different purposes."
– Mr. Green

"Who owns the record? If my doctor hasn't explained [a test result] to me yet, do I own it before he explains it or after he explains it?" – Secretary Leavitt

"If I want to use a client server on my laptop at home that's integrated to my health care organization, that's great. If I want to use CVS, who is supplying a free personal health record, I understand there is some limitation to that. They may not have access to all the various different networks that have information on me. It may be a much more limited record. But I think that's ultimately going to be the consumers' choice." – Mr. Hutchinson

"The lab industry has been supplying this technology to physicians' offices for quite some time but it's not integrated into their workflow, and that's the biggest challenge…One of the biggest challenges that the labs are most interested in is the order process, and that order process is not been standardized on a lab-by-lab basis…so orders are still going paper [and] results are coming back electronic. I would challenge all of us as we look at this particular process, especially as an EHR subgroup, that we focus on the entire lab process of how we get orders electronically and how we receive the results as electronically as well." – Mr. Hutchinson

"[The VA] has a rule that if there are things like new diagnosis of cancer or HIV or something of that sort, then that data doesn't go forward until the physician has indicated or the clinician has indicate they had provided counseling." – Dr. Perlin

"Can the patient who gets care in one environment have the results available to another clinician in another environment and to themselves in a third environment? Maybe the insurer actually gives the patient an insurance discount because they have a health record and they share their health record with their insurance company and the insurance company gives that patient information about better control of their diabetes or exercise and nutrition." – Dr. Perlin

"Standardized peer-to-peer fits the bill of allowing electronic orders ideally to come in with electronic data coming back but it doesn't fill the need of totally integrating with the rest of the care experience elsewhere. The portal is the 'Google' model…but it doesn't necessarily resolve the issue of getting that order electronically to the lab company. It may have more effectiveness as a viewing engine. The third model…the RHIOs…[can] result in greater efficiencies and higher safety, higher quality. [There is] value to each. Each actually brings the adoption curve forward, with specific opportunities and specific challenges. Clearly the RHIO is by far the most complex." – Dr. Perlin

"From the consumer perspective, certainly we want the provider to be able to read our lab results and tell us what the problem is. We'd also like to be able to easily get that information. But more importantly,

we'd like to know that that information is not going to be used against us. For example, if we think we may have a genetic predisposition to something, I'd like to feel comfortable that I could go in and have that test without becoming uninsurable." – Ms. McGrath

"[The] broad charge to us was to speed the adoption of electronic health records and in fact...I think there is a market dynamic that helps them to move forward and ultimately the market forces will help determine which are best approaches." – Dr. Perlin

"We can do better. We can be safer. We can offer higher quality. We can improve the efficiency and in fact, with these sorts of systems we can protect the privacy in ways that you can't ensure with faxes back and forth and phone calls and voice mails." – Dr. Perlin

"It is important to think about that incremental change over time…the peer-to-peer interface lays groundwork to the bigger vision and it really is to get to the standardized part and there is nothing about moving forward to that that would prevent further development of greater ability to share. So I think it is a good starting point." – Ms. Worzala

"The two greatest barriers to adoption of electronic health records by physicians and others are cost and lack of interoperability. The focus of the workgroup at present on laboratory interoperability, laboratory data interoperability, is an excellent focus in terms of immediate results. All three models are important and when you go from lab to the entire EHR, all three models have to exist in the system to assure interoperability based upon geography and different populations" – Dr. Henley

Biosurveillance Workgroup Presentation

Dr. Gerberding, Biosurveillance Workgroup Co-Chair, reviewed the Workgroup's membership and noted that this presentation was focused on the following specific charge:

- Make recommendations to the Community so that within 1 year, essential ambulatory care and emergency department visit, utilization, and lab result data from electronically enabled health care delivery and public health systems can be transmitted in standardized and anonymized format to authorized public health agencies within 24 hours.

Dr. Gerberding discussed enablers to accomplish this specific charge, such as starting with a minimum dataset that can be readily captured from the health care delivery system. Data linkers can protect privacy and provide event-level data to public health to facilitate analysis and follow-up investigations as needed. In addition, existing local, state, and federal biosurveillance programs sharing biosurveillance data should be built on to help meet public health needs. To support these enablers, data should flow simultaneously to local, state, and federal health departments. There should be a focus on a narrow scope of data across a broad geographic scope to maximize coverage and detection of public health threats. As feasible, intermediaries or RHIOs can capture data from providers and then share with local, state, and federal health departments.

Open issues include addressing the following key questions:

- Do local and state health departments have the capacity to receive, analyze, and act on steady stream of electronic data?

- A lack of standards impedes data sharing with public health—how can we standardize the format of data?

- Beyond altruistic early participants, how can we incentivize health care providers to participate?

- If voluntary participation is not sufficient, are there other options?

