

**Making the Health Care System Safer Through
Implementation and Innovation:
Strategic Framework for Improving Healthcare
Through Health IT:
Update from the Office of the National Coordinator
for Health Information Technology**

June 8, 2005

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[START RECORDING]

CAROLYN CLANCY, M.D.: - does not need an introduction, but I will provide one. David was appointed by the President and then by the Secretary of Health and Human Services, Tommy Thompson on May 6th of 2004 and I think that it is fair to say he has packed more into the past 13 months than anyone that I can think of. He too comes out of the University of Pennsylvania, where he got a Ph.D. from the Wharton School in Managerial Economics and is also an internist. Somebody here, I think it was Jan Root earlier this morning mentioned the fact that the Utah Health Information Network is one of the original chins. I do believe if I recall correctly that David's Ph.D. dissertation was about learning lessons from the chin movement. It was that that inspired him when he ran the company care sciences for 10 year prior to joining HHS in his current position to launch the very successful health care information exchange project at Santa Barbara. So much so that I do not even think we site Santa Barbara anymore; we just say Santa Barbara. But, I think that you all remember that we are talking about the effort that David and a number of his colleagues with him now led. So, without further ado, I give you our national coordinator. [Applause]

DAVID BRAILER, M.D., Ph.D.: Well, thanks Carolyn.

ARC is such a lean and mean operation that they do real time

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mic'ing. I get mic'ed up as I walk to the stage. I actually thought whenever I came that I got to do something that I had been dying to do for a year in Washington, which is to sit out there and ask questions of the media and turn the tables on them. [Laughter] But, I got here a little bit too late. Well, it is good to be with you, in particular here with ARC. Before I go any further, I just want to have you all understand what incredibly good partners ARC has been to our organization. We were started from scratch. It does not happen that often in the federal government that a group gets created and has to do all of the things simultaneously. You look around and figure out where do we have support and where do we have people that have common cause. One of the steadfast and unrelenting partners to us has been ARC. They have fought for us. They have fought with us. They have fought to get things done. I just want you all to help me in thanking them because we would not be where we are today without Carolyn, Scott, Helen, and the whole team at ARC. So, thank you all very, very much. [Applause] I would also just like to call out and thank Dan Gaylin [misspelling?] and Janet Marchabroda [misspelling?] who are instrumental in this meeting. I know many other people were, but unlike the Tony Awards, which were going on in Washington and New York when I was up there on Sunday and Monday, I am not going to stand here and thank everybody,

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including all of their parents. So, you all thank you very much. I know that you have done very, very hard work. It is really great to be in this room. When we had the July 2004 summit – did anyone go to that? My staff is not putting up their hands. [Laughter] They are still suffering amnesia from that event. It was in this room and that was where we launched the strategic framework and really started the process of getting all of us to start talking the same talk, being on the same page, and really understanding how it is that we can take this cause out to the American people. So, it is great to be back almost a year later, again under the guise of really figuring out how we can go further and further. Well, I am shocked at how far we have been able to come. It is just unbelievable to me. I came during an election year. I came to see if I could get some things done, quietly get things together. So, about this time, about the time a new secretary would start, although I was not quite sure how it was going to play out, that we would start actually going public and starting to tell Congress and the American people and hospitals and physicians about what it is that we want to do. I am still breathtaken at how rapidly this issue has grown and how much it really has become part of everything. It is just astonishing to me that it still has legs. That is good and it is good because it is real. I think it is very often like many CEOs of

