Opening remarks from Sec. Leavitt

The promise of health information technology is known to every person at this table, I don't think there is a person at this table who hasn't given speeches about the promise health IT, probably dozens of them, many of you hundreds of them. I wish today not to spend any time on the promise of health IT. The work of the community needs to be about actual progress, serious measurable urgent progress toward a goal that we all share, and that is a goal that the President has laid out for health information technology. We all have spent time on a number of different organizations. There are hundreds of different organizations, all of whom work in serious ways to try to move us toward progress. I would like to talk about why I see this group as being different – what are the distinguishing differences that make this group worthy of our investment of time and how will we change the world. I think our difference can be expressed in two words – market power.

Sitting at this table as we have gone around . . . and all of the public health community and private employers who just sit at this table, let alone private employers generally representing huge segments of the healthcare system. Let me focus on the federal players who are at this table. We represent by my calculations north of 40 percent of the dollars that are paid in the 1.8 trillion segment off our economy. When I became Secretary of Health and Human Services and it became evident that this would be part of my task I consulted with a lot of people about it and there is this very active discussion what the federal role ought to be. Someone said you represent 40 percent plus of the market, you ought to just move. You have the ability to go out and get it done. It is happening in places. People are using different standards. The federal government is the only place where there is a concentration of enough 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 one, we won't do it right. We have to be very careful not to interfere with the innovation of the market place.

It has become clear to me and everyone else that there needs to be a federal role here. We do need to lead with our feet, because we do represent a substantial amount of the market. Unless the federal government can really act to create the forward-leading momentum it is going to be difficult. On the other hand, we need to move in the right direction. Without being about to have consultation and direction and help and without the full involvment of those who are the innovators in the market who actually create the innovation, we might move the wrong way. This has really been a marriage of the market power of the national and local and state government and the innovation power of the marketplace. That is one of the things that makes this very different from the other opportunities that we have.

What this represents is a collaboration. I see the world beginning to intuitively organize itself into networks – not just in technology, but in every sector. Nations are beginning to weave themselves into networks. The EU for example is a group of countries who all decided to operate like a group of networked PCs. We're seeing it in business, we're seeing it in medicine, we're seeing it in science, we're seeing it in war. We are seeing it

in virtually every aspect of society. Intuitively we are beginning to organize ourselves into networks. Collaboration, in my judgment, is simply the sociology of a network, and learning to bring diverse portions of society to work together as 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 has had to develop – how do we organize ourselves to create momentum in networks. What we see represented at this table is an opportunity to begin that progress. Good collaboration is a lot more than just compromise. It is a lot more than sitting down and just splitting the difference. There are problem solving expeditions, they create tireless momentum toward a defined end goal. I need to confess and all of you know it that sometimes they are messy, sometimes they are difficult, sometimes they are complicated, but in markets this complicated, they are absolutely indispensable. And that's what the community is about is creating a network to begin working forward.

I want 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 that distinction. We chose not call this a committee. We chose not to have the title of this be commission. We chose to have it community, and I will talk a little bit about that in a minute. 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 nevertheless it is quite workable. I will, of course, need to maintain the autonomy of the office that I have sworn to uphold, but I would like to make clear that it is my intention to weigh very heavily the advice that I receive here. It will, of course, need to be converted to action. I want to make clear that I as secretary intend 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 payors, meaning Medicare and Medicaid and the Indian Health Service and FDA and others. . . There are others at this table that have similar capacities – the Department of Defense, the Department Veteran's Administration, 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 affect a profoundly important part of the health care market. Also sitting at this table are others who have influence among private payors. So what we are 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 a form of whatever regulatory action or rules as necessary for us to implement them, and it is my expectation from our conversations that the same will be done at the Department of Defense, the Department of Veterans Administration, and other departments represented in the public health sector that are here.

It is my hope and belief that the same will begin to occur in other sectors, because when you move 40 percent of the market, it is going to move the market, Our objective here in 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 on the pathway of health IT. It is often clear that in some cases for us to implement as a federal government, we'll need to work through the Department of

Commerce and NIST (?) and there will be certain occasions where that will need to occur and that it's so important that Michelle and her colleagues are part of this.

I mentioned the word community and I want to emphasize it again. There are 17 people sitting at this table. 17 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 you are here representing not just a 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 in terms of being able to provide advice and then being able to book it through to the year of progress will require all of those. There are hundreds of groups that continue to meet and make great contributions to our efforts. 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'll give you c couple of examples. The National Committee on Vital and Health Statistics has significant expertise. I have had extensive conversation with Dr. Simon Feldman (?) and they have indicated the desire to continue their own important work but to make it accessible unto us and 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 had been laying a foundation for this work over the course of many months. Yesterday, as a matter of fact, we announced the signing of some agreements on the development of the 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 have heard David say that the great thing about standards is that there are so many to choose from. That doesn't work. Ultimately in its totality there has to be a harmonization of those standards. Therefore it will be very important to incorporate in this the work of the Health Information Technology Standards Panel. If any kind of system is going to work there has to be a certifications process. There has to be some means of creating an independent group that is outside of government that can look at products independently and say .. NIST (?) we are 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 there is a harmony about what we are doing to move forward and to create a sense of certainty in the marketplace. The bottom line here is that if you are a standards development organization, I am talking to you. You are part of this community, and we need your help. If you are concerned about privacy and confidentiality, I am talking to you. If you are involved in groups and organizations, we need to have their assistance and their help and we need to have this community to serve as a hub to be able to bring that together.

We'll be bringing in public dialogue in as part of this. We'll have meetings, we'll have workshops, forums symposiums, mini summits and maybe some major summits. But the point is we are working as a community

I'll refer to today as breakthrough tasks. I am a believer that to get things done you need a task in the context of that task you are able to breakthrough different obstacles that were there to begin with but it needs content. We'll talk a little bit more about that in a minute.

I want to talk a little bit about how we operate as a community with collaboration. I mentioned the fact that way this vehicle …our role is to advise the Secretary. I want to operate in a collaborative way and I want to move with a model of the consensus. Let's talk about what consensus. To me consensus is not unanimous. There likely won't reach a unanimous agreement on everything. I tend to manage our group as chairman that will determine when we are for the most part in agreement, because this is an advisory committee to the secretary we are able to do that. The measure of our success will be that at certain points along the way we are going to reach milestones of conclusion. When we reach those milestones of conclusion, if as the chairman I have bypassed . . . too many times, it is going to manifest itself, because the majority of this group is going to agree. If that is the case, 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, to understand with certainty if we are on track. But for the most part I intend to keep us moving forward in a very constructive way so that we are not bogged down in details that might not be as weighty as the conclusions otherwise would be.

Let's talk for a minute about our agenda. I think it is important to acknowledge that there is a significant number of cross currents that we are 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 is 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 cross current of pressure between adoption and interoperability. I want to be clear that I believe we have to deal with both problems. Unless we are able to create adequate adoption, interoperability is a hollow victory. On the other hand, it is my belief that adoption will never adequately occur until there is a level of certainty about the market.

I was out at Stanford a couple of months ago and I stepped up to the bench of new pathologist who was about to leave the university and go to practice law in another western state. He said "I have heard you talk about health IT and I want you to know that I agree with it. I just need to know what to buy -- I can't afford to do this more than once and I've got to be right. Just tell me what to buy." I couldn't tell him what to buy with exactness, but it pointed out very clearly to me that the small practitioner needs certainty if they are to have adoption. 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 what I think we aspire to do. So here is the point I want to make. We will take on adoption as a department and a government. But our efforts here need to be more about how to create connectivity and interoperability. There will 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 will 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 uses the same term for everything and the information is electronically exchangeable.

I think all of us have some version of that vision, but that vision changes over time, It also changes with the perspective of the person is viewing it, but there is in all our minds a pure vision. That pure vision will take a decade or more to achieve and it will only 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 immediately available progress with the long term pure vision.

I believe that can happen. We have seen it happen in our discussions already. There is another rather significant cross pressure – what should the emphasis of our efforts be? We have talked today a little bit about immunization records. That is a very clear consumer or retail manifestation of the benefit. We have talked a little bit about the avian flu. I am going to talk more about that in just a few minutes and the need for electronic health records at the heart of our biosurveillance. We have talked about the need for hospitals to be 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 the way to merge those communities of benefit and find a balance.

I want to talk just a minute gain about the importance of in terms of our agenda of action. I indicated that I thought the most significant part of our capacity to implement was market power as represented in federal expenditure. There is another one, which is the belief on the part of the marketplace that we are going to act. I believe that the 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 sponsored by the government, we will not have succeeded. However, if we can choose a series of early breakthrough anf accomplish them, the combination of that action and our ability to move the market with our expenditures will signal great progress.

Let me give an example of how I believe and what I believe we can act quickly and we can act in ways that will profoundly change the health IT community. As Lillee mentioned her personal experience with her family in New Orleans. I experienced it. Julie Gerberding did as well. I went to 17 different cities in seven different states …it became evident to me that somewhere around a million people or maybe more who are now functioning in the world without healthcare records. I sat next to a cot with a woman who told me about watching her purse and her false teeth wash out the back door from the top step of her landing. She said, "I am 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 am supposed to take a yellow pill everyday about noon. I don't know the exact name of it, I don't know the exact dosage of it." In my estimation there is some 40 percent of the people in that situation..

With some very good leadership by Dr. Brailer and a lot of other people in the community --specifically the AMA, the gold standard, the Markle Foundation. . . the Louisiana and Mississippi Departments of Health and the group got together and in the course of a week solved the problems necessary through available information, through available technology and they created a system where a physician could go on a secure Web site, reassemble prescription drug records of virtually all of the people in that area in a week. Don't tell me that it should take a year or two or three to make substantial steps forward in health IT. The progress is available to made, What simply needs to occur is that we need to come together with a set of priorities, move forward with a set of standards that we can all agree to and implement. I believe that's what brings this group together with such potential.

With that, let's talk about the way we are going to assemble a decision on how we will proceed. My grandparents, my father's parents, lived in a little town called Bunkerville, Nevada. 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 quite a deliberate way of going about it. She would lay all of 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 would go through all of the pieces that had a straight edge and she would line them up so there was a border. Then she would start looking for the corner pieces. Once it had taken that much shape, they would begin to sort them into piles that had different colors she would family together and every member of the family was assigned a different sector of the puzzle to work on and over time every piece would one at a time be put into place, and over time it would get easier, because you could see what piece you were hooking to. 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 have begun to put in the corners in the form of a standards organization, in the form of a certification organization. Soon we will put into place an architecture, we will put out announce the results of an RFP that will begin to allow us some alternative architecture.

