AV 09.30.08 HS 1: 2nd day, Summit start, Panel 3 Standards and Following Floor Discussions

(Secretary Kempthorne) Take your places. We will begin day two, building upon a very successful day one. Aloha! Talofa lava! Hafa Adai. Yokwe yuk. Kaselehlia. Ra annim. Kefel. Len wo. Alii. Howdy!

Nice to see all of you. President Mori, thank you for being here, President Chin, and Secretary Villagomez, Commissioner Fludd. Secretary Villagomez…it's funny, that term 'Secretary'. When I became Secretary I thought it was pretty cool because it was National Secretary's Week. They've done away with it! I never even got a card. Anyway, I'll write you. You send me a note, I'll send you a note. Happy Secretary's Day to all of us.

Once again let me thank Dr. Peake, Dr. Chu. Let me acknowledge, Dr. Garcia was called to another assignment. Tom Lorentzen, we appreciate you coming in, you have Region IX. Here is the game plan: We have two panels this morning, we have two opportunities of the open mic. So we're just going to roll. And then I would like to get as much input as possible. I will tell you right now, all of these proceedings have been captured in recordings and from this will come a compilation, a condensation of the key points. They will be organized, and it will be distributed to all that are here. That gives us good data from which we can work. And then the working groups will be established and proceed. Before we begin the panel, let me just ask, Dr. Peake, any initial comments before we begin?

(Secretary Peake) I just appreciate the forum that has been created here and the sense of community that it really represents. And as I kind of wandered through the crowd at the reception last night, I think everybody really appreciated the opportunity to get the issues on the table and to talk them through. And so I'm really looking forward to this day as well.

(Secretary Kempthorne) Perfect, thank you very much. Dr. Chu?

(Secretary Chu) Let me just reiterate what Jim Peake said. I appreciate your leadership in organizing this, and I certainly learned a great deal. It's clear that there are some points of consensus. There are also points of disagreement. But very valuable to hear all those perspectives. And I look foreword to what the afternoon session may produce in terms of ideas about the way forward.

(Secretary Kempthorne) Very good. Tom?

(Director Tom Lorentzen) Yes. Mr. Secretary, I want to thank you for this wonderful event. It's turned out to be quite outstanding, and I reported back to the Secretary's office this morning that I thought that this has worked out exceptionally well. And the health and well being of the Insular Areas is certainly in everyone's interest. Maybe this

format is something to look at in considering to be done on an annual or bi-annual basis in the future to go forward.

(Secretary Kempthorne) Good. Very, very good. Let me also thank Governor Togiola Tulafono, my friend, thank you for being here with us this morning.

We have referenced the Inspector General's report. This meeting is not a result of the Inspector General's report. It happens that he issued a report, but this (meeting) is an outcome from my trips to the islands. This is an outcome from my discussions with these wonderful leaders here and with our island leaders. There are things in the report which are serious and sobering that we must address. But let me say, there are positive things that are happening in the health care in the islands, and that is also part of what we are doing here and will be captured in this task force. So let's build upon the good, let's correct the challenges. But let's acknowledge the outstanding devoted caregivers that have devoted their life to this. When I met with those 125 nurses, I met with 125 angels. When I meet with the physicians and the caregivers, the people, the administrators, the hospital administrators, you all care. You advocate. And I think we have now enhanced your partnership. That's the key.

Alright, with that, we have a wonderful panel this morning that is going to be discussing improving standards of health care quality, quality-insurance programs, hospital sanitation. I think this is a very key panel and I'm really looking forward to your comments. So, with that, Captain, you are once again our moderator.

(Captain John Walmsley) I am still John Walmsley and I am still with the Office of Pacific Health in Region IX in San Francisco, working for Admiral Ron Banks. Welcome to the second day of discussion here. I would like to remind my panelists that each person gets a finite amount of time with the time keeper up front who will be flashing stop cards. At the front of our panel is Mary Rydell, Dr. Skilling, Julio Marar, Justina Langridik, Carmelo Rivera and Neil Palafox. I'll ask each one of them to very briefly introduce themselves right now.

(Mary Rydell) Aloha. My name is Mary Rydell and I work for the Centers for Medicare and Medicaid Services (CMS). I have the best job in my agency. I actually work alone here, in Honolulu, and I cover Hawai'i, American Samoa, the Commonwealth of the Northern Mariana Islands and Guam.