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hospitals who always told me in my former life that they were going to cancel all of their subscriptions to PC magazine. It is because every time an issue came out, they had a physician come wandering into their office, having read it about some new application and totally dazed, their heart beat is up, their eyes dilated wide, and they are flushed, and it is because they have seen this new capacity. That eventually was called a "advanced states of technical arousal". [Laughter] So, you know, I just want you to know that as a physician, I do diagnose you with suffering from advanced states of technical arousal. I think that is very good because we have to be able to get everybody in line with this to be able to make sure. Ultimately, you are the leaders that are going to drive this change. One of the things that have been adamantly clear and I know that you heard from Secretary Leavitt, that this is not going to be a regulatory-driven process. We are not going to issue 3,000 pages of detail, telling you how to go about your lives. It is going to come from the ground up; from the grass roots. And, you are the people that are going to make this happen. We are here to help, provide a frame – I cannot believe a federal official said that I am here to help you [Laughter]. We are here to provide boundaries, guidelines, resources, and tools and we want to make sure that you really have the ingredients that you need to go out and make these

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things happen because we still have a long, long, long way to go. You did hear from the Secretary this morning. He is an outstanding person. I have to tell you that I have a long standing skepticism about all people that I meet. It has really become a very handy tool here in Washington. [Laughter] Actually, it has become much more, even substantial, since I came to Washington. Mike Leavitt is the real deal. He gets it. He told you that he is a techno-geek. I can sure tell you that he is. I met him quite awhile ago, but as he started in his nomination process, he and I started talking and after the first conversation of an hour and a half about UNIX, I said, "Oh my God, we are in serious trouble". He is just fantastic and I have had real privilege of working with him to be able to really begin shaping where we go as a department and how it is that we go about accomplishing his goals. He feels a lot of ownership about this. He probably did not tell you this morning but he called me late last night and we were chit chatting about a few things and he said to me, "David, do you consider UHIN to be a rio [misspelling?]?" And, I said, "Well, I think that they do." Is somebody here from UHIN? He has a rio? Not sure? [Laughter] I said, "Well I think they probably do" and he goes "Wow, I started a rio." [Laughter] But, this is the kind of hands on leadership that we have got and one of the reasons that I am so confident that we are going

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to see real things happen, see very tangible progress and not a lot of the conceptual error that so much surrounds things here in the beltway, because he is locked on and he is a very pragmatic guy about what it is that we can get done. So, what you saw is what we are going to get and I just ask you to pay attention. By the way, he also asked me to tell you that all of you that stay through the end of the day, and I know that the last dregs of the day before cocktail hour takes an extra effort, all of you that stay are going to get as a door prize a clock and a train set. [Laughter] You have heard a lot of speeches today. This is my 14th speech since Monday, so we are about equally fatigued. Why don't we just wrap it up here and go home? What do you think? [Laughter]

Well, you know that the vision that we are after, safety is a huge issue. It is at the very root of what I would call the midterm issues that we need to deal with. It is right out there in front of us. Medical error reduction, being able to improve compliance with evidence, being able to make sure that therapies become appropriate and we reduce the variation around them are the nuts and bolts of why Health IT has got to come to the table. But, you need to know that the President laid out vision that went far beyond that. The vision was for us – says the President and things happen. [Laughter] Just aside, I gave a speech this morning opposite Patrick Kennedy,

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which was the second time he and I talked in 2 days back to back [Laughter]. I am not going there. But as Patrick got up to talk, this giant American flag on the Capital building next to him started sliding down the flag pole. [Laughter] These groups of people rushed over to it, trying to stop it from hitting the ground and trying to get it to go back up the flag pole. There were like 5 people trying to do this. He is here trying to give a talk with this, like [inaudible] are going on behind him. [Laughter] Eventually, they just roll up the flag and carry it out on 3 backs and he was like, "Are you done?" They brought it back in before I started and it was quite immediate during my time at the podium. But, the President had a vision that really brought me here because his charge to me was how we make health information, not health information technology. Technology is a means to an end. How do we make the information change the way consumers engage health care, to know about their health status, to know about their options, to start looking out for their own treatment choices, to be able to begin managing their own care in a way that is similar to how we manage other things in our daily lives. I thought that was powerful because I watched for a long time as a quality improvement person how none customer centric health care is and how difficult it is to make us focus on patients, despite the best intentions of every good person in the system. This I

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thought was a means to an end that was really powerful. We have a weigh station with errors and safety, but out there we have something even bigger, which is really bringing consumers in to be partners. This place that is going to happen is out in the regional projects, where it is not about what Washington does or some document, booklet, TV show, or website. It is about eyeball to eyeball: people looking at people who are offering care and services to them and saying, "What are we going to do together?" That is what you all stand for and I think that is one of the most powerful parts of this. The grass roots movements that are going to change those pieces of health care are going to be much more sweeping than anything that ever happens in the august city of Washington.