But the next step will be for us to begin to divide up the pieces of the puzzle that we want to solve. The logical thing to do will be to divide them into some categories, so I would 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 will call consumer as power breakthroughs. 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 has been about being able to create large public health benefits. All of 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. Michelle talked about it's a priority for me to have an immunization record. You talk to about any mother of preschool children and that would be a good thing, if they could

go to the Internet, despite how imperfect it might be, and have a record when their children were immunized -- that's a winner. There would have been a lot of people in Louisiana, Mississippi and Alabama who would have 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 they could just have a PDF of a lab report or a doctor's diagnosis record, it would have been terrific. While that is not exactly the pure vision that we are after, the technology exists for that to occur and occur soon. I think 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 . . . but in every case I know of incremental progress toward a pure vision comes perpetually preferred perfection. That is what we are dealing with here -- finding ways to move toward the pure vision, but at the same time take the available opportunities for progress.

So what I would like to pursue our agenda, we have identified in advance of your coming and have reviewed with all of you 14 potential puzzle parts. 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, 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 would like to have us consider in putting this puzzle together, that will become an inventory of "breakthrough" projects. In our work we will then begin to look at those and conclude which ones we want to under take and then, just like my grandmother, we will organize some workgroups and I will ask one of you or two of you or more to chair that workgroup. Then . . . the broader community can identify the best people we can, the people who need to be at the table if we were to use existing technologies who could make it happen just like the Katrina pharmacy project. If we identify this task and send them out to figure out how they can do it, we'll ask them to bring it back and we'll want to filter their products 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 and 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.

After the break I would like to begin looking at potential puzzle parts. I would like to tell you about one puzzle part that I think is of compelling national interest. 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. . . different countries over the course of a week. We are going to deal with the potential of a pandemic influenza. It is of vital importance in this country that 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. What is happening currently exists because we have devoted people in emergency rooms and clinics and other places to identify the symptoms and to report them through public health channels. Regrettably that often takes two to three weeks before the docs to begin to connect when it happens more than once. That is unacceptable -- it needs to be between 2 and 3 *hours* because our capacity to respond to either a pandemic situation or in a bioterrorism event absolutely depends on our capacity

to define the area in which it has occurred. 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 the reporting of public health incidences related to bioterrorism or pandemic flu or other public health threats. That's the only puzzle part I have absolute certainty about. It is one in which I believe we have a responsibility to act.

In summary, I do believe this is a unique opportunity we are connecting market power with market innovation with a commitment on the part of the 40 percent of the medical market to move it will require us to balance between the various competing priorities, but we will do it like a puzzle. Breaking it down into small parts we will begin it to 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 will be meeting somewhere between every month and every six weeks, but in addition to that, I am going to be asking you to deploy on a lot of these work groups. This is going to be an active group. I think our success is dependent on our ability to deliver serious momentum and action. That means that we have action. I have to act as secretary. It means the Department of Defense has to act. It means the Department of Veteran's Affairs needs to act. It means that the Department of Commerce needs to be prepared to act if we are to use this market power in a productive way. I am 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 time frames or faster than what we do. It is my fundamental belief if we don't lead the market we will be a drag on the market, and if we are a drag on the market, we will have failed, and I have no intention of failing, and I know that is not the reason you are here either. With that, we have time for a break and we'll come back. If you have any comments about what I have suggested, we'll take a few minutes to do that and then we'll get right down to dividing up puzzle parts. Thank you.

BREAKTHROUGH DISCUSSIONS
Review and discussion of framework

Secretary Leavitt: I would like to ask Dr. Brailer if he would … I think you all have been provided, under a sort of orange looking tab, . . . the potential breakthroughs dated October 7. I am going to ask Dr. Brailer if he would begin to describe them. I think our purpose would be to go through all of them and then to come back and have some discussion. As he describes one, I am going to pause and if you have a question or a comment or some level of commentary you would like to make that point, this would be a good time. I don't want to have a lot of priority-weighing until we get through all of them, but I would like to have questions or comments about them that would be appropriate. So Dr. Brailer. . .

Dr. Brailer: Thank you, Mr. Secretary. We have assembled 14 potential breakthroughs and I would like to describe the concept of a breakthrough. These are health information technology applications and uses that could produce a specific and tangible value for

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 health care
- Health improvement -- which is how doctors, nurses and other clinicians do their work
- Public health protection

These breakthroughs are not an exhaustive list as the secretary described. This list is a compilation of archetypes, of categories and 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, time tables, barriers, etc. This again is not exhaustive and there are many others that we will 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. and the individual can use to access information about their children perhaps if they are ill, or about an ill parent. These tools are used to communicate with clinicians and be able to tract health status and be able to integrate personal health information with advice and other treatment options. Any questions or comments about what is intended by the concept of personal health record?

Secretary Leavitt: Let me just speak and say that obviously this could take a lot of different forms. It could take what is available at any of a number of a large number of hospital groups or softwares where there is an individual, but I think what we are looking for here is an ability to create something that is more universally accessible. I have had conversations over the last little while with a number of different people who have made the point to me that "if I had the ability to even have access to something that was available in an already commercially available format . . . a PDF. If could go to a web site 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 would like for you to put them into a PDF format so that they could be assembled on my behalf. I am prepared to take responsibility for the privacy of my records. I am not asking to have access to your system. I am simply wanting to have access to my records and I would like for them to be sent to me electronically in a form that I can have assembled somewhere else. That would be a very simple way what I would then have is potentially have my immunizations, potentially have my lab results, potentially have the information I need.'" So I think we are talking about a large range of options here – from something quite basic like that that could then lead us to the more pure vision to what Dr. Perlin described is available at the VA and actually what Mitch carried in with him. The problem what Mitch has I assume is that he got that from one hospital system.

Mitch Roob: Actually three different . . . all Indianapolis hospitals . . .

Secretary Leavitt: OK, so that's an example of the kind of thing we're talking about, where through some available formats, the 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. I want to acknowledge that having my health records available on an Internet site might be secure does bear some risk, but I am not speaking here in terms of my public policy hat. I am just saying that Mike Leavitt would like to have that on me." So that is one idea that I think would have some consumer appeal to it and would begin to connect consumers to this idea of having access to their own information. If it were available, we would begin to migrate toward the pure vision. Any other comments?

David Ayre: That is sort of along the vision we have for the consumer … I think that right along creates an accountability for patient or consumer or employer or whatever it is and they are responsible for owning their information and that will help them …that is . .. because you can do that worldwide. So the concept of creating that power and accountability and the responsibility to the patient to the patient to fill the gaps in you cannot have everything electronically available. It may take us 10 years. In the beginning if they can go in and if they .. . and they actually get a piece of paper an they put it in themselves that will give them a long .. in the situation

Chip Kahn: I think there is a host of issues here. I won't go over all of them. But at the very face of it we have the problem of the interface between paper and anything else, and that develops a . . . How time-sensitive is this? And second, I don't know if I called my internist today he would be willing to give me my record. That is always an issue. If he was, he's going to say, "Oh, but if he had to give the record to every patient." And he only has paper – and most of those files are this thick. . . the question is who is going to make a copy, who is going to scan? I think that we're easily getting into one of the problems is even thought in itself at the surface, it seems like a baby step forward, you immediately get into all the issues of infrastructure and the underlying issues and problems because there is going to be interaction of paper with anything that is futuristic and electronic.

Secretary Leavitt -- This is a really important point and naturally would come up in the context of the first one because I am guessing it could be said of any of them. But it is a good way for us to illustrate in my mind the way I believe we ought to work together. Everything you . . Chip, I think is true, and ultimately I think will be true of all of these. What I would see us as a group doing we are defining the where -- where do we go. We would then organize a workgroup who would have people with the right expertise to identify the issues and 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 the puzzle piece, and then we will come back and have conversations 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 this initial stages because there isn't a clear business model about who will pay for this conversion, scanning, so forth. But if we create the technology, this harmonized technology pattern, what could happen in the market will

begin to drive it and people will figure out the business model, they will figure out if they want to offer it, the market will allow these things to unfold. So I would like to say you are asking exactly the right kind of questions, and we need to do that. But that is where I see it as heading into the question of what we take on as a matter of problem-solving.

Nancy Davenport-Ennis: My comment I think from the perspective of the consumer and patient community is that indeed I concur with all …I think that the consumer community and patient community has demonstrated to us over and over again that if they are taught, instructed what their responsibility is in the new process, they will engage on it. It may take 10 years before all consumers have access to all of their personal health records or electronic medical record. I think from the consumer perceptive it is 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 expressed to us in conversations we have with groups across the country as one of the major concerns. While patients see huge benefits in having access to this record and they want to have access to it, they know two things: it is going to take the cooperation of every medical provider for them to have it, and number 2, it is 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 those I am here to represent, I think this is one of the very important breakthroughs that we would like to see as a result.

Doug Henley: Two comments and observations. I totally agree with Nancy. This important work … and at the end of the day, it is not about doctors, it's not about hospitals, it's not about vendors. It's about patients, improving the quality of care, improving the safety of the care they receive, 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. When that usual source of care relationship exists, quality goes up and cost efficiency is improved. Revealing a .. bias as a family physician, there is also significant literature that shows when that personal medical home is with a family physician or other primary care doctors, that quality situation increase even better and cost efficiency improves even better. It is important then as we talk about personal health records electronically that the technology, the architecture, the standards or whatever we may be talking about that they are integrated so that patient physician relationship is enhanced in that process so the patient can get that information when they need and want it and it's not site specific. That it flows back and forth between that personal medical home and where that patient is. And even in a pay . . . system today there are those technologies that can do that. 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 it has to be integrated so it flows across and back and forth so that patient physician relationship, that patient provider relationship is further enhanced.

Secretary Leavitt: I'll go to Kevin and then I want to go to the next one. We'll come back to these as we go.

Kevin Hutchinson: Just some brief comments, echoing what Chip said and also what Nancy .. as well. One of …representing ancillary services is the sources of the data. There is a lot of information in health care that is electronic at one stage in the process but it is turned back into a paper environment, whether that be lab results, whether that be medication information that at one point was in an electronic state. What we need to consider as we look at all of the different elements where are the 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, an electronic health record. One of the things that we learned during the Katrina health project was around authentication. . . So privacy and security as well, but authenticating that this individual .. whether it be a physician – in this case we were very fortunate to have the AMA involved in the project tot help us authenticate physicians and physician access to that. But that is a big feat. Otherwise ….

Secretary Leavitt: The next two or three begin to look like sub-parts of what we just talked about. I think the question of what we just looked at is the whole cost?.. Now's look at small pieces.

Dr. Brailer: The next is medication history, which would be a compilation of someone's prescription, potentially over-the-counter products, but certainly prescriptions as we evidenced in Katrina Health. The purpose of this as many of you know is to have that information available both for the consumer to their clinicians to, their clinicians who need it. Either because of episodic care or events like an evacuation or many other things. This is directly linked into the advances that are happening with prescribing and other components and other healthcare electronic advances. There are probably are others with silos of information… could be lab etc., but the consensus (?) of this evaluation was that the highest value, most easily accessible sub piece of the personal health record is the medication history.