(Vita Skilling) Good morning, I'm Vita Skilling. I'm the Secretary of Health and Social Affairs for the Federated States of Micronesia and I'm here today to represent three of the four states in FSM, working along with Dr. Marar.

(Julio Marar) Good morning, my name is Julio Marar. I'm the Director of Health Services in the Chuuk State in the FSM.

(Justina Langidrik) Good morning, my name is Justina Langidrik, I'm the Secretary of Health for the RMI.

(Carmelo Rivera) Good morning, I am Carmelo Rivera. I am the Chairman of the Government of the Virgin Islands Hospitals and Health Facilities Corporation.

(Dr. Neil Palafox) Good morning, my name is Neil Palafox. My day job is Faculty and Chair of the John Burns School of Medicine's Department of Community Health. But I'm also a Board Member of a volunteer organization in the Pacific called the Community Health Foundation; and also a member of the Compact Impact Committee in Hawai'i; and also have a program where we take care of the nuclear affected people from the US Nuclear Testing Program in the Pacific. So, wearing many hats today.

(Captain Walmsley) Okay, thank you panelists. Reminder to the audience that we will follow the same format as yesterday, where each person gives a brief presentation and when we are all done at the end we will have some questions and answers. Mary…hit it.

(Mary Rydell) Okay, anybody who knows me, I'm not Puerto Rican but when you put a microphone in front of me it's kind of hard to make me stop. So I just wanted to talk briefly just to give you an overview of our HHS initiatives, then Medicare Hospital compare. But I want to go through the first ten slides really, really fast cuz I don't have a lot of time. But I do want to talk about our Quality Improvement Organizations and our Survey and Certification activities and how to stay informed. So the first thing to do is to introduce my agency. We administer three very large health insurance programs. We spend an awful lot of your tax money every year and we do have the responsibility for monitoring the health and safety of our providers that serve our beneficiaries. All of our funds are used very specifically for people who are either entitled or eligible for our program so we don't cover everybody, unfortunately.

The four cornerstones to value driven health care, and it was very important that we used the IOM study published in 2000 about medical to come up with a lot of these things. But health information technology is very important because we can control quality, and it provides a way for systems to talk to one another. It's important to publish quality information. Starting in 1998, when we started with Nursing Home Compare, you knew more about buying a car than you did about where you were getting your health care so it's very important to do that. Also, measure and price information, you guys are paying for this, you need to know how much it costs. And obviously, promote quality and efficiency to save us money. And it's important because we are basically going broke and the next few slides will show the prices and increases, it's just phenomenal. So if you look at this chart, there is less workers for each Medicare beneficiary, and this one gives you an idea of where we're going if there aren't any changes made. So there are some very smart people in Congress and you are very smart people and I trust that you will come up with some solutions. So I want to talk a little bit about Medicare Hospital Compare. Once providers are, "coerced", into providing quality information it really does help them improve their quality. And I want to emphasize all of these things are kind of at a starting point. We worked on nursing homes and home health for a number of years, they're always being refined and changed.

Basically, we look at three outcome measures, 26 process measures and 10 measures that we get from surveys of actual patients that get services at these places. Hawaii hospitals reports the measures, Guam Memorial reports the 26 process measures. If you want to go and check this out online, it's actually pretty cool, especially if you live in Hawaii you can check out the Hawaii hospitals. So you go on the website…I'm going to search for hospitals in Honolulu, this is what pops up (of course, if it's Guam, it's only going to show Guam Memorial Hospital). I selected three hospitals. I didn't do it to target them in any way, just to show you how this tool works. I'm going to select a quality measure, and this is what pops up. So you can use these comparison tools as a consumer, along with the inspections and other things we do at CMS to give you some idea of who's good at what. So this is a survey of those surgery patients who received preventative antibiotics one hour before incision, and heart attack patients given the beta-blocker at arrival, and the discharge instructions for the heart failure patients. Then we also have mortality rates that are also presented here. So all of this information continues to be refined, we keep adding measures. So this is really what I wanted to talk about. We have Mountain Pacific Quality Health Foundation, it's located here in Honolulu and it serves Hawai'i and the outer pacific, just the three jurisdictions in which we have programs. They are a group of practicing doctors and other health care professionals paid by the Federal government to monitor the quality of care, also to work with all the facilities and providers, including the physicians in quality improvement activities, the quality measure reporting. They handle Medicare beneficiary care complaints.