Now, that vision had a lot of barriers. Between us and there are real challenges. Challenges that you all are facing on a day-to-day basis; challenges that we are facing here; challenges that are undeniably a direct result of what health care is all about today, which is there are multiple pieces and fragment, conflicting incentives and cultural divides, barriers and challenges. I just want you to know as someone who has been involved with the kinds of projects that you are involved in, that this is hard work. There is no easy pathway to do this. It was so hard that I just gave up and came to Washington. [Laughter] It is hard work, but it is valuable.

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It can work. We are not longer in the world of theory, where talking about regional efforts coming together is somehow a grand vision like it was 10 years ago. We are not in a world where we hypothetically talk about what we could do. There are real models living and breathing in the United States about what could be done in disease improvement, in patient safety, creating registries, common systems, sharing data, interoperability, patient centeredness, longitudinal care improvement, etc. etc. etc. This is the real laboratory of what is happening. I think the fact that ARC is able to support the community efforts as a research platform speaks allegiance about where the future of health care is. I think that is one of the really promising parts. But, just understand that you do have people here in Washington that are not making assumptions in some gratuitous way. That you guys are out there ignoring stuff and we are doing the hard work. I understand and I know my staff understands and ARC understands that what you guys are trying to do is hard. We are going to help you every step along the way. A lot of the things that we are going to do to help you is to make sure that we stay out of your way. We are going to make sure that we do not do the things that could really block your efforts or stimey them, slow them down, or somehow make you regret that you ever had such grand visions.

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Now, what are we doing? Well, if you think of Health IT and the grand vision for interoperability, there are 2 huge challenges. I think the Secretary probably called them years. There are 2 years. One of them is interoperability, which we can cut past all of the technical definitions and say, "Does health information follow the patient? Does it go where the patient goes and not where they do not want it to go?" Interoperability is a set of technical, legal, financial, cultural, practical issues that ultimately result in seamless, timely, portability of information. We are no where near that today. Part of the epidemic of health care quality, of safety, the cost issues, all have to do with we are trying to move information around in a way that makes it impossible for it to be useful when it is needed. American knows that. 50% of Americans report that they carry some form of a personal health record because they know their data will not be available when they want it or where they want it to be and they are starting to vote with their feet. This is one of the reasons that I think we have huge capacity to move this forward because once we show the American people that we are connecting with what they see in their daily lives, we are going to get real legs. The people on the hill know this, the media knows this, and I think we are getting to see it become very practical. But, the interoperability challenge is huge. Lower interoperability

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means that we have had a technical victory. Yes, everybody is using computers and we get some decision support and quality improvement benefits. So, we have optimized every hospital in America, but we still have not dealt with the real issues of why people are sitting in hospitals. We have optimized physician offices, but as soon as they get a hand off to a specialist or to another site of care, they go into a black hole. Without interoperability, we have not solved the systemic problems that make health care such a deeply challenging industry for someone who is ill. The second part is the adoption gap, which is the today, we have "have's" and "have not's". Large integrated systems, risk barring systems, large hospitals, and large physician groups are adopting basic Health IT at a rate of exceeding 50%. The forecasts are pretty optimistic for the future. Survey after survey have shown that they are basically doing this. It is seen as a cost of doing business and it is a necessity. The health status evidence of using decision support and electronic health record is so powerful, it is undeniable. They are doing it and they are doing it in relatively large numbers. Unfortunately they make up a small share of American health care. Small practices, smaller than 10 physicians – which I think by the way as quite large – smaller than 5 physicians, small hospitals, rural safety net, and other practice sites are not doing this. 10,