Secretary Leavitt: Why don't we go through the balance of the … and then go back and talk …

Dr. Brailer: The next is even more scaled back from the personal health record which is the health record locater, which simply an index of where it exists for that person – a set of pointer, if you would, that perhaps either tell 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 is .. data and here is how. This is at the core, as of many you know, of the centralized personal health record to start with and could be a stepping stone or could have its own intrinsic value, but it itself it would not be the data but indices of a way to find the data, the tags, the pointers. And finally a piece talked about by many people here today is a central set of registration information, demographic -related, insurance payor information, to be used when someone arrives at a doctor's hospital or handling a component of the explanation of benefits on the after-care side. This would be essential a single, centralized, updatable data base for each person that any person that want to get

access to that – an insurer, a provider, a lab – could access to make it easier for the patient to not fill out these forms. So this would be an electronic clip board if you would.

These are four categories, four types of things. As many of you know, there are many other variations of this. I will try to summarize both .. the types of ways .. personal tools …

Secretary Leavitt: Take some time, David, to elaborate on the range of sophistication or the ways in which, how elaborate these could be. What is the range of operation these could take? For example, there are a lot of different ways a registration system could be configured from that would require some sort of electronic interconnection between all systems – much harder to reach -- or some Internet-based system.

Dr. Brailer: Starting there and working up, clearly there could be for example, a portal that someone could go to. . . . enter updates of their home address that could then be accessible as a Web portal (?) from any doctor, hospital or lab, or if was automated .. . tied into practice management systems or billing systems, etc. so the question is here is how integrated is …into the systems . . . of those … The health record locater has various ways that it could be constructed …it is an identity of a person that provided by a data holder and some information about a URL, Web address or access codes, or phone number or fax number for that data holder. And the question then 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? Most of these projects are happening in regions around the US -- they are quite diverse. If the system is online it does have a Web access tool. If it is not, it simply has a phone number. It is quite, if you would, flexible in terns of the various types of data.

The medication history to Kevin's point the . . .problem with the electronic data holders at this point. Recently Katrina Health was able to make rapid progress because a large share of the data was held by a very small number of entities. Because prescription data has become so concentrated . .. 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? There is a great degree of variability each with more value …. I think it is a question of how far we want to go.

Craig Barrett: Back to my earlier comment, the Internet as an entity allows one to access to essentially all of the world's information except Medical records. If I were to put Michael Leavitt into a Google or Yahoo or MSN search engine, I would get hundreds of thousands …all sort of information about you .. but the fact it contains so much information with standard technology it is inconceivable to me that you can't engineer a system with existing technology to also provide a personal health record to allow you to encrypt, password protected, or biosensor protected or some thing that you could have your record inputted. Not being in the medical community and recognizing that 80 percent or more of the records are paper-based you point out very clearly that you could scan those in and .. format. I just have to encourage the community to recognize that that

this vehicle already exists to search and sort information with existing technology – we are jut not using it in this particular case.

Lillee Gelinas: I wanted to weigh in on the side of the …part of the breakthroughs really represents personal accountability. I think that the more that push to the consumer the better, I am personally accountable to pay my taxes, I am personally accountable to stay healthy, I am personally accountable for my social network with my family, I don't depend on anyone else to be accountable for me. When I was talking to Dana when we were going out 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 under water and irretrievable right now. We will never be able to scan them. It's an imperative that has really 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 out of frustration "I couldn't get this, I couldn't get that," and 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. It is a matter not of debate, it's a matter of a place where we've really got to act quickly.

Scott Serota: Conceptually I don't think there is any way to dispute the fact that … and I support the notion that the technology already exists. The issue of personal accountability is also one that on the payor side we believe is essential if we are going to keep health care affordable. My concern relates to health literacy and the fact that we are beginning to ask people to do things …I think it is important if we move along this path of personal accountability and personal health records, it's got to be coupled with some mechanism to improve health literacy in folks, because we can't ask people to be accountable for things they don't understand. And we have a large portion of the population that either don't have access to computer or who aren't computer literate. I worry that we may exacerbate the uninsured issue and create an even greater spreads between the haves and have-nots…in access to care. As we look at this we have to look at this in the broader context of not just people sitting around this table saying "yeah that would be great for me because I understand it and I would do it." I think about my father in Florida, 80-plus years old who doesn't even know how to turn on a computer and say "now, you are going to be responsible to make sure your records are OK?" and he would say "my what? I don't know, I can't find it , I don't have a computer." I think we have to look at it … a transition. Of course, my kids and all of our kids, they could go down there and take care of everybody's records. We need to be assured that we look at it from that broad as possible perspective and when we give people accountability make sure we also give them the tools to accept that.

Secretary Leavitt: (?) Did you want to comment on that?

Robert Kolodner: Thank you, Mr. Secretary. I think one of the things that we have heard is this issue of personal accountability …for getting started and not trying to force it on anybody, but have people choose to raise their hand to move forward making these

available and possibly having people choose which parts they want to have. And it's really the way to move forward and I think what we have seen in VA is that the people who are .. 49 percent of our patients are over 65 – obviously the Medicare population falls into that –that the issue of privacy is less important than getting information to the providers. So there will be groups of people who will choose this …because they trust the technology or because they don't have a job that's at risk or health insurance that's at risk. Their health is more important. They will choose to join in, and I think the other part of it is even if a solution .. a person doesn't have to be technologically savvy, they can have someone do it on their behalf and there will be entities that will arise – just like the bank takes care of my money – I don't need to know how to do the transfer. …or older family members for younger family members. Again, its according …

Secretary Leavitt: Let's move down to Nancy. I would say the last two months before Katrina I went to 51 cities in 32 states to talk to seniors about the Medicare prescription drug roll out. What it provided me was a one-on-one opportunity or a small group setting with literally thousands of different seniors really sensitized me to the difference in circumstances of different seniors. And how many of them are dependent on their child as a caregiver. On the other hand, there many who are quite engaged and just want to have control. What I hear all of you saying is that there are some people who would benefit differently because of their circumstances.

Davenport-Ennis: I certainly concur with all of the comments that have been made around this subject. But I think the community would have the opportunity as we are looking at how to implement a breakthrough in this area for consumers, that we would 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. . . 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 .. model that would say in different circumstances this is how you still have access and then moving back to the patient accountability and the costs that may be accrued to the system to make these records available. I think that is 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 who cannot perhaps can …system where they can get their records in an alternative . . .

Secretary Leavitt: Thank you. Chip?

Kahn: I think this is an important point. I hate to keep using the Katrina analog but if you look at Katrina, there were a million people who figured out how to get out of new Orleans. There were 200,000 who didn't, and we sort of want to ….this. I think we need to be careful wherever we go that there will be even maybe a majority of people who can figure out how to navigate …critical .. On the other hand , if we look at sort of the dynamic of who's more likely to need this system and be sick versus who's not, probably that 200,000 use a lot more health care proportionately because of the nature of the population. I think whatever we do, accountability is critical, but I think we have to be realistic about accountability, but I don't know where that gets us, I don't know where

that gets us in terms of cost, but that's gotta be there because as we were saying, my sisters can figure out -- they're in their 40s -- they can figure this all out. I just know with my parents this drug benefit .. few months, having to try to deal with the other card we got this great national experiment and I think it is going to be …The trouble is we need to use that national experiment to understand …

Barrett: I just wanted to point out with all of this question of access to computers and the Internet .. I find it really interesting that we are here in the United States talking about this subject and you go to a country like Brazil, which has far less than 10 percent of the PC Internet … penetration, over 95 percent of income tax forms are put in online in Brazil. It's entirely possible for countries with essentially no infrastructure to go 100 percent electronic for something like filing tax forms. We may be discounting the ability, the capability of the average citizen in the United States to use this capability, discounting that substantially.

Secretary Leavitt: Kevin, did I see your hand?

Roob: Mr. Secretary, I am a bit more optimistic in terms of where medical records are today. In the case of Medicaid, we can probably reconstruct … claims data .. today. For the least insured, most at-risk patients, we probably have somewhere in our databases ..have a lot of that information already in the public health clinics, that provide a great deal of the indigent care. Those records likely exist electronically in more cases than the folks that are privately insured. I think frankly the lower economic status we may be farther ahead than people who don't deal regularly …

Secretary Leavitt: Mitch, your comment is a wonderful illustration. 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 means that there are two very difficult places to penetrate, and we may not even want to go there in the long run. One is the sanctity of the database .. by provider. If I am a provider, I have very serious worries about anybody going into my records. That is a bad place to be for anybody who is not authorized to be there for very specific purposes. I think that is a place that is going to be a place that is going to be come somewhat sacrosanct. The second area is the .. of aversions 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 and I would just like to have it. It wouldn't be the end of the world if that happened to me, but I ought not give that up for anybody else and 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 that is resident in everyone's system is electronically interconnectable and the person that is not naturally capable or whatever circumstances not able to use that data on a voluntary basis, it would be available to some caregiver who would want it. If I am a physician, an emergency physician, and I have someone presented to me it would be very helpful .. You hear people talk about, I am not here to in any way promote this idea, but you hear people who talk about having a chip under their skin and the physician will hit it and it will know where you live and your medial record. That would be a very helpful thing to an

emergency physician. We obviously have a lot of other concerns. In the two areas we have to be very careful to not do anything at least in the early stages of this to deal with are access to people 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 . . one is going inside anybody's system. There may ultimately need to be either a market incentive or reason for people to send data out to me, but it doesn't penetrate either one of those sensitive areas.
Other comments. Yes, Michelle.

Michelle Springer: I'll take a slightly different perspective on this issue. Looking at the overall architecture and thinking about this .. characterizes.. particularly with my health record locator being a stepping stone, if you will, we see enormous benefit in starting it …starts answers to questions (?) about where is the data and how do we find it. I think if you look at that as the underpinning of some of the other parts, sub-parts, in the overall records, it would be an interesting place to get started …launch ..

Secretary Leavitt: What I hear you saying is if I had the ability to walk into a clinic and they handed me the clip board and I could at least say to them "Here is the way I identify myself. Go on the Internet and it will call up my name and my address and my latest information on insurance and so forth" and it could go into some kind of standard format that that would be at least be a step forward.

Springer: Yes.

Secretary Leavitt: Yes, Bill?

William Winkenwerder: You asked for initially our thoughts on these four areas. I agree from our perspective .. these are the areas to focus on in terms of consumer involvement and empowerment. But secondly I just want to comment that there have been some very good comments here and concerns and expressed objections about certain things. I think one of the things the group might well turn its attention to, and I suppose I have to be careful about this, but is getting better educated about what is working. Craig gave an example of something that is already happening. There are lots of those examples and I think it could alleviate some of the concerns frankly about privacy, confidentially or how this particular thing can work you know or not. There are many examples out there.