We have some really good success stories in the outer pacific: at LBJ Tropical Medical Center between 2004 and 2006, they set up an electronic registry for diabetic patients and they saw the reduction of the problems they've had as far as all the routine maintenance type of testing and other things that diabetics need. There was a reduction from about 80% not getting those services to about 56%. They also work with two home health agencies on Saipan. This is a dramatic turn-around, re-hospitalizations. They work with the two home heath agencies, there is only two there, so it makes it a little bit easier I guess, and they worked with the hospitals and these agencies and they reduced re-hospitalizations in two years from 70% to 10%. That's really dramatic. We also have a quality improvement organization just for our dialysis centers. Unfortunately, dialysis has increased in the outer Pacific and Hawai'i by 546% in the last 10 years. That's a very sobering statistic. So we are very concerned about people in our dialysis centers. So we have ESRD Network 17 that provides these QI activities specifically for those dialysis centers. What we'd really like to is prevent the diabetes that is 70% of the time, if it's unchecked, causes people to go on dialysis. But for the moment, this is what we look at in terms of the quality improvement activity.

Another part of CMS contracts with Hawaii Department of Health Office of Health Care Assurance to do our survey activities. When someone enrolls in a Medicare program, there are certain qualifications they have to have. We actually go out and visit the provider depending on the provider type on site. Non-accredited hospitals, as are the 3 Pacific hospitals that we cover, are surveyed every three years. The normal for survey and certification is compliance and regulatory duties. But they've developed a de facto technical assistance role, especially with Hawaii and the Pacific islands. They review

these hospitals to make sure that they meet our conditions for participation (COP) in our program, and I want to emphasize that those COPs are basic. All hospitals should be striving to be above that. You can go on Medicare.gov and look at the surveys, for nursing homes and home health agencies. You can actually see how a specific health facility did on their last survey. They end up providing technical assistance to providers through a plan of corrections, re-survey processes, and Federal comparative surveys. One of the things we've been talking about in Region IX is federalizing the survey activities in the outer Pacific. And the reason we might pull them back from the state is that we'd really like to provide more technical assistance rather than just compliance activities. This is in discussion in Region IX and the consortium. What happens when the state survey guys go out, they have their job to do. We pay them so much per contract, and they don't really want to do anything extra because we're not paying them to provide technical assistance. These are some of the websites, HHS.gov and the Hospital Compare, these are really good websites. I'm happy to email them to anybody. You can come up and get my card.

In Region IX for CMS we have what we call a Stake Holder Call. It happens every month and this is the number you call into. And again, I can provide that information to you directly. It's an opportunity for providers and anybody else who has a stake at CMS business to ask us questions. But we also have an agenda of updates that we provide so that you can stay informed by calling into the Call. Or even if you just get on the list, we'll send you the minutes from the call. It is 8am Guam, CNMI time on the 3d Friday. Thank you for kind time and attention. And this is my contact information. You can ask me any questions you have at the end.

(Vita Skilling) Good morning everybody. I align myself with the greetings that were done this morning and with all the recognitions that were done yesterday. In the interest of time, even though this topic is confusing because its talking about Quality Insurance Improvement programs and hospital programs, I will limit my presentation to the quality insurance improvement and sanitation. I would also like to recognize the three hospital heads that have given me the blessing to come and present this morning and that would be: Mr. Gilmar from Yap, Dept of Health; Dr. Liz Keller from Pohnpei Dept. of Health; and Carolyn Shrew, representing Director Post from Kosrae Dept. of Health.

Before I go on, I want to give an overview of what the hospitals look like in size and the budget they have to operate per year.

> Kosrae is a 38-bed hospital that caters to 7000 people with an annual budget of $2.5m per year and it's more than 20 years old.
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> Pohnpei is a 90-bed hospital servicing 43,000 people on a budget of $5.6m per year and it's also more than 20 years old.
>
> Yap is another small hospital, about 36 beds catering to about 10,000 to 12,000 people with a budget between $4 to $5m per year and it's more than 20 years old.

Of all the hospitals, when someone came to review it in the last three to six months, we were told that with the conditions that they are in, they will be condemned and be closed. Fortunately for Pohnpei, it's the only state that has a private hospital. The rest of us might as well stay home and not go anywhere else because we have no other choices for hospitals. According to information I've received in the past 6 months, the condition of the Kosrae hospital calls for a totally new hospital. Electricity is no longer safe for the hospital, the general condition is not good either. So this is what the conditions of the hospitals are like, and I want everybody to understand before I go on to my presentation. So what standards are we talking about? What is our reference point here? These structures are in need of expansion to meet the need of additional populations, additional equipment, additional services that did not exist before they were built 20 years ago.