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12, 15% maybe adoption rates and I think those are generous. This adoption gap is a direct result of the fact that Health IT is a strategic investment. You do it with a long eye onto the future about where your organization is going to be 5 years down the road. How are you going to have a market position? How are you going to be able to control costs, negotiate contracts, handle care optimization, and deal with risk mitigation and litigation control? If you are a small practice, 5 years is forever; you do not think out that far. One year is about as far out as you can think and 6 months is as far as you can spend. There is no way for these incities [misspelling?] to get onboard if we do not level the playing field and make sure that this miracle does not become part of what separates good care from bad care. So, we have these 2 pieces and you can imagine a world where we could have part of them solved. I will tell you in my view, the adoption gap is easier to solve. Probably expensive; it is going to result in tough choices, but there are not a lot of complicated moving parts of the end, but figure out how to get good technology into the hands of doctors. That means 3 things: 1 is lowering the cost. There is a lot that we can do. There are open [inaudible] systems that are coming out. Vista office EHR product is coming out in August. But, I think more importantly, efforts have been paying off for vendors to start

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seeing that physician offices and small settings of care do not need to take a product that was built for a hospital, strip out some things, and offer it to them. It requires a specialized, low-cost product. I think there is a lot that can be done to lower costs. Secondly is improving the value. I think it is really hard to figure out for a physician office how to improve the value of these tools because it is a challenge. One thing that we do not want to do is have the value realization be through, what is the nice way to say it, increase in billing you. We have started an effort to develop a 21st century cyber fraud capability, who develop law enforcement tools to help prevent, protect, and prosecute fraud using electronic health records. We have done that specifically to help the government caution itself from being opposed to electronic health records because of fear of up coding. This is an issue that we need to deal with. The third piece is risk, which is that the truth is for most people adopting electronic health records, it is a risky decision. We are talking about a 30 or 40% chance of failing, not getting to the goal, or being partially there, or getting a big setback. This is a challenge because it is multifactorial. People buy the wrong product. They do not contract for it the right way. They do not implement it correctly and they do not change their businesses around that. That is why big organizations can do this well. They have the

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capacity, the technical, managerial, and financial capacity to really milk the value out. Small offices need a lot of help and to this day, we have some ways of lowering risks, but we do not have a magic bullet to bring along these big changes. So, the adoption gap is really one of the key issues that we want to focus on. We have put our efforts at the federal level for the adoption a little bit out in the future. The reason is because we are focused on interoperability. I will tell you why. Imagine that we had a world where we did not address interoperability and we focused on the adoption gap. What we would have would be lots and lots of electronic health records, propagating the proprietary fragmented islands of care that we have today. Without that, we could actually make the problem worse because we will have then created a huge sunk cost legacy investment that would make it harder politically for us to bring about the interoperability revolution. That does not mean that adoption is not going on. It should and it could. But, in terms of responsible and diligent federal policies, we are not going to drive adoption until we get interoperability in place. The announcements that we had this week that the Secretary shared with you are about getting that wheel turning and turning as fast as possible. We took a path towards market-oriented solutions, not only to not drown you in red tape and regulations, but to start recognizing that the fastest

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way to the goals that we have for interoperability is to make use of existing market capacity, market institution, and know how. That is why the standards harmonization RP is asking existing SDOs to come together with the user community and create the capacity to develop a road map and a fabric for one set of standards in the United States and to do it within one year. Then, develop a process for keeping that up to date year to year to year. So, we have a new process that does not disrupt what SDOs that give us that kind of confident output so developers, doctors, or hospitals do not have to say, "Wait a minute. I have 2 different standards and they are different. How do I piece them together?" That is a failure of a standards process if we deliver a standard and no one knows what to do with it. I am confident that we can make this happen because we have all of the building blocks. We need the will. The federal government is providing the will and I am confident from my prior meetings with the standards community that they are going to welcome this and take advantage of it. We need to have certifications so the electronic health records can connect to the kinds of networks that we have and we can give buyers so that electronic health records better competence so that their risks are going to be lower, the risk that they buy the wrong product. The RRP for certification is to put in place a process to make sure that we have a basic inspection