The final thing I want to say is sort of the principle that it has been our experience in looking at progress we have made in the Department of Defense in the last four or five years in this issue, and we believe we have made huge progress, is that a bunch of that has been borne out of necessity and if there is sense of necessity. For example, we had been promoted to really make a quantum leap on the health information we collect on our service members on the battle field and that is probably about as difficult a place as you can imagine to collect health information, but we do it today. We do it electronically, We are able move that information back to our central date repository in the United States,

The reasons though that we did it frankly or focus so much on it on it 2001 and 2002 was there was a terrible track record from the 1990s …the first Gulf War about all of the illnesses 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 in the area of security we had a break in three years ago into one or our facilities and records and personal information .. And it was a wake-up call about what we needed to do in the area of security. So we did a massive overhaul of our approach to security. Today we feel like that's something we've got tacked down pretty well. I think we've all got examples to share of things that work that address some of the biggest and most difficult problems …

Secretary Leavitt: Good. Kevin?

Hutchinson -- Getting back to your analogy of the puzzle, the pieces of the puzzle. Actually, as you talk about personal health records, there has been a lot of work done in this area specifically the Markham (?) Foundation … area that is interesting to the analogy of the personal financial record. If we go back in time back into the Microsoft Money and we all start using these things, we remember that we were writing checks were inputting information into these applications that had no connectivity to these banks. So the value in 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 all of my checks only to print them, sign them and stick them in the mail to someone. I also did graphs, pictures of my financial record (?) which I never used.

Then there was the day that I could actually get electronic access to my bank and I was now able to do reconciliation of my statement and that was valuable and now I have a lot of information and it is useful. Then we moved into the investment area where you could actually do investing online. It became much more valuable to people to start using. So back the source of the data, if you take the puzzle, actually there are pieces within this that we have to focus on, going back to the sources of information that are electronic today. I hear time and 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 and I could learn a lot about a patient just having that information in front of me." …It's not a complete record, but it's a start and there is value in that and the same thing with allergy information. As we look at these pieces under the personal health record I think that something we have to break down. It's not the complete record day one but what the elements and pieces we can deliver them …

Secretary Leavitt: That is a terrific illustration of the pure vision and the integration of immediate progress moving toward pure vision. I never thought of that. I understand that you said you started off a very early adopter.

Hutchinson: A geek

Secretary 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.

Hutchinson: And I don't think the major market will go through those early steps, but I think we are already at a point in health care where we can take advantage of some sources of information that is already in an electronic form to ..those manual entry steps. There will be some manual entry you may want to add to the record itself, but we already have sources of data that can be electronic. .. whether it is pharmacy or payors or labs that we would be able to input and send this information electronically …

Secretary Leavitt: Another thing I was taking from your comments .. that if only 10 or 15 or 20 percent 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, those who benefit in the last crunch of the doctors have benefited from what has been learned in the capacity of deciding to move in steps toward the pure vision.

Julie Gerberding: I am thinking about here is an analogy to banking and recognizing there is kind of third step and that is when the bank begins to send you information or alert you that there is a problem with your account or something that you should do. …These elements of the personal health record would also lend themselves to that kind of alerting. You know, "you are 50 years old and you need those 50-year-old tests" or "you need to seek medical attention for this that or the other thing." So there is a way that ties this into the second category of health improvement without relying on the consumer per se to have the knowledge to make use of the information directly.

Secretary Leavitt: Mark?

Mark Warshawsky: This is a general point relevant to these four as well as the others, and I am wondering at what point do we bring this in. What are the specifics, not the general, the specific policy levers that will create …I know it's important because as we prioritize we want something that has a very high probability of achievement in a quick framework, so we have to have some sense of how that is going to happen. We may not know all of the details at this point, but we have a little bit of the sense of what is doable and how it can be done. In particular, Mr. Secretary, as you indicated, there is 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 use in any of these?

Secretary Leavitt: It would seem to me that that clearly has to be part of the discussion. Maybe one of the things that gets teased out by a workgroup to bring back to us. Part of the assignment of a workgroup needs to be what are the public policy implications of this and then have a full discussion. Good point.

Someone else raised their hand.

Kelly Cronin: Building off that concept, I …request public information … request information on what the agency's roles should be in trying to encourage the use of

personal health information and PHR adoption. We're in the process of …through all of that now and working with Office of Civil Rights and making sure within current law what are our appropriate first steps we can be taking not only getting a lot of claim data out (?) It could be Medicare and Medicaid data – but how do we actually think about, to our current authority, what we can do as an agency to push this forward. So I think that would work really nicely with any kind of workgroup that's formed.

Doug Henley: I want to make a two points. The first one is back, Secretary, to your …about demographic data of a patient, registration data, and they walk into a hospital physician's office and they want to rather than fill out the clipboard three different times, they say "my data is available on www dot 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 is one thing to have the patient in this case in control of that information, which is great for updating purposes etc, but most places in the system now – forget the HRs for moment – have for want of a better word practice management systems in their electronic. What we don't want to have happen is for that patient to show up with a memory stick with that data or a Web site and somebody to have to go to it and re-key it and re-enter that information. It has to be able to flow into other systems freely, interoperably, so that hands don't have to touch it any more in terms of mistakes that could be made. That could be a VHR, 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.

Point number 2, Craig alluded to this and I hope I interpreted his comments – I have never been accused of being bashful, so I will go ahead and say it – it appears to me and I am not a geek in this area at all -- but it appears to me that we always talk about technology in health care as somehow different as technology and the rest of the world, and it can't be that way. In my impression at this point and time having put some emphasis on this the past couple of years is that a lot of the technology and standards in health care are old and they haven't kept up with the marketplace, and the marketplace being the rest of the world, whether it's the banking industry or whatever it is, and somehow we have to integrate that as well. We've got to get over this idea that the technology has to be different for health care. Now there are different requirements perhaps in health care and different reasons and so forth, but the technology needs to be seamless throughout the whole world.

Secretary Leavitt: Your comment about integration of the data. I would like to have a standard established that the providers – there are some 200 vendors that make practice software – it would seem to be that if we could from this process create enough of a standard that the way information was recorded at a Web site or on the chip or whatever medium of carriage is, that they could then begin to adapt over time their software so that when I give them it to them on a chip or link to the Internet or whatever it was that it immediately populates the fields that require my insurance information for the seventh time. And they want to have lot 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 can adapt to it. This has been a really helpful conversation. Do you have a comment?

Ayre: Do not underestimate our consumers who adapt to accommodate to get where they need to go. I think about it from Pepsico's standpoint, we decided to go into a wellness program the year and . . . ago. We had 80,000 people that we wanted to make it available to and we wanted to do it Web-based. We had every debate about privacy and "they won't be able to use technology and the front-line people won't have access to computers" and went through the whole thing. So we went out and we did it anyway and 27,000 people of the 80,000 signed up and 92 percent 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 a health-related issues. . .to change their behavior. Not perfect. We have all kinds of issues, but this year we hope to have 45,000 …

They got it there. And you know what they have personal health records, they are putting in by manual. They're doing it like you do and printing it out when they come to the doctor, but that's way better than sitting around saying "you know what, until we got the perfect solution …get there." And I believe the consumer will adapt just like they started with Quicken and then made their way to my mother who at one time I had to show her how to use a microwave and now calls me on her Blackberry. That happens. If we just keep that positive . . . moving forward, we'll get there. And you'll make mistakes -- consumers will reject some of it, but don't try to get it perfect before you go with something..

(another voice) ?? -- Has your mom figured out how to use her VCR yet?

Secretary Leavitt: My mother discovered e-mail. As I mentioned I am from a family of six boys. We all get what my brother calls low-overhead lectures now. She used to call us. Now we just get e-mails. If you're out there mother, I apologize.

I came into this conversation with this thought in mind. If there is a feeling among this group to go the first step is which is my registration information, that might be a good place to start, test out of our workgroups. I've got to confess to you I am emboldened a little by what I am hearing around this table. And here is the conclusion I think I would draw. Let me just express it and see how the rest of you would respond. It seems to me that a workgroup that could explore the boundaries of this -- say what is available, how could a system work? What would the public policy implications be? What would be the ramifications of registration? 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 pure vision and have them bring that back here for our discussion would be a very productive step. I would just like to get your reaction to that.

Dr. Winkenwerder: good idea if we had some examples. . .

Barrett: As we all talked, I think the technology is there. I don't think there is anything unique in the healthcare industry. I think privacy is just as important in financial

transactions as it is in health care. I think a definitive model brought back and let the group look at something real as well as hypothetical would be great.

Secretary Leavitt: Other thoughts?

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

Secretary Leavitt: I saw another hand.

Serota: I am also supportive, but I would encourage us to include the economics – it's a great idea, but how do we pay for it? Who's going to pay for it? .. This is a high priority that I see would represent a true breakthrough.

Secretary Leavitt: Kevin?

Hutchinson: I'm all for it as well. I think we also need to recognize some of these elements, for example, the health record locater if we. . . limited to the consumer side. This is an element that actually crosses over into other pieces of the electronic health record. Physician connectivity among physicians and hospitals and other environments at the community level. As we launch the group, we need to determine whether that will be focused on just the consumer side of that health record or if that's something that takes on a broader approach.

Ayre: The childhood immunization record, is it in the right category or should there be new category ? Maybe there is a reason that I don't understand?

Secretary Leavitt: That's a good question. I think the way we are talking about it as one step. I think the way it is being thought of in the public health arena is much different, is actually part of the pure vision -- where epidemiologists have the capacity to get nondescript data and scan (?) 50 million people and say x, y and z. …Julie is that a fair statement?

Dr. Gerberfing: It kind of fits into all three categories. It has elements of each.

Secretary Leavitt: We probably ought to look at it in the context of both.

Chip?

Kahn: I have two questions. The first is childhood immunization records. It seems to me that considering the challenges ..and second, this becomes really problematic because the

childhood immunization record, in general, is fairly easy to grab onto because it's either going to be a pediatrician's office, a community health center or a public health department of some type, whereas as soon as we are to adults and immunization for the flu, it could be any place – it could be my office or it could be at any pharmacy or a senior center. All of a sudden you are in non-medical environments where the flu shot is given and the question is where is that communicated? Why are we just talking about kids on this one?

Secretary Leavitt: I think that's a very valid point. My guess is … here's where it started. When I was governor, we were last in the country I might add in immunization rates, and to my wife's credit, she took the issue on with a 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 am very proud of her. When I became Secretary I found out that was happening in a lot of other states too. And that there is maybe 30 or 40 states that have a similar system -- none of them are compatible . So one of the (?) things that makes Dr. Gerberding and her colleagues at the CDC crazy, because they would 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 could raise the vision here that we are going to Asia because we might need at some point every man woman and child in a very rapid way and if we know who that .. for would have it …it would be able a very helpful process of being able to protect the country against a pandemic or a bioterrorist …or whatever so that's a very important contribution.