- What are the future roles of RHIOs and the Nationwide Health Information Network as a means of providing public health data to local, state, and federal partners, and who pays for this service?

Dr. Gerberding discussed the Biosurveillance Workgroup's next steps, which include the following: (1) develop a short- and longer-term scope, (2) analyze barriers and recommend ways to overcome them, and (3) evaluate complementary technologies supporting interpersonal communication and traditional case reporting to ensure coordination and integration.

Mr. Roob, Biosurveillance Workgroup Co-Chair, thanked the Workgroup members for all of their work and support, noting that "we have not allowed the perfect to be the enemy of the good here." Creating the minimum data set took an enormous amount of effort, but having it gives the Workgroup the "what." The "who" are the emergency departments and associated ambulatory care facilities. The "how" involves moving that data through RHIOs back to the Centers for Disease Control and Prevention (CDC) for quick analysis. Mr. Roob expressed optimism that the Workgroup would meet its deadlines.

Mr. Roob noted that there has been some degree of consternation among the traditional public health communities, and the Workgroup has reached out to many in the public health community, particularly at the state level, to obtain their input in terms of how that data are moved. State health commissioners want that data for people who live in their state to quickly get into their systems; Dr. Roob emphasized the necessity of this activity. If a RHIO model is adopted that is designed around a multi-state facility, that RHIO will have to be able to feed data to multiple state health departments as they feed the data to CDC as well. Although not an insurmountable barrier, it represents a key point to keeping the state health commissioners onboard in this effort.

Discussion Highlights

"What you want is within 24 hours the results of the prior day…What part of the health care system already has some form of electronic record keeping or electronic health records which are ultimately searchable because they are big databases? How big a sample do you need from those existing databases to have an adequate measure of a pandemic, something to be able to differentiate between the onset of flu with the first day of hunting season and a real pandemic? How big a database do you need?" – Dr. Barrett

"The problem I think will be that if you get a plane landing and you disburse that population, [they are] outside the boundaries of a RHIO. Unless you pull that together, the only person that will see that is going to be Dr. Gerberding because they're going to arrive in emergency departments in ones and twos." – Mr. Roob

"Just how big a database do you need and don't we already have enough of these existing EHRs in that are searchable today?" – Dr. Barrett

"We are talking about finding 5 in a universe of 5 million and that becomes the place where we want to catch it. A sample of 5 million might only require 1,000 different pieces of information but it won't find the 5." – Secretary Leavitt

"If we are looking for a few cases of serious food borne toxic illness in the population…with people coming in with diarrheal illness every day, we've got to have a very sensitive system with a lot of data elements in it and a lot of trend…But if we are looking for a signal above background…for example if we

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are just looking for an increase in influenza-like illness in the population, then we don't need to have such a comprehensive set of data elements in the system because the number of events we are seeking for is large. It really does depend on exactly what we are expecting the system to be able to define for us."
– Dr. Gerberding

"Is the problem divisible? Can it be partitioned into two pieces? If you're looking for five needles in the United States haystack, that's one issue. If you're looking for onset of a more common disease or flu or pandemic…you don't need such a large population…There are some pretty sophisticated databases today and I'm not sure we have an integrated system to search those databases as opposed to starting with some something new. I'm all for building on what we have." – Dr. Barrett

"That's why we will go through the RHIOs, which in many cases have this system existing today. So we won't build this new. This is not a *de novo* system. This takes existing data elements and analyzes them more effectively. Thank goodness some company developed a really effective processor for churning through all this data because the amount of data that we capture here is just unbelievable." – Mr. Roob

"Right now the DoD and the VA contribute many of these data elements to CDC in a 24-hour time frame, so we are including already a catchment of information from the federal health care facilities in the sort of prototype of the surveillance system we have under development" – Dr. Gerberding

"Wouldn't the 'hub-and-spoke model,' the rapid deployment of data to the different elements serve [some] value? Because isn't it possible that something could be going on in my neighboring community and I'm unaware of it because of the sequential nature? Wouldn't it be available to come back to me and wouldn't that kind of close the value loop?" – Dr. Perlin

"The downside of this is the reality of our public health system…in many cases…where there really is no capacity to make use of the information as it comes in, we have to rely on the nearest neighbor or the state to take on the responsibility for some of the local jurisdictions where they just simply don't have the investment to develop the capacity. Fortunately that's not true in every location. We have some marvelous local health departments large and small that are able to do this already." – Dr. Gerberding

"We believe the value proposition is there in speed, in sensitivity, and in getting the treasured epidemiologists that we do have to be doing something about the problem rather than spending their time acquiring the information and manually looking at it. That can be an automated process and decision tools and algorithms can be built in to warn people without them having to go to the computer to look at the data so they spend their time in…action to respond and try to prevent the problems." – Dr. Gerberding