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system to make sure that electronic health records are secure, have decision support, and have the kinds of other protections and the kinds of other workload support that make them useful to doctors. This is going to be critical to allowing electronic health records to plug into a national infrastructure just like without Verizon Wireless or T-Mobile, your cellular phone is not that useful. My 4-year old son carries my old blackberry and he is clicking away on it with the sums like crazy. He has no idea that it is not connected to any service. But, it is okay. It will work for a 4-year old; it will not work for our goals in health care. The third is an RRP for prototypes of a national architecture. It is very important to us that we do not have islands, regional islands of interoperability that use different standards or different architectures that prevent a national, seamless solution. It is not enough that data moves from one side of Salt Lake City to another or that information moves around the Bay area. Information has to move with the patient and to do that, we need a unifying architecture. The RFI respondents were very clear: local solutions, local optimization, local governments, and national architecture and standards. These prototypes will give us open-source architecture in the public domain, non-royalty bearing, that we can all build from and prototypes that can be used to start developing this solution.

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We have a lot of building blocks that we can pull together. But, that is going to happen very fast. Finally, the RRP that ARC is putting forward, which I think is incredibly insightful and progressive, is to begin asking questions about how we advance security and privacy into the future. An interoperable world is about not controlling data disclosure. That is a concept around manual data sharing. In an automated world of data sharing, where data by definition is shared, portable, the issue is no longer disclosure, but control of data. Who controls the navigation and flow of data. We do not have a policy. We do not even have a conceptual architecture for that. That produces a huge barrier to interoperability. We do not want to live in a world where innovation goes far, far, far beyond the capacity of us as a society to have a debate. We are going to be able to carry that out and understand what that means. Those are the RRP's. They are out. You can go look at them. Has anybody looked at them yet? A couple of people. Those must be the techno-geeks. We are going to bring this all together with the AHIC, the American Health Information Community to roll together public and private oversight. They have a common agenda, a unified scheme, and a time table that we can march forward from together. We are going to pick use cases or breakthroughs. We are going to prioritize them and we are going to use those to tie together the work of standards

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and certification, of architecture, privacy, and security. This is going to give us the ability to really move fast and be opportunistic because we are not trying to boil the ocean. We are not trying to change the social order of America. We are trying to improve health care and we are watching the clock because everyday, people die. Everyday people die. This is one of the toughest parts of this that it takes awhile, but we have to recognize that we have got to move it along quickly. Regional projects can play a critical role in both of the wheels that I talked about. On the adoption gap, there is a lot that you can do to band together and look at ways of lowering the cost of IT adoption for local communities. There is a stark exception already out for community efforts to help finance IT adoption by doctors. There are other things that you can do in group purchasing. You can do things to improve value and you can certainly lower the risk. So, you have a lot of pools that are underway and many regional projects are underway already. Taking this up is one of their mantras. You can do a lot for interoperability. My advice to you is to not wait on the federal government. It is our job to catch up to you. It is our job to be able to provide ahead of you the infrastructure and the tools and the capacity that you need to do your jobs. If you ever find yourself waiting on us, you need to stop and think about what you just said to yourself – I

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am waiting on the federal government? So, just think about that and make sure that in the end that you follow the same mantra that I do everyday. I am an entrepreneur. I came to government to get something done. I came to help develop a strategy to help the President's vision to be realized. I am not a long-term career federal officer. I came for a specific reason. One of my hardest challenges is whenever there are people either focused of the risks or that do not understand the context. One of the challenging things for me is that given that the status quo of health care is not acceptable. With people dying, with the kinds of economic issues, with companies laying off employees because of health care costs, we have to take risks to be able to get the kinds of results that we want. This strategy that we are taking on a market base to basis is not the safest strategy. It requires actions of the private sector for the government efforts to succeed. It is not something where we can just say that the reg is out, good luck, it is required, and God forbid someone not follow it. This is different and it requires interaction and trust. I think you all need to think of yourselves as entrepreneurs too. You are out there and ultimately you have to ask yourself how you get the goal, not how do you take the safest way. I know that you are here for that reason. I just encourage you to go out, try, push, expect stuff from us, and keep pushing us to