Here's where I think we are …who could begin to frame in the world of what's possible with existing technologies 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. I believe on that proposition I would be prepared to declare a consensus and I would like to propose that we bring back or I will ask the staff to bring to our next meeting such a – by that time will assemble a group, create a formalized charge and a time table, a work plan and whatever budget requirements they would have – for discussion here, and if we can agree at that point or we can reach a consensus on it, I will then implement it as Secretary.

With that, let's go on to the next category which would be health improvement. I'll ask Dr. Brailer to begin the discussion.

Dr. Brailer: Thank you. There are a number of things in the health improvement category and again these are illustrations and they are somewhat amorphous and overlapping. The first is one many of you know well the electronic health record, which is the primary tool clinicians use or would use in their interactions with their patients, communications with each other, treatment decisions, collection of information and potentially communication with payors and other entities. This is an effort that has gotten a great deal of attention.

Secondly is e-prescribing, that as many of you know is the .. was a subset of that that involves the selection of medications, the transmission of information related to those, the checking for formulary, drug-drug interaction, drug allergy, other parts of the patient communication, etc. This is an effort that is already under way because of the Medicare Modernization Statute, but we thought we should include it for completeness sake because it does provide a mechanism to carry other efforts forward.

The third is quality monitoring and reporting which is a standardized .. by which you are able to collect information from practices about quality in 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 they have enough cell size (?) or volume of information to make meaningful interpretations. At the same time, there is a, if you would, an educational or disseminational component of how that information can be made available to the public, to payors, to other providers, other entities to be able to make decisions based on that information. CMS has numerous activities going on with this, the private sector. CQA (?) and other organizations too, but the sense is there is 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 who 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 inpatient and other high-intensity services. These could include home-monitoring, personal device monitoring, automated weight monitoring, variety of other solutions, so this is a large category that falls somewhat into the disease management category or into to new methodologies for monitoring health status. This chronic disease monitoring area is one that certainly has been highly discussed by many people.

We talked about the immunization record, the childhood immunization record being a subset, and certainly childhood immunization component would fall into, would involve a relatively narrow subset of providers and involve the parent in that, because on a broader basis as we just discussed it's 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 health care to have tools to help them select providers, to select treatments to be able to understand their own health status issue, etc. Again these are in the context they could be overlapping with consumer empowerment methodologies. We saw this (?) within the spectrum of how particularly people were managing their health care in the work place. There are many other manifestations of this in other populations, but this is the one that has been identified as a key component.

Secretary Leavitt: An observation. What I expect (?), is there are some that link back to that consumer discussion we just had, but unlike that consumer discussion these seem to be more freestanding, while linked like the puzzle, they are more freestanding as projects in 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. This is revealing an early bias…this chronic disease monitoring. I am seeing a huge movement in chronic disease monitoring in wellness program, diabetics being tested in the home with the capacity to send information to their physician, a lot of chronic heart. Physicians here will be able to tell me more cases …but the device business and the ability to monitor at home and then have them link into an electronic record looks to me to be a very big part of the future. One of the thing 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 would need to bring a group together and I think bring them back and we would drive the cause forward quite a bit if we had that. But it is likely a different proposition than what we are talking about.

So let's just have a discussion on the whole class of activities and talk about …Chip?

Kahn: In terms of this class of activities, one that I sort of gravitate toward is quality monitoring and recording. Let me just say a couple of things about it. First, I see this as potentially a subset of all the activity you are 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 the main standard so they could easily would be transferred to CMS or to others collecting information in the hospitals…so we can get it all together. Because we are being asked through the hospital quality alliance and mandatory . . .to collect information on managers and right now that is done in all different kinds of ways. There is 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 is going to be seamless. And one of the things that the Hospital Quality Alliance has hopefully undertaken, although I am not very confident about 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 are sending the information with what's implied here in terms of sort of the collection of information and so whatever kind of task force you want to set up be brought into the fold so that all of that is being done together. I think if the proper priority is set on it, that we can over the next couple of years sort of settle that and have just one repository of information but the have all of the .. for standards you want to accomplish.

Secretary Leavitt: This is a huge area of the future Medicaid, Medicare. It is gong to be a conversation that pressurizes very quickly on Capitol Hill because of the physician reimbursement rates and the connection 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. In think the question is going to be is it the first one we take on or do we need to take it on in a longer- term perspective because it is going to take a while? It looks to me. . .

Kahn: I guess I am arguing that, one, other people are already thinking about it so that I think part of it …. The interface between this group and that. Second, I think going back to your whole point about vision, if there isn't developed a specific plan, even if it is a three-year plan, it is never going to happen. There will be pieces of it will happen, but it's never going to happen in a coherent way that is going do anything but burden the …So I guess my argument would be that I'm not sure this group needs to play the key role, but at least 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 Leavitt: The truth is, your point is well taken, if that vision is not possible unless I have some form of interoperable pure vision. It doesn't work to do pay for performance, for example, unless you've got some way of measuring performance and doing it in a broadly accepted, automated way. And so all of the public policy conversations in the world won't work unless we are able to get down to the …I think we may want to…Let's .. the conversation and come back to it.

Dr. Gerberding: I just want 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 20 years has been done using some standard for what's in the data elements and more recently under John Luke's (?) leadership a standardized reporting format has been created and now that hospitals are being asked to report their infection rate at a state…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 Leavitt: Good comment. Let's have Lillee and we'll go straight down the line.

Gelinas: When we were talking on the phone I said, "gee, I'm only from acute care. How is 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 is being heightened by the pay for performance movement – or as we like to say at VHA it is really is no pay for poor performance – is this notion of making transparent bad care. There is a lot of bad care going on right now in America. And you read the Rand Corporation and all the evidence around . . . really Americans get only bout 55 percent of the right care on any one give day, so this aspect is highly charged, scares a lot of people because it is going to make transparent bad care, which is actually the right thing to do. The question I want to pose is how does the VA and Department of Defense do this because there is such a bright spot on the horizon to strive for – how does the department of defense and VA do this and do this in a meaningful way and are there as many gaps in practice in the Department of Defense and in the VA as we see in the public sector?. When I went to the Navy Nurse Corps to civilian nursing, I thought we had just lost our minds in the civilian sector, that 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 Leavitt: Yes, please.

Dr. Kolodner -- In VA we have combined the information systems along with performance measures (?) and so we used a performance measure when we started this 10 (?) years ago we had the starry, starry nights in terms of the scatter of total range of performance and each year we raised the bar so that I believe next year's target is the 15th percentile so we know that 15 percent are enough …for next year. That's how we achieve the kinds of performance that we have where on the 18 performance measures …not only a regional level and a hospital level

Dr. Winkenwerder: 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 the same measures he does and look at how we do and we do pretty well. In the healthcare delivery, we are 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 continued improvement has been an easy one. It's always difficult because you are talking about dealing with providers changing behavior actually doing something about poorer performers. They say 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 is a bit more of an infrastructure to take action. On the other hand, we don't have maybe the same pressure that may exist in the private sector from the consumer, although our beneficiaries have every right to information and so forth that civilian consumers have. In fact, many of them are civilians – they are retirees. But I think the marketplace helps make things …so it's a combination of activities. But the data is key.

Secretary Leavitt: Thank you.

Ayre: I am going to be known as the consumer maniac on this panel, but I will start with that same premise again that an informed consumer is better than an uninformed consumer. And an informed consumer will potentially make good decisions for themselves and for the system overall. If you get the vote on what you've offered up, I think you start the ball rolling down the track in this, knowing that 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 health care 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 10-year vision.

Secretary Leavitt: Thank you. Dan, did you have a comment? I'm sorry -- Kevin.

Hutchinson: At the risk of losing my seat on the first day of council meeting, I am 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 a feeder system or infrastructure that's needed to feed data into the healthcare system in an automated fashion, whether it be on quality monitoring, 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 that 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 patients choice of pharmacy and a physician, but the reality is there is a lot initial clinical exchange of information – allergy information that is exchanged between physicians and pharmacists, as well as medication history information to be exchanged along with that to provide a safer infrastructure. On chronic disease monitoring it is 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 and adherence and compliance. Because given that the vast majority of care is in the outpatient environment, in those single-doc practices in those environments, then one of those major tools is around compliance and I think there has been a number of studies that have shown the value of patients being compliant in taking their medication in lowering the price of care and improving the quality of care by staying on those medications. I think as we look at chronic disease monitoring, we should consider the fact that 15 percent of the physicians in the United States write 50 percent of the prescriptions and 30 percent of the physicians in the United States write 80 percent of the prescriptions. So you have a unique population in that outpatient environment to really focus on improving chronic disease through monitoring …and an infrastructure that actually allows that to happen through the ability to exchange prescription information between providers.

Secretary Leavitt: Dan?

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

Secretary Leavitt: A thoughtful comment. Doug, did you have a comment?

Dr. Henley -- Building on Kevin's comments, I would totally agree that this section gave me the most angst in terms of looking at this as pieces of a larger pie. I think we need to look at the whole pie. When David started out with his description, he described the electronic health record as the as the greater vision and 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 is the electronic health record. Functional, interoperable, connected, .. at least speaking for the physician community, there is movement, there is significant movement in the last two years moving that way and I think the wave is building and moving rapidly 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 – and on these issue we have taken the tack that that at the CCHIT to focus on certifying full electronic health record technologies. 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 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 but probably will be, then they will have to plug and play with the certification standards of the CCHIT. 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 – and just take quality monitoring reporting – the whole effort will be inadequate and confusing. If 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, .. decision support etc. I think we need to take on the whole enchilada here.

Secretary Leavitt: This real interesting and helpful conversation here. Robert?

Dr. Kolodner -- I think one of things that's not clear is the relationship between the community and some of the major efforts that were introduced and already going. So where we talk about the HR is that something that becomes a breakthrough or is that something where that is one of the major efforts and what we are looking at is something to boost all that's moving forward.

Secretary Leavitt: That's where this begins to reconcile to me. This guy's been (?) appointment to come with an electronic medical record, a health record. There are component parts to that that are difficult to come up with, but the whole effort is about coming in with the other and, David, I'm going to ask you to speak to that. Before I do, just say that yesterday, the 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 role on exceptions to the Stark Amendment, which would have, will allow hospitals and other medical providers to begin to proliferating and we did it in a very deliberate way. We said we are going to make that exception and this is why. Until we have been able to create a pathway to the electronic medical record at which ....we've got certified systems and we want it to be wider. It's a very deliberate decision and I see the same thing happening, for example, with chronic disease monitoring -- Medicaid, Medicare TRICARE, VA, we've paid for a lot of monitoring devices. And at some point – I'm not talking about tomorrow

– it ought to be said that were 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. I guess the reason I saw it fitting into component parts is we are all about the electronic health record and somehow we've got to begin bring these together. Now we came up with independently – Congress acted on the electronic, e-prescribing in the context of saying "we've got the Medicare Modernization Act and directed the Secretary to come up with rules .. " 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 have been seeing it as a component part is because our whole effort being about creating electronic health record. David, do you want to talk about that?