Closing Discussion Highlights

"There is high optimism that [the Biosurveillance Workgroup] will, by the end of this year, be able to provide [a broad] set of data from existing databases that can in fact be accumulated, assembled to those local health departments who have the capacity to handle and use it, and beyond that at the Centers for Disease Control where it can begin to be processed and learned and refined." – Secretary Leavitt

"Let me add the states. I would be remiss if I didn't." – Mr. Roob

"[The Electronic Health Records Workgroup] will meet in March. You've defined some very important questions…we still have the pure vision in our sights, but there are some interim steps that we can accomplish this year…if I can get peer to peer, ultimately I can build on that and different models will emerge through the market…but the first step is getting peer to peer with standards that make the data exchangeable." – Secretary Leavitt

"[The Consumer Empowerment Workgroup] came out with the feeling that our specific charge is to have a medication record and a restoration summary and have recommendations on that by May. Along with that, we felt very strongly there should be consumer principles applied for privacy. We're feeling comfortable that by May we will have some very definite recommendations on what we can propose, along with certain population groups that could be tested." – Ms. McGrath

"Very similar to the other workgroups, [the Chronic Care Workgroup] believes that you need to build off an existing base and then leverage that base and demonstrate that in fact you can increase the quality of care at lower costs for people with chronic illness…So if you want something by the end of the year, it has to be built off of that existing base and probably some subset of that to demonstrate there is increased quality, decreased cost, increased efficiency. We had a long discussion about…incentives…We have a lot of work yet to do in that space." – Dr. Barrett

"I know there is a lot of work going on in the workgroups and I want to express appreciation for that. I also want to keep the sense of urgency that I feel in front of you. I've made a commitment on HHS's part that we intend to take these standards and to convert them to rule making which will in fact empower HHS, specifically Medicare and Medicaid, and other health care entities within HHS to begin implementing them." – Secretary Leavitt

"We all want to move forward on this together but the power of this Community is our ability to move the market in a responsible way…If we wait too long, the opportunity will pass us by." – Secretary Leavitt

Public Input Session

Speaker Number 1 – Jason Dubois, American Clinical Laboratory Association. Mr. Dubois commented that achieving the pure vision related to the Electronic Health Record Workgroup's charge is possible; one of the major steps needed in taking this forward is standards development. Currently, no standards have been recognized by DHHS for results reporting. A consensus-driven effort, known as "E-Links," is being housed at the California Health Care Foundation. The current version includes approximately 95% of the top 100 commonly ordered tests; Version 1.0 was adopted by the Certification Commission. Ultimately, this or a similar effort would need to be adopted by HITSP and the Department. Mr. Dubois concluded his remarks by noting that adopting the peer-to-peer approach can help reach the pure vision— helping advance standards development in terms of peer-to-peer and using a product such as E-Links would be a major step in the right direction.

Speaker Number 2 – Dr. Alan Zuckerman, American Academy of Pediatrics (AAP) representative on the Certification Commission for Healthcare Information Technology's Interoperability Working Group and Co-Chair of the Consumer Empowerment Youth Case Committee within HITSP. He expressed appreciation that the Community focused a large amount of discussion on targeting the pediatric population, but reminded AHIC members that children grow into teenagers. He urged the community to confront the issue of when the ownership of a child's record transfers to the child from their parents and what rights teenagers will have within their records. He also noted that many of AAP's members now are sharing PHRs from their EHR systems with their patients; however, an unexpected problem has arisen in that when these are brought, either hand-carried or on Web pages to various hospitals and emergency rooms, local security systems sometimes defeat access to them.

Dr. Zuckerman reminded the group that some of the current commercial payers are sharing not only laboratory result values but also ICD9 diagnoses from claims. The issue of direct sharing from claims data and including laboratory results to patients needs to be addressed within this process. Many of those portals for laboratory data are run by hospitals and hospital laboratories. A great deal of attention has

been paid to moving data on medication lists between the ambulatory and inpatient setting. There also is a need to make hospital laboratory data available within small offices. He commended the Community for keeping portability in mind and recognizing that the ability to change providers for both EHRs and PHRs will be a critical factor in adoption.

Speaker Number 3 – Dr. Carol Bickford, American Nurses Association. Dr. Bickford commented that there was a discussion about laboratories being the model in the EHR Workgroup and pharmacies serving as the model for the Consumer Empowerment Workgroup. She commented that this gives the impression that there are two "silos," and asked whether this is the case.

Dr. Brailer noted that this question will be posed to the workgroups, adding that these breakthroughs are necessarily segmented to create a clear path for the workgroups to find a solution. Although they had to be isolated, one of the challenges facing AHIC and the Office of the National Coordinator is ensuring an integrated solution.

Closing Remarks

Before adjourning the meeting, Secretary Leavitt thanked all members of the Community and those who provided public comments.