

Dell e-Health Summit Speech  
Delivered by Governor Phil Bredesen  
April 10, 2006

“Thank you, Kevin, and thank you very much for serving as the convener and host of this effort and for the long friendship serving the state of Tennessee and health. I know Secretary Leavitt was in here earlier, and I will see him a little bit later here, we’re doing some things, but I will say to you that he could not have been and could not be a better friend to the many things that we are trying to accomplish here in the state of Tennessee in the area of health and he has been a wonderful partner in that.

I was very interested in and excited about the invitation to come here and talk with you today at lunch, because this is an important subject to me. I’m coming to you, really, with two hats on, first of all as the governor of a state that I think very much is stepping out on this issue and has placed itself in the very top few states in terms of the size and the commitment to it and the energy behind trying to find ways to establish and make portable medical records and health records, but also, coming to you, frankly, as an individual who believes that information technology is vitally important and vastly underused in the area of providing health care to the citizens of our country.

As many of you may know, those of you who read my biography (which I’ve spent a great deal of money making sure you’ve all read over the years), I came to the world of health care actually through information technology. My college degree was in physics; I spent a long time in the world of computer systems and came into health care through that door, so I have a natural, ingrained, genetic belief in the importance of information technology to that. The field that I spent most of my time in in health care, health maintenance organizations, is very much about the coordination of care and bringing together in single threads all the various pieces of information, the various things that a person would need to know about them to treat them holistically and to care for their medical needs as effectively as possible. Over the years, it has been an area that as a private investor I’ve invested in and feel very strongly supportive of it.

I graduated college in 1967, and at that time, I believe I thought that universal health care and universal electronic medical records were just around the corner. I have now had a very complete life in the ensuing years, and they are still just around the corner, certainly no closer, but no further on their way than they were in 1967. To me, this is a very important subject. I’ve always believed in the world of business or in the world of politics that one of the first things you do with complex problems is just get your arms around the data. Get to understand what is going on in ways that you can sort through it and understand the basics and make decisions then based on that kind of knowledge. And certainly, the field of health care is, to my mind, very lacking in that kind of comprehensive ability to get our hearts around the data.

I’m going to talk to you today about electronic medical records, and I understand that there are different phrases that apply to different things. People talk about electronic health records when there are more than a single institution, but if you’ll allow me to use the phrase ‘electronic medical records,’ I’d like to talk to you about what they’re not, a

little bit about what they are and can do and a little bit about what they are doing here in Tennessee and a few words about where we need to go as a nation.

First of all, what they're not. I know this is blasphemy—they're not a short-term cost saver in the health care system. Politicians love to talk about electronic medical records, because it's a way to talk about saving money in health care that doesn't have any bite to it. Nobody's ox is gored, nobody objects to the notion that somehow you're going to save an extra lab test by having the information down there. But it's part of that recurring theme that you always see in the political world which is that everybody wants to do everything that they're now doing, we're just going to do it more efficiently and save y'all money and give it back to you in a tax cut or something. It doesn't work anywhere; it doesn't work in health care. I think they have enormous potential to improve deficiencies in the economies of health care in the long run; I do not believe there is a short-term solution to any of the large problems that we have in the costs of health care.

I believe in the business world and in the political world, that in the short term, the only way to change costs significantly is to stop doing something that you're doing now that's not in that category.

Second, what it is. It is, over the long term, absolutely a cost saver. I think it comes from that by being a quality improver, and that's where the savings come from. I fundamentally believe that cost control in health care and quality improvement in health care are absolutely not at odds with one another, but two sides of the same coin. They go together hand in glove, and if we concentrate on real quality in health care and the information that can be provided to us to enable that kind of real quality, we will see enormous changes in the cost and in the growth rate of the cost in health care. It's very difficult. I don't know of an area in which there are such huge variations in scale in an industry. You have organizations sitting here at the table with a doctor who is at the Harvard Medical School, you have at one extreme the major teaching hospitals, which are as complex mid-sized institutions as you will find anywhere in the world. On the other hand, 43 to 45 percent of all physicians are in solo practice out there with a nurse and with an individual. I know of no other industry that has anything like that kind of variation in scale, and that's something that has to be dealt with.