Dr. 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. We are triangulating a huge amount of federal, state and private sector resources on making the electronic health record come about – not as a standalone but part of a continuum in an interoperable infrastructure. As some of you know, in the original draft of this document breakthroughs did not have an 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 our actions will determine things that this man will determine where we will go as a department and others will as well. The question is you're going to form a workgroup that will take it on and carry it further if you believe we have enough apparatus. Because I think the question of the breakthroughs is about charging …and do things on your behalf in addition to or in lieu of things that are happening out there. So I think very practically this is a work management question, not a question of priority or vision or capacity, and I do recognize these breakthroughs are like -- 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 discreet pieces because they are so overlapping, but this is the challenge I think the secretary laid out that we have to find things that we can punch through to create new fronts on this either through or around the electronic health record. So I do this… the question is you have a workgroup of working on this in addition to the 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? Excuse me, Robert, then Scott, go ahead.

Dr. Kolodner -- This is one opinion is…as we look across these choices. ..of these categories, it's really an investment decision. With that dollar that I invest do I want something quick, because some of these are going to come quicker? Or are there are some that are so important that I should start now getting the standards in place even thought the real benefit of that may not come later? For example, the issue of chronic disease monitoring -- right now the VA has about 8,000 patients on home telemonitoring of some sort and we're increasing that by about 700 a month. And so we are 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 it's 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 …feedback

Secretary Leavitt: Thank you. I am going to go to Scott and then I'll go to Craig.

Serota: A couple of generic comments I guess and then I'll get more specific. But we look at health care, kind of an integrated system already… we're really trying to bring this industry together and that's part of what we've doing here. In that regard, I can't think of anything we could invest in in this category more important than developing a quality monitoring process. As I speak to our insurers and our customers and others around the county, the …I always get is "why can I find out more about a television set or a computer than I can bout my doc?. ..I'm going to get health care and I can't find out anything about that quality, but I can find out every component where it's made, who's faster …about virtually any other equipment that I buy that has much less of an impact." No individual – and we insure 94 million people – and we don't have it. We have 30 percent of the market and most places we have 40 percent of the market and we don't have enough data – even within our database -- to do this kind of monitoring program, because when you break it down into the components of who's performing well in each individual 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 in the hospitals. If I just extract my sample, as big as it is, it's still as sample. So we still need more data. I think from a macro perspective we have to as a society totally embrace this quality monitoring 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 to commit to it. That being said, that's a long-term process. It's not something that you're going to wake up tomorrow morning and have it in place …The low … clearly is e-prescribing. There's no question that if mandated we can do it, there are short-term payoffs to doing it, there are quality implications, there are safety implications, a whole host of issues. I kind of thing the balance here … e-prescribing. I don't know that you even 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 the piece that's missing.

Secretary Leavitt: Craig?

Barrett: I think I want to second both of those comments. I had my first discussion on monitoring and health care and why doctors and hospitals didn't publish the success ratios 25 years ago. I think we have made a little bit of progress since then, but I think it's still a topic that covers the waterfront. It's a huge topic and the charge I believe you gave us was to look for …so I would totally second the prescription issue for two reasons. For one, I think there is a quality issue there and an interaction issue with allergies and drug interactions, 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 I think it was the 85/15 rule. 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. The topic listed here for short-term RAO, I would vote for e-prescription and chronic disease monitoring. Just because of the dollars involved in the

one and the subset of the population we're most interested in their medical history and using that information to help themselves. The other just drives everybody into electronic …

Secretary Leavitt: I would like to hear Nancy's comment and then Julie's quickly, and, Mitch, did you have anything you want to say? When we make those quick comments, I would like to try to draw this …

Davenport-Ennis: I concur with the comments that were made by both Scott and Craig completely. From the perspective of the consumer, the issue of quality monitoring and reporting become for many a life and death issue when they are making a decision about where to seek health care and the best quality of care that is available to them. And that applies across the board, whether it is a person with a chronic, life threatening, debilitating illness or whether it is a parent making a determination of where to go for the best service for a tonsillectomy for an 8-year-old child. The issue of quality monitoring is being addressed in some of our federal agencies today. We are in the middle of a demonstration project 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 for Medicare and Medicaid in the area of chronic disease management, so we may be further down the road in that area than we think today and if we can retrieve some the specialist representatives from the chronic disease group to work with us in a working group as we look at that particular issue, I think that would be a fairly quick turnaround on what we could 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 health records and personal health …

Secretary Leavitt: Thank you. Julie?

Dr. Gerberding: I do think the value of immunization records and .. one thing about the childhood immunization record is it is probably the only category that has 100 percent inclusion, because all children are supposed to be, almost all children have immunizations, so you would actually develop a cohort of the entire population over a period of time as a base for the content of those health records, so it's probably relatively easy to do because pieces of it already exist and it would have tremendous value for being able to have access to a population of people over time.

Roob: This is purely a question. In terms of how you define chronic disease monitoring, you include mentally ill, developmentally disabled and that population, or not?

Dr. Brailer: 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 the workgroup would be to find where are the …points and so we didn't attempt to do that here.

Secretary Leavitt: I would like to state I think a logical conclusion to our discussion and get your reaction to it. What I hear you're saying is that there is a broad belief that because e-prescribing has moved so far in advance of our coming we've got proposed rules and final rules and a lot of discussion that it would be value to have a briefing for this group at our next meeting on the progress that's been made and how I could interrelate with other things. Chip?

Kahn: I hate to break in -- just on this one there is no question where its on the outpatient side or the inpatient side that the technology's there, that you move forward with certain standards and regulations, but in some ways I'm not ..this is one of the most problematic areas of all in terms of where the rubber hits the road. I've got many members that would do computerized prescription order entry tomorrow, which is the inpatient version of that, and the resistance from the physician community is so great that at best they are on two- or three-year timelines to try to persuade doctors what could be done literally in six months, because the technologies are all there. On the outpatient side the exact same is true. All the people that serve on the board of my company are still grappling for a business model regarding outpatient e-prescribing because doctors are just not buying retail the instrumentation which is not that expensive to get into e-prescribing, so I think in terms of the reality of this, is that the infrastructure is a no-brainer. The problem is here the physician community, for whatever reason, has not moved, and I don't know what we can do, because part of this is a business model issue on the outpatient side. On the inpatient side, part of it is just telling docs they've gotta wait up, but most of the hospitals in the country have voluntary medical staffs so .. I think somehow whether it's moral suasion (?) or whatever, I think there is something to do here beyond the obvious of what is already being done.

Leavitt: Your comment and Julie's reminds me of an important discussion we need to have on how we order in the long term …I would paint a picture. Let's just assume we have this box of ideas – the puzzle pieces. We have those puzzle pieces on the table. I see each meeting we would analyze our capacity and conclude that we have the capacity now to move to an additional project. I would see this conversation taking place where we will pick one of those up and put it in another .area of the puzzle, which is the active discussion area. And then at some point we will move from there to either say that's an idea we are going back in the idea area or we are going to move it forward to a workgroup. Immunization I'll use as an example. Clearly we've got to do that. The question is do we start today or do we do in October of next year or do w e do it in July? When do we start that comes from our capacity. I have indicated to you that I want to keep our agenda fairly clean in the beginning because I want to deliver some stuff – fast. And 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 for short-term victories, make clear we've got a pattern that can be implemented. At the same time I want all of that to be headed toward a longer term vision so that natural conclusion to me comes to this point that we recognize this quality monitoring reporting we've clearly gotta deal with and I would propose that next meeting we have a substantial portion 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 .. it may be a puzzle of its own. We ought to have some sort committee of the

whole discussion of it. I would like to suggest that what I'm hearing is that e-prescribing the briefing might reveal other things that can go in the idea box and that that there will be parts of it that can just keep going. 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 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 time frames, here's the budget and then we can rapidly deploy it.

Can I get reaction to that? Could we build a consensus around that proposition?

Hutchinson: I would agree with that and I feel compelled to comment on a lot of the discussion on e-prescribing …I would absolutely concur with the comments made around the adoption. It's one thing to have all of the pharmacies come to the table and .. utilize this. We have to remind ourselves as I stated those numbers before, it would be great to get 100 percent of physicians to do e-prescribing, but if you could get the 30 percent that are writing 80 percent of the prescriptions in the United States, it's those physicians that we really need to focus on if you're really going to make a short-term impact on that ability …The financing and incentives of how to get physicians to adopt those technologies, as we move to that ultimate vision of electronic health records, which I 100 percent agree with, is a difficult one.

Leavitt: We have …of that conversation in the form of a proposed rule that has now been put forward where we are 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? So I think that would be an appropriate ..space (?) Any other comment?

Dr. Winkenwerder: …include in the consideration ..this 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 forward – not because we're the military, but because we say, literally, "this is what we are going to do." .. I know the VAs have the same for too (?) large systems. But the leadership .. we're committed, we're going to do this. There will be stragglers, yes, but once people know something's going to happen, most of them figure out a way how to come on board. And not to be punitive. It's not about being punitive, it's about getting to a better place.

Leavitt: It's about the marriage of market power and market innovation and that's exactly the kind of conversation we need to come to. The chair is gong to declare a consensus around the proposition that was stated. And I will at our next meeting be prepared to move forward …

The final category I spoke to earlier – what I believe is a compelling national need on biosurveillance and given the nature of the time we have today, I would just like to ask your forbearance of an acknowledgment that I do intend to form a workgroup, I do intend to bring it back here. This is something that we need and I think we can add a great to this, because it would clearly have an integrated piece that clearly fits into the entire

vision we are talking about, but it is one I feel a need in my other responsibilities to move forward. We will be reporting to this group and asking for your advice at the next meeting.

So this is the way I would summarize our conclusions on agenda, and one is that on the public health side. We'll bring a workgroup back with an agenda, time frames and so forth on biosurveillance. At our next meeting here we'll have an extensive discussion on quality monitoring and reporting. We'll have a workgroup formed on chronic disease management and monitoring and we'll have a briefing for discussion on e-prescribing, and we'll form a work group and bring back a product and path forward on the whole category of consumer-driven electronic records that will merge into the pure vision.

It has been a very productive morning and .. the agenda we are right on time. I'm pleased with that. I believe this afternoon there are a couple of things that need to be accomplished. One is some opportunity for some public comment and we're going to swear you in at 1:00 and we'll have, as I mentioned, public input. I have been asked to attend a meeting with the President in a little while, so I am going to depart from the meeting at this time and I will ask Dr. Brailer if he will take my place as chair, and I will be departing, but I want to tell you this has been a very, very productive session. I expect our future meetings will be longer than the five hours we have 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 and subjects we've teed up today and use the same pattern that we have. Your comments privately will be appreciated, and if you have suggestions on the way we conduct this, and with that, Dr. Brailer, the chair would call a break for 15 minutes. … we'll meet back at 12:15.