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deliver what you want. With that, let me say thank you again for coming to Washington on such a very, very hot day and I hope we have a few minutes at least for questions. Thank you.
[Applause]

CAROLYN CLANCY, M.D.: We have a few minutes for questions.

JAN ROOT, Ph.D.: Hi. I am Jan Root and I am with UHIN and it is a little scary to know that Governor Leavitt is talking to you about us. But, he was very instrumental in bringing UHIN to light and we greatly appreciate his efforts. One of the sorts of long term concerns that our board has been discussing recently about the whole movement, UHIN moving from being a chin to being a rio, is the issue of differing privacy laws by state. I am sure that you are very aware of this. I was NCVHS yesterday and spoke with them about it when I was talking with them on some testimony around rios and privacy and security. I was just wondering if your office – I mean I realize that it is a tremendously sensitive topic. I was involved with a lot of the discussions during the Wheatie [misspelling?] implementation of and writing the privacy rules and the security rules. You know, it is different now. With HIPAA, that was an administrative issue and to a large degree I think people just sort of wrote it off as a cost of doing business. But with a rio, we are talking again as you

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mentioned about patients' lives. It is a different issue. I am just wondering if there is anything going on that you are aware of within the federal government to begin to possibly address this.

DAVID BRAILER, M.D., Ph.D.: That is a great question Jan and let me say first that the question of privacy variations by state law – I think there are 30 states that either because of administrative determination, legislative statute, or in a few cases judicial interpretation, states have superceded or exceeded or somehow gone beyond what is interpreted to be the minimum requirements of HIPAA. I think that issue is small compared to one that I look at that seems to me to be the elephant in the living room. The reason I it is small is not to trivialize it. But, let's be honest. We could get together 30 states with everyone else, figure out how to harmonize some things, and they could work through that. There are a lot of examples of states doing that. The challenge that I think is incredibly hard is that HIPAA appropriately built into it flexibility, so that entities, covered entities like hospitals, doctors, labs, pharmacies, could adapt their privacy and their security to their size. A large cyber target or a large high volume facility, like a Kaiser or an Intermountain, will necessarily have more stringent, more complete, more authoritative privacy and

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security capacity than a small office. Those produce huge barriers because there are not 30 that we can get together. There are thousands and thousands and thousands. Our look at this has a sense that there is a lot of variation. The ARC RFP is specifically to evaluate the extent of that enterprise level variation and what options there are to come together. One of the examples that we mentioned in the RFP accompanying documents was given that it is nearly imponderable for us to be able to think about standardizing, literally having a uniform, required level of security and privacy rules that would impose huge costs on small practices and probably lock it into regulation forever, regardless of how the world changes. So, how do we create a more organic kind of chain of trust or broker arrangement so that a rio or a regional project can play a role of helping catalyze data sharing and privacy. I think they are huge issues. We know the judicial interpretation yesterday and even before that there are a lot of questions about entities whose purpose is to mobilize, move, and share clinical data, whether a consumer trust or a rio. Are these covered entities? Are they business associates? Are they none of the above? Here is what I have said to a lot of people: I think that the debate about HIPAA and was it right or was it wrong? Does it need changes or does it not? Is [inaudible] on and have it? But, we need to recognize something bigger, which

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is the world of interoperable clinical data needs a new chase. That chase has to start with a concept of patient centeredness around data and how we let them control data, not just protect their privacy. That debate has not begun. I think the ARC effort is going to be thin end of the wedge on that. Again, I think the separate question is going to be not only the substance of it, but who decides. Our starting point is let's see what the states can do with this. Let's see how far we can get because we can manage state variation. We cannot manage thousands and thousands of other units. So, you are obviously going to be one of the real leaders and thinkers on that and I hope you really pay attention to it as it goes forward. Your question is really right on. Thanks a lot.