It is a deeply fragmented industry. There are communities within Tennessee certainly at which different health care providers see themselves as deeply competitive with one another and I also think that as payers move toward more paper performance, the thing that falls under that category is, something has to happen. We are going to move behind and beyond simply paying for a specific service or be associated with more things that are related to pain-performance, and adherence to standards, and the like. Obviously, the information technology to underlie that is going to be vitally important and is necessary before we really can move into those areas. I'm personally interested, as governor you have responsibility for a lot of people who are on Medicaid in various ways, for whom the state is responsible for their health care in some fundamental way. It's well over a million people in the state of Tennessee. I've just had an object lesson in the fact that what we focus so hard on, which is extending health insurance to larger and larger numbers of people, leaves whole areas of the health equation untouched. We have had, for the past decade, almost a decade and a half now, the most comprehensive health insurance program in America. We had the highest proportion of the people on Medicaid; we had the highest proportion of our state budget devoted to Medicaid of any state in the

union. We also rank in the high forties in several key indicators of health: the incidents of diabetes, the incidents of heart disease.

Despite the fact that we have, for over a decade, had this comprehensive program, we have not moved those indicators one notch during that entire ten or twelve year period. In order to move those, we are going to have to go at it in different ways, and the underlying information about who these people are and what kinds of access to health care they have had and getting out in front of this is going to be absolutely essential to making that happen.

So I think of information, medical records and the use of information technology, as being central for the long-term growth and quality of care that we provide in this country, and also, the long-term growth of our ability to reach into pockets or simply making a physician or a hospital available just doesn't begin to get at the problems that we have.

In Tennessee, one of the reasons we've stepped out is that I think we're particularly well-suited to be a lab and to be a staging area for some of the efforts that are going on in the area of electronic medical records and the application of that technology. I acknowledge that Tennessee is not high on the player's list, (we have many communities that still need broadband access and some of those issues,) but we are an absolute national center for entrepreneurial health care. HCA, which I know has been here, probably started the whole process years and years ago. But there are health communities and prescription benefit companies and different kinds of payment companies and a variety of health care, entrepreneurial, information-oriented companies, which I think make a wonderful structure for us to begin to build on being experimental in this area. We have Vanderbilt and we have Blue Cross, both of whom have been leaders nationally in this process and are huge resources, and last of all, I don't know how important you'd consider it, but at least for the time being, you've got a governor who believes in this stuff, and I am trying as best I can to move forward.

Just to tick them off, we have here, you probably know, we have the mid-South eHealth Alliance, which started in 2004. It's a partnership in West Tennessee with Vanderbilt, and the state has committed about \$9 million to that over a five-year period. There's an AHRQ grant to add an additional \$5 million. I think of that effort, as it builds a little bit around the Vanderbilt model, as one that tries to bypass the problems associated with defining what's in a health record and provide an approach to getting into those records which is very flexible and depends more on putting pretext and limited structure into the records. I think that's a very good line to be trying to work with. We also have the Shared Health Model, the subsidiary of Blue Cross, which is working with TennCare, and it's contracted to provide electronic medical records for TennCare. That effort, from the payer's side, is based more on what seem to be charge tickets, although it is increasingly bringing other information to bear on it. I see it as another facet of or another view into the entire issue. Up in the Tri-Cities area, we have a more classic regional approach, work done by a community coalition with everybody with accounts in the coalition participating in a central Appalachian regional prototype. They have a substantial grant, a little over \$5 million from HHS, and we have one just getting started in the Knoxville area, the East Tennessee Health Information Network. It is a collaboration of poor hospitals, and it has received funding through the Physician's Foundation for Health Systems Excellence up in the Boston area. These are four different approaches, and believe me, I'm doing everything I can to move them along and sort

them and begin to use them, especially in regards to TennCare, in a real environment so we can start to understand better.