PUBLIC COMMENT

Dr. Brailer: I want to thank you all for taking time to participate today and for the wonderful discussion. The secretary and I were just talking that this is really a remarkable and unprecedented discussion around health IT. I know that it has happened in many quarters, but it has not happened in this building. So this is something we consider a remarkable achievement and a landmark.

We will now turn to public input and I will ask all of the members of the community to listen and reflect on the comments that we get. These comments are all being recorded and will be available with the entire meeting on the Eeb. Our Web site is HHS.gov/healthIT and that would sometime by Tuesday of next week or Wednesday.

We have a number of people. We ask them to make their comments in a minimum of two minutes and perhaps up to five minutes, depending on the number of people that we have. Just a reminder that these comments should be focused on the work that the community has set out and we should not have any promotional activities during these comments, Members of the public who do want to provide comments but can't do it in person today

can either mail them to us at our US Postal Service address, which is 200 Independence Ave, SW. Washington DC 20201 or by via e-mail at Onchitrequest@hhs.gov.

With that we will turn to the first person

First speaker: Good afternoon I am Katheryn Serkes. I represent the Association of American physicians and surgeons and the national nonpartisan association since 1943, dedicated to preserving the sanctity of the patient-physician relationship. I have two comments and then I would like to pose a couple of questions about your committee. My first two comments are specifically 1) about the issue of informed consent. We urge that anything that you any of the recommendations that come from this committee, whether it is about identified or deidentified information, be included in electronic records only with the informed consent of the patient. The second issue that I will address briefly is the issue of about the quality and the quality monitoring. I think one of statements that one of the members made earlier the comment about transparency and that many providers are afraid of transparency, because it would expose bad care and all of the bad care we have in this country. With the implication that the only people who are afraid of resist some of this are bad doctors and bad providers. I like to respond to that as you go through this so you can understand the concerns of the physician community. We are concerned not about the technology being set up in and of itself, but that it sets the stage for third party payors to oppose pay for performance. Even if electronic compliance regulations doctors could only be paid for what that third party decides is the quality of care and the appropriate measure and under what circumstances and with what results. In other words, only for care that follows the guidelines, then we are back to the thing that people didn't like about managed care by the way. If only paid for successful outcomes, physicians who desire to remain financially solvent have a problem – do they take sick patients or do they not take sick patients? And we are concerned that this will move the doctors away from taking sicker patients if they are being measured only in outcomes.

Patient privacy, the first issue that I mentioned, is already hanging by a slim thread because of what we have implemented under HIPPA, which is only an advisement of how your records may be used as opposed as a true informed consent. Patients repeatedly tell us that they want two things when it comes to their medical records – first they tell us that they want full control over who gets them. Second they want full access themselves -- they want to get to their medical records, which I think makes a good as you've already included in your agenda, the personal health record, we have strong support for patients for that. The only people they want to have access is the clinicians, the people who are actually treating the clinical situation. We urge you to consider these two things as you go along. I also heard a comment from Mr. Kahn about that quality control was the most important thing. I am not sure that that is the right approach – that quality control is not the most important thing, that *quality* is the most imporatn thing,. Znd if we put the resources that might be targeted into electronic reporting and some other things into actual delivery of medical care, it would be money better well spent and .. it if tis a life or death issue and the issue should be in the hands of the physician.

A couple of questions Your charter calls for a privacy expert and I am wondering if you could identify for us today who is designated as the privacy expert? 2) Your charter also calls for secret meetings under the Federal Advisory Committee Meeting Act. What circumstances would you foresee calling a secret meeting of this committee and, third, how do you envision this committee interfacing with the National Committee on Vital and Health Statistics, which has already been in formed and is advising the Secretary on issues of standards of technology and medical technology? I have some comments for the record that I have outlined in more detail that I would like to enter into the record and to give to the committee members. Thank you … for starting off on the right foot and including public comment in your first meeting.

Dr. Brailer: I appreciate the comments and questions we will go back off line and have answers to these questions posted as part of the minutes of the proceedings after we have chance to review the questions.

Second speaker: Good afternoon – my name is Agi Lurtz. I am here from Oklahoma and I have to tell you I am so excited to hear about this community because I'd like to share with you my personal story. For my father's last 10 years of life, he went well into his 80s – and I went with him to all of the appointments and I can related to all of the stories I heard today about filling out forms about all of those things. I was carrying his medicine trying to get him to see the doctors and the information was not being shared. We went for a simple test, went upstairs and filled out the admission forms, went down to the lab and filled them out again. I questioned why we were doing them twice. We went up to the OR and had to do them the third time – the same forms -- and I thought "what a waste." If I had failed to write all of the medications each time, it could have killed him. As a matter of fact, there was mistake that almost killed him and it wasn't a mistake I made, but it was a mistake – it was a mistake in them not sharing files. So I believe what you are doing is incredibly important, and I felt like having worked in the medical community myself in the '80s, it's kind of amazing that nothing had changed. In twenty-some-odd years records are still done the same way. It's very archaic, it's very sad because we are a very technological society and I will say that I knew after taking care of him that something had to change and I thought someone has to go with something that equally benefits the caregivers as well as the patients, because a lot of us are the sandwich generation – we have children and we have parents, and maybe even grandparents that we are taking care of. It's a very difficult place, but it also has its benefits to physicians their staff because they are overworked and they are working hard and everyone thinks doctors have all the money in the world, but they don't. They have so many expenses ..it had to be something in between.

I am not here to promote what I am doing, but I would like to offer my services if I could. I do have a Web-based service up and running now for two years. It shares the data throughout the entire United States or anywhere I the world. It is very secure. I know it can be done. I would love to see anyone pull this together on a national basis, whether it be with mine or your own. But I would be glad to give you any input I can help with to make this happen, because I do believe this is very important. Thank you very much.

Dr. Brailer: thank you very much for coming and sharing your thougst with us. I do have an amendment to the e-mail address for comments, which is onchit dot request at HHS dot gov. I apologize for the error. Next.

Third speaker: Good Afternoon. My name is Brian Holland. I am here on behalf of Deloitte, and we are delighted to be invited to participate in the community and listen to today's discussion. As you are probably aware, we represent a number of healthcare hospital systems across the country, so some of the dialog we have heard this morning is of keen interest to our clients.. .I am calling on the Community to think about an issue that is not necessarily the technology pieces, the human pieces. What I am asking the community to think about is the adoption of technology requires obviously sometimes training, workforce training. I would encourage the community to think about not only the adoption technology but then the subsequent piece which is how do we train people within the hospital community to maneuver the system, and how to actually integrate that as potentially a . . . program or other ways of building (?) that human resource and workforce development (?)

Dr. Brailer: Thank you very much. Next.

Fourth speaker: Good afternoon. My name is Steve Lieber. I am president and CEO of HIMSS, Healthcare Information and Management Systems Society. In a short time our sector of the health care IT industry has responded to a number of major initiatives. Four of these are these on standards harmonization, certification of the HR products, streamlining privacy, and security policy in NIH IN (?) prototypes. There has also been a CMS request for information on personal health records, the release of additional healthcare IT legislative proposals that attempt to a variety of solutions for achieving greater HIT implementation across this country and draft regulations on e prescribinhg and the start of regulation exceptions. As an organization, HIMSS applauds these activities and these examples of the level of private-public engagement that need to occur achieve widespread improvements to healthcare quality, efficiency and cost effectiveness. We know from a variety of studies that billions of dollars in savings and quality improvement is impossible and can be a byproduct of an interoperable healthcare system. Your efforts to coordinate a collective approach are critical to achieving that level of savings and quality improvement. I would like to offer a couple of suggestions as you begin to move forward: HIMSS believes the AHIC success will be greatly enhanced by interaction with healthcare and Hit subject matter experts, particularly through the breakthrough groups you've discussed today. Our members can be a valuable resource to the community from national public policy discussions on interoperability and healthcare delivery to local data-sharing initiatives. Our 17,000 individual and 270 corporate members and 42 chapters across the country are engaged in addressing the clinical and financial challenges that you are chartered to address. HIMSS believes that the Community should not only be a key advisor to HHS, but also a focal point for national discussion on the development of comprehensive health transformation road map that sets goals and priorities for healthcare improvement and the basis for implementing other transformation activities, including incentives, process, technology improvement and legal reform.

HIMSS encourages the community to get to know that interoperability exists in health care already. There are examples for you to see and observe. Integrating the healthcare enterprise is a seven-year initiative between HIMSS and several other national associations that made connectivity a reality for many healthcare stake holders, Also there are other demonstrations and exhibitions that show very practical solutions and firsthand experiences of interoperability.

In summary, what we would like to say is that HIMSS offers its endorsement for the charter of this group. Its members provide technical expertise and support of your work and its resources to help mobilize and inform the industry about your work.

Dr. Brailer: Thank you. Are there any other public comments in person? Again, we can receive comments by mail or by e-mail. I appreciate people taking time to spend with us to share their thoughts. At this time I want to open the table for other thoughts from members of the community. Given the other topics we have discussed, I wanted to make sure we had a chance to get other thoughts about issues or approaches or things that we should begin considering in the agendas for forthcoming meetings in addition to the breakthroughs and the idea box that the Secretary described and the particular work that were going to be coming forward, particularly the e prescribing briefing and the discussions around quality. Are there other thoughts or any reflections on the meeting that we should be considering today.

Davenport -Ennis: Dr. Brailer**,** just a couple. For the idea box, would it be helpful if each of us serving on the community were to advance to you electronically names of organizations that have programs today that may be helpful to the community to review and evaluate how those programs are working in any of the areas that we discussed this morning as a possible breakthrough area that we'll be dealing with moving forward? So that before we have the next meeting, we can have a universal body of resources available in many different categories with contact information and individuals who may serve as experts.

Dr. Brailer: Nancy, I think that is a very good idea. In fact, we didn't really talk about this in a very enumerated way but we are going to charge the workgroups or I think some of these ad hoc groups that will help us in the short term start our work by doing an environmental scan of what is happening, what is the context, where do we see successes, what has been tried and failed. One of the requests I had for the end of the meeting, I will just put out now is that in the areas we have identified some going forward strategy – consumer solutions, the e-prescribing, the chronic disease monitoring, biosurveillance, or really any topic in the breakthroughs where you know of people, project, groups we should speak to, please let us know because we are going to start and charge a group to bring forward a very rapid lay of the land so we can understand where we add value and how we act. That would be very helpful.

Gelinas: Dr. Brailer, could you clarify just a bit, and maybe you will do this when we align our workgroups, the appropriate process for getting others involved. Do we have

free rein or are any boundaries that should be considered here? It struck me when Steve was talking from HIMSS .. he's right that's a huge organization to tap into. We each represent a lot of very large organizations, could you please clarify that?