MALE SPEAKER: Hi. Can you in your crystal ball and see as the world is looking at interoperability [Laughter] - .

DAVID BRAILER, M.D., Ph.D.: I normally do not bring it with me. It is an ARC meeting so by definition I have to be out in the future.

MALE SPEAKER: Anyway, looking into the ball over in the first row, as we are looking at interoperability, is there the killer app, the e-mail equivalent for that small provider office that is going to make everybody jump on board? We hear about Pafer [misspelling?] performance and we hear about ERX and we hear about different things. Do you see a sort of

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logical pathway that lets the office get to where it needs to go?

DAVID BRAILER, M.D., Ph.D.: You know, I do not. I will tell you why. There is a tautology that is crippling for IT adoption, which you all know and I will just say it just so we can talk about it. To really have significant uptake of IT, done the way America does it, in the south interest of the entity that puts it in place, we need to have economic incentives, which means we need to pay for value. We have to pay for performance in health status. Well, to do that, we have to be able to measure output and we need that data to do it because as good as the indicators that we have today are, there are so few of them that we can only value a couple percentage points a payment around them and by the time they grow, it is not possible to do it manually. We have this world where we need Pafer performance for IT to be put in place. We need IT in place to justify Pafer performance. And, managing that ladder walk I think is the essential federal policy [inaudible] because it sits at the feet of Medicare because of the way other payers follow that process. Even with Pafer performance, I think there is a significant question because by definition, performance improvement favors organizations with the organizational capacity to improve. It is not just about IT. This is not about widgets and software. There still is

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question about the small office left behind. If we did not have that conundrum, I think we would be in the world where the rate limiting step is technology innovation and the killer app would emerge. I think truthfully it would have already emerged. But, it has not because the rate limiting step is demand. So, most of our strategies, with the exception of the National Health Information Network architecture, which is a supply-side strategy, our demand side. It is a tough going, I will tell you. We think we can do it.

MALE SPEAKER: Thank you.

MALE SPEAKER: I wonder if you would speak to the roles of schools of medicine and the National Health Information infrastructure.

DAVID BRAILER, M.D., Ph.D.: I am sorry. Can you say the first part of the question again?

MALE SPEAKER: Sure. Schools of medicine: how do they fit into the picture?

DAVID BRAILER, M.D., Ph.D.: Well, schools of medicine tend to be affiliated with large hospitals, which tend to be in the realm of the world that do have electronic health records in place. I think that we do have an interesting challenge. Interns who started this year were born the same year that the IBM PC came to the market. Those people shop, travel, bank, date, everything on an online basis. They are what I consider

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to be the backup plan. What I mean by that is that if we are unsuccessful in getting this done in the President's time table, there is no question that that generation will not tolerate the kinds of things that physicians, nurses, and patients tolerate today. Our goal is to make it go faster and smoother because the world that could end up without a managed process, as much as I like the free market, could be one where we end either with a big adoption gap or non-interoperability. That kind of magical outcome of everyone on board and everyone connected together is not a natural, stable endpoint. I think it is our goal to get it there. But, medical schools can and do play a role. In fact, I am speaking at the AAMC meeting on Monday, where we are going to talk about a variety of strategies that we have been working with them to develop around teaching and around research. Let's be clear: academic medical centers are the places where most of the good research on Health IT utilization has come from and our ability to really justify the kinds of investment of time, energy, capital, and will in this come from the quality of that evidence. Luckily we have ARC here who has anticipated the future and is investing far ahead of the curve about where that is going to look like. I really hope they do play a role, but that alone will not be the basis for where we succeed in the short term.