I'm proud of these efforts. We're going to continue to support them and our many excellent people who are committed to it. There's no question that some good ideas will come out of these efforts. What I want to say to you here today, though, speaking from a national perspective, is, 'It's not enough.' And we're missing a real opportunity in this field, and I think in this country right now. This is an area that cries out for some central decision making, for someone to decide what medical records are and define them in some way and how the interfaces between those things work. This approach of funding state, local, federal government a thousand flowers and letting them bloom across the country, it's like the only example I could think of when I was walking up here is, it's like if J.F.K. had called the country together in 1962 and said, 'We are going to get to the moon by the end of this decade,' and everyone said, 'Great, great, this is wonderful. America's on the move again.' And then he said, 'The way we're going to do that is, we're going to give grants competitively to a whole bunch of different states to try different approaches to getting there.' You would have lots of ideas, you would have lots of people carving out territory, you would have lots of sharp elbows, but I think you'd agree there would not be footprints on the moon as a result of that effort.

It cries out for a common vision, for some overarching structure and standards for electronic records that can be a foundation for all the brilliant people that we have in this country to build upon in ways that we can't see yet. It's like a vision for going to the moon. We've set the vision, we've set the goals, we've set the standards under which we're operating and then allow the brilliance of our nation and its universities and its companies and its hospitals and its non-profit organizations and its entrepreneurs to make the pieces work to get us there.

For e-Health, for the idea of true electronic medical records that will be the foundation for transformation of the care of people in our country, we need a common vision. It should not be written by bureaucrats, either in Congress or in HHS or anywhere else. It certainly shouldn't be solely written by industry.

There needs to be an open and extensive review and we need to have ways to get input from all ports. I say all that because there is a perfectly relevant model out there right now and it's called the Internet. The Internet is a body founded on a series of universal standards. There's "tcpip" and there's "http," and there's "xml" now, which is transforming the world in a lot of ways. For those of you that have players, there's "mp3"- there's a whole bunch of different standards. The vehicle which is used to set these standards is actually a document called an rfc-"request for comment." Those of you who are in the industry know exactly what I'm talking about. The idea is these are standards that are drafted by some group, they're put out for technical comment, they're fixed for a while and frozen for a while, and they then provide the vehicle around which people can work to develop their products. I'm sitting here with the CEO of Dell Corporation, and when he makes a computer, he doesn't have to worry about how to hook that computer up with an IBM computer to send e-mail to for example, an Apple computer. There is a set of technical standards that defines what those relationships are. He can spend his time working on the best darn computer that does the most kinds of things with that information at the best possible price. We need the same thing to happen in the field of health care with regard to information technology that we have there. Some

elements in these things remain essentially fixed forever. I don't know whether the "tcpip" standard has been changed substantially in years. There are other things that have evolved substantially. But what the Internet has showed us how to do is to have a way in which you can define overarching standards. You can define them through a very open process in which anyone who cares to comment or have input into it can do so, industry, professors, but you then provide the framework in which the intelligence and the creativity of American business and American universities can function and flourish.

I think it's different from the Internet in this way: Most of these things with the Internet started out when pieces of the industry hadn't already developed a long way. That's not true of health care and I think this is something that has to start with leadership from the federal level to establish a founding group and obviously, to help enforce the results. Anything that Medicare and Medicaid say is going to be part of the future will be part of the future in health care.

The process now...understand the rationale, you try various things, you let competition decide, you let things work out and good ideas float to the top, but you know, if you put a BETA Max in a VHS player and it doesn't play, you miss a movie. If you put a medical record in a computer that doesn't understand it, you might well lose a life. They're very different, and it very much calls out for some federal creativity at the outset to set up the mechanism, not to set the standards, but to set the mechanism that's broadly agreed upon to deal with these issues.

So I'm here today, just a real short thesis, and I'll leave some time for questions if it's okay with you, and I'll be glad to try to answer them. Basically, the thesis is this: Electronic medical records, I think, are vitally important for a bunch of reasons. I don't need to go over them. They're past due. I don't see them as a short-term cost saver, but as a transformational element, ultimately, in the quality and in the cost of care in America. We're pursuing it in Tennessee through four different fronts and we're making progress on those fronts and we're going to continue rowing the boat as hard as we can, but it's not enough. This is something that cries for an overarching, common vision with the federal government as a convener of that vision. The Internet provides a wealth of experience on how to develop this common vision and the standards in the twenty-first century through an open process, and we need to step up and begin using some of these tools. This is one of the real frontiers in medicine. It's one of the real frontiers in providing health and health care to our citizens. Let's do it like a moon job. Thank you very much.