Dr. Brailer: Sure. First the workgroups that will be convened will be considered subcommittees of this Federal Advisory Committee and we are doing that so they will be subject to the same transparency in public access that any meeting of this group are. That also means that we have a burden of diligence in terms of ensuring that the people appointed to those subcommittees are qualified and don't represent undisclosed biases, not unlike the process that you went through. That will take a little bit of time, and one of the reasons we wanted to identify the tasks or breakthroughs was so we could have the context for finding those people and at some point -- I would say not quite yet, but very soon -- we are going to be asking you for advice on people to name to those committees. Most likely we are going to ask for one federal and one non-federal person to chair each workgroup. We will also be looking through the thousands of names that were nominated for the Community, many of the people we followed up with indicated their interest in serving on workgroups and other resources. To your broader question, Lillee, the Secretary and I have had this discussion about the Community. He had alluded that the Community is not 17 -- it's many people and we have this construct of the larger health information community. For example, the Certification Commission for Health - Information Technology has its own public-private group that operates in the public space not governed by federal rules per se, but governed by rules that are as binding, which is legitimacy, trust and authenticity. And it has workgroups that are quite large so we see that following in the same thing with the new Health Information Technology Standards Panel and all of the SDOs and user communities, the same thing with us convening essentially all of the state governments under the new health information security and privacy collaboration. And likewise, soon when we make the announcements later this month, the architecture contractors who will need to put together a very large syndication of groups from technology groups to regional market players where they will test demonstrate these technologies are all resources available to us as well as NCBHS and others, so the question is not how do we have many many many resources, it is how we triangulate them and have everyone focused. We see the ultimate balance being how much time we spend focused on these very particular breakthroughs where we are asking people to do very specific things as opposed to very general things, which we are trying to do with this group as well. So it's my hope that we can apply the rule that I've used in everything I've done in my office, which is nobody leaves the office without an assignment and a homework project and we do the same thing here so that VHA and AAFP and many o the other constituencies that are here as well as in the room have a project and something to do with us. I think we have to get our house together quickly to know what projects we are going to focus on and how …this very rapidly moving environment so we can make sure that that works productively. Is that fair?

Gelinas: That's very fair. I was really shocked (?) when Nancy was talking and I think maybe Dr. Winkenwerder first, how do we keep out the exemplars and the best practices

in this area that are out already there and how do we have those for consideration for making decisions. It's a tough job.

Dr. Brailer: It is and the job behind that is how do we create a milieu that made them successful for many people that don't have that environment so I think that's really this question of the adoption gap as we move from the conditions in the DOD or the VA or Kaiser or many other large delivery systems and try to apply that to small doctor's offices, rural hospitals and health centers. So I think the we've got two pieces: finding it and trying to replicate it or create the conditions where it can be yielded (?). That's pretty much where I think we want to go.

Barrett: Two very mundane mechanical questions. First of all, I think it was a challenge to get this meeting scheduled and I just was wondering about the next several meetings – are they going to be calendared early so we reserve that time? It would be very convenient to have several meetings schedule in advance. Some of us, especially those on the West Coast, can't just drop by.

Dr. Brailer: Our scheduling people have gotten to know all of your scheduling people quite well, and I just wanted you to know that no matter what you say that this meeting comes first. I told them to say that. We do want to have (?) six months of meeting scheduled and we need to do that for the Secretary's schedule also. But we weren't sure, to be very candid, of how much progress we would make today and therefore we didn't know if we reschedule in 30 days or 60 days, but we will be looking for an earlier date rather than a later date for the next. I think we have some temporary holds on calendars further out.

Barrett: We will give you top priority. The second question was the designation or priority areas today. I am just interested what is the next step in terms of forming subcommittees and how will the mechanics of that work?

Dr. Brailer: We are just to remind you of what we have. We have a briefing on e-prescribing, where we will ask people from CMS and perhaps the private sector to come in so we can …of the experts of the state of the art on. . . the map? That is going to lead to a decision point in this group about is there further work or is there a specific charge you can delegate to a workgroup. We have this discussion on quality monitoring work we'll do in essentially the same way. We will prepare a briefing and I have asked ARC to be involved in that already along with CMS and we'll talk to NQF and some other organizations. We have a very brief and precise we have decision point about, follow, keep in the idea box or charge. In the areas where we do have a charge, the consumer empowerment area, we are going to create that as an ad hoc group first because we don't think we can charge a group that's that large, so we'll ask the group to come together more as a scaffolding to help us work through the issues so we can then have chargeable items, and that group will start with an environmental scan, potential specificity of projects that have this kind of two-year outlook and a quick summary of what actions that are needed to get there. In the spirit of helping this group turn that into charges. I think we feel confident unlike the others, that may or may not result in charges, that

something will in the consumer empowerment area. In the chronic disease monitoring and biosurveillance (?) we will move quickly and perhaps not by the time we have the next meeting put together a workgroup that will start again with and environmental scan and begin working on the goals, the time table, specificity and then the barriers. .. and actions ..

I think those two are cued up and we going to be interacting …to begin thinking about how to frame that to meet your expectations. I think this process we use …as things move up to our area of activity that will then charge a group. I think its very important as we bring these groups together, particularly given so much other activity going on in all of these that we are quite specific about what they are to achieve. Otherwise I think we could set them up to be just part of the continuum. Is that fair?

Barrett: I am just kind interjecting my industrial background into this in terms of what, when, where. I totally agree with the definition of exactly what problems you are trying to solve. ..but it is really the formation of the groups and not waiting six weeks, two months to try to get started on this.

Dr. Brailer: Our thinking on this is we will start these workgroups with federal staff that we have available to us so that we can work quickly to help define an issue and then we actually begin bringing outsiders and people from private sector and other settings to supplement that. I say that because we can direct federal staff to do what we need to do quickly and .. the work without the kinds of clearance and screening we have to do for others. . . But it can't be federal groups that do this work. The whole point of each of these groups is to be public-private, So we are trying to balance moving quickly with all of the overhead tasks that actually creating the infrastructure from moving at all. Let me maybe answer this question in a different way. It's the Secretary and my expectation that by the end of this calendar year, there will be some number – perhaps three, maybe four – specifically charged groups with deadlines, specific goals, a pretty well designed set of barriers and actions that need to be worked and an accountability structure coming back to this group already underway with staffing and support including whatever contracted resources we need and relationships with our other contractors to begin to …We may be a little elliptical getting there with some of them, some of them will move faster than others, but we want the .. underway within three months of now at the very very outside.

Dr. Gerberding: Question. Because of the powerful levers that we have, particularly in the federal agencies, to deal with regulatory requirements or other authorizations, how …their own ..are we working on mechanisms to perhaps accelerate the landing ground for these ideas and these changes as they emerge from these workgroups, because I always fear that we can work very fast to find out what to do, but then the how to get done in government might be the right limiting step in the process unless we really think that through now.

Dr. Brailer: Yes. In fact, that question is before us now. I'll give you one example. We have proposed the start of self-referral exception in the anti-kickback safe harbor related

to chronic health records, and that would contemplate certification, and that certification would come from the advice of the certification commission. So here we have the certification commission with a highly legitimate public-private process for vetting and coming to consensus on the criteria for what constitutes an ambulatory electronic health record. It would then make a recommendation to this group, technically through us, since it is our contractor. But we are going to present it to this group… and the question then becomes when it goes out as ….., does it actually have to do that or can we actually .. ask general counselor about with the clear goal of not having triple commentary, but to allow a legitimate regulatory process and it turns out we probably do have degrees of freedom there, but I can't be specific yet. And I think this question is going to come up every place, because we don't want this to just add burden to the overall goal.

I'll give you another example with the National Institute for Standards and Technology. We will make specific handoffs from this group on standards, so they'll come from the heath IT standards panel to this group. When this group acts it will have the standing of a voluntary consensus which allows us to pass it to NIST to become part of the federal employment procurement standards process that will be under way for agencies. It's a very long-term process. Again this group plays a critical role in doing that and we couldn't do it without it. So that's part of the regulatory tools piece that we are going to be asking the federal staff to understand what could be done and how do we make sure we get the get the result as expeditiously as our boss wants it.

Hutchinson (?): How do you see NCVHS fitting into this process as well with all of they have being doing in this area?

Dr. Brailer: We have met with Simon Cohn, and I have met with the executive committee of the NCVHS a number of times about this, and we see them to some degree providing a little bit of a counterweight to the community in this sense. And that is that while we take this kind of radical focus on breakthroughs and let's find progress, we clearly all know there is a long-term infrastructure that needs to unfold in a way that is logical and may not be coherent with respect to any given breakthrough. For example, a standards context. The U.S. needs to have a singular set of standards – not just in cross section, but over time. This is a charge NCVHS has taken. Same thing with privacy. In fact, given that they have what I consider to a highly legitimate privacy subgroup already under way with extensive hearings. Our sense was that we should not reproduce that here. So we want to make their committees, their testimony if you would, their work available to here. So we see them kind of working together in that sense. Again, I think the rubber is going to hit the road with these breakthroughs. Because the issue is going to become not the global privacy issue or the global standards question, but what are we going to do about the standards we need for chronic disease monitoring breakthroughs? How does that fit into a long-term standards context?. That polarity of short term versus long term is where we would the interchange between this and NCVHS, so that's ready, everyone's decided that's what we are going to do, but we now need the specific subject matter to put into that to get the findings.

Any other comments or questions that any of you would like to raise about our agenda, our goals? Lillee?

Gelinas: I just have one and it is long-term and not answerable now and I understand that. But it is the financing question that we can make recommendations and do all of this work. It just strikes me. You see fast federal financing has to change to deal with the disasters in the Gulf Coast. Huge dollars, we're not talking small dollars at all. So I would hope that somewhere along the way, we do address, we talk about budget availability for the capped portions of this subgroup. In the big picture, the last thing we would want to happen is have a process in place, ideas ready to launch and no funding for them. So resources match the ideas is the point.

Dr. Brailer. Sure and I know all of you know that the charter for this group essentially carves a way those questions of financial recommendations to the federal government and I want to share with you why that occurred. There was a sense that the Secretary alluded to that we had this trade off that is perceived between adoption and interoperability and we are trying to bolt those to together very clearly so that each step we take bring both adoption and interoperability and that means in the microcontext. Lillee, we will speak to questions of adoption support and we have various entities here, whether it's treasury, commerce, others that can help us speak to that, and we even have CMS, an example of a financial support, could be the way we liberalize regulations to prohibit these relationships between these doctors and hospitals to have these lifesaving technologies, so they're in that context. But the second is that because of the regulatory sphere and the control sphere around federal finance, we didn't think this committee could solely take that question on and so the breakthroughs are where we will pull all of that together and ask all the questions. You know the goal of the breakthroughs is to say "how do we achieve the results?" On the other hand, this group is not asking big questions about how do we take the whole strategy forward if you would from a financing question (?). So there's a subtlety there, but I think it is one that I am comfortable with can give us a lot of progress and create the success stream that'll lead to the kids of results that we want to have.

Any other questions?
Is Tamara (?) with us now? I think it is time for your swearing in.