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MALE SPEAKER: Let me suggest too that I come from a community school of medicine, not an academic health center and I believe that there are far more of us than there are the academic health centers. So, keep us in mind.

DAVID BRAILER, M.D., Ph.D.: There certainly are and now our job is to convince the academic medical centers of that. [Laughter] Okay, thank you all very much.

CAROLYN CLANCY, M.D.: The [inaudible] comment reminds me of when I went to visit one of our research projects and they had planned this very lovely intervention with computers. This is how they were going to deliver the message to physicians' offices. It was very well thought out and I said, "Well, how many of these docs have computers in their offices?" This was a few years ago. There was a long pause. It became clear that no one had actually thought about that question. But, one of the younger docs said, "Well, of course they all have computers because that is the only way to shop around here." [Laughter] This has been an incredible day, starting off with Nancy Johnson, who I think you all had an opportunity to grasp just how much she gets it. I thought her prepared remarks were wonderful, but her answers to your questions I think give you a very clear sense about how much and how deeply she has been thinking about a lot of these issues that are very close to all of our hearts and how much she can see the

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connections between improving safety and quality, the need for IT, where that fits into disease management and so forth. Secretary Leavitt – you heard about the new American health information community. I wanted to be clear because a couple of you have asked questions. The charter for his new commission that he talked about will be released in the next couple of weeks. There will also be a call for nominations. I have had some questions about or what kind of people are they looking for. Can I be on it? Can I get my friends on it? That will all be a very public process, so please watch the HHS website, I Health Beat, and other types of venues for that information. There is nothing secret about it. It just has not been put out just yet. The Hill staff you will all agree were pretty amazing. If any of you did not think that the work that you are doing is relevant to what they are struggling with right now, I think that the discussion that we had with the staff from Capitol Hill this morning was incredibly illuminating. Not only that, it is really hard to describe how hard it is to get them from Capitol just to over here. Forget Rockville. They have very, very hectic lives. These issues are breaking very quickly. They are just back from a recess and I think the fact that they all made the time to come here, these are fairly senior folks in the health policy apparatus in the Hill, shows how much they value your work. I do not know

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what I can say about Reed Tuckson except I felt incredibly energized. You all got to ask the media panel and hear a whole lot of questions and hear from David Brailer. I think this has really been a fabulous day, but we would not have had fabulous day without having all of the work that you are doing to celebrate and to put it in a larger context to where this is all heading. So, with that I think I wanted to ask Janet Marchabroda [misspelling?] to come up who wanted to make an announcement.

JANET MARCHABRODA: Thanks Carolyn. I just would like to say as we move towards the end of the day that I would like to take a moment to invite you to a reception to honor ARC and than 200 leaders, grantees in both patient safety and IT. After we close today, just head over to the right when you come out of the ballroom and we are at the Renaissance in the ballroom from 6-7:30. It will be a lot of fun and I hope you will join us to celebrate, ARCs work and all of your work. Thank you.

CAROLYN CLANCY, M.D.: Well, thank you Janet. I will be there and I am certainly ready. [Laughter] I also recognize that this is a crossover day and some of you may be going home before we close up the full week on Friday afternoon. That means that I have to give a couple of sets of thanks. We have been talking a lot today about dream teams,

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where the people who know HIT and the people who know safety and quality come together. That is really what we need because it is one part technology and 2 parts all of those human interactions that you just heard David Brailer and others talk about all day. The team that put this conference together is truly a dream team. So, I particularly want to acknowledge Deborah Queenan. Is she here? Well, someone can tell her later. [Applause] All of her colleagues in the center for quality improvement and patient safety, Danny Gaelin [misspelling?] and his team at Newark that includes the e-health initiative and so many others. There will be a much longer and detailed recitation, but I do want to let you know how hard they have been working. My job was incredibly easy because of all of their hard work. So, with that, I bid you adieu. I will warn you if you are not from Washington, it is still really hot out there. Thanks. [Applause]

[END RECORDING]