Given the budget they have, some issues on the priority list will not be covered because we will attend to the top priorities that we can afford. For people who take things for granted, we do not have gloves 12 months of the year. Not even for 30 days of the month on other times. So if we're pressed for picking up gloves for picking up trash, we cannot use them because we have to save them for the emergency and operating rooms. We can not even afford to buy the shot containers so we improvise by using plastic containers. And guess what? Those plastic containers, like water bottles and Clorox bottles, are limited because they're the same containers that the local people use to store their water, kerosene, gasoline and other fluids. Given the budget we have, it would be very difficult to purchase everything that we are expected to use.

The other situation is that, yes, the IG Report does tell the truth in a way, but perhaps it was a report that was taken at one point in time; perhaps that's the worst day; the worst week; that's the worst month of the year that the hospitals had at the time of the report.

The fourth point, using the standard of a developed nation to assess the underdeveloped nation's condition is like using the budget for buying a used pair of slippers at the Good-will store to purchase the latest fashion shoes an exclusive store.

Number five point – I couldn't help but understand what Dr. Kuartei articulated yesterday. While the nurses and the physicians are too busy to clean up the hospital, the Departments of Health managers can not afford to purchase another service, the janitors who do not work at the standard hospital think they're doing their best. So it all comes down to, we do the best with what we've got.

The other issues to realize that has to do with health care sanitation also affects the whole nation, we have water problems because two out of the four states have the fortunate of having the blessings of having the water that they can donate to probably most of the islands in the Pacific. The other two islands do not have that luxury. We have problems with electricity so that if you live in one of those islands you better be prepared to have a back up because the electricity will be on for sometimes hours of the day, three days of the week, period. That's it, you have to learn to do everything else without electricity. Maintenance is also very difficult because the quality insurance plans that was implemented, or planned to be implemented for the nation, was too compartmentalized to

the point that nurses they only do this, they don't do anything else for the doctors. Janitors do this and there is no more integration of work. We do have policies regarding hospital sanitations but for reasons I can try to explain later, some of the policies are not always explained.

Yesterday we talked about commitments and ownership. The hospitals were built by the government, therefore they are owned by the government. And believe me, in Micronesia we haven't think of ourselves as government. We think of the President, the governors, the directors as the government, and the rest of the people in the community – we're just the people, we're not the government. Then there is also the inadequacy of the spaces like I alluded to. The hospitals have become smaller than they were intended to be and since we do not have enough nurses to take care of the patients at the hospital, we bring the family attendance. And many times the open wards are too small for everyone to stay there, and they have to pay $12 round trip on the boat to go back and forth to get their belongings and their food to stay at the hospital and they have to pack. It's like me this week having to pack to come to Honolulu. And you can't imagine where they're going to put their suitcases, their foods and everything else they have with them at the ward. In terms of existing policies for improved sanitation, infection control protocols were instituted about seven or eight years ago. And yes, some of them look very good on paper, but some of them don't do very well. If, for example, the protocol has dress code for the doctors, it says we have to wear coats and shoes. You can imagine on a salary of $24,000 a year trying to support a family of six, there is no way we can afford to purchase shoes and coats. The examination rooms are closed because of confidentiality and privacy, there are no air conditions, there is no breeze, we are going to be cooked wearing coats in those rooms. Garbage and waste disposal policies are available; attendance policies; no smoking, no chewing policies, and designated green days are done. Once a month, everybody has to stop their work and just clean up the whole campus. Clean field of work is an understanding. But how come they're not being coordinated? Perhaps there are other reasons that can explain those.

The weaknesses in terms of management – maybe we don't have time, maybe there are other reasons, and maybe just plain we do not want to obey the rules. And it's not that we want to be dirty, but sometimes you can not just take something that is just pushed down on you if it wasn't you who decided to take it. What did we do to implement these standards? The quality assurance coordination office has been established. We have unit audits, designated green days like I said, incentive awards. And the challenges are like I said before, deteriorating facilities, personal attitudes, need of training, inadequate management and support.

[Comment to Kempthorne and co-conveners] A review of our hospitals has been done. The IG report has successfully informed us of how far below we are from the standards. I have presented the weaknesses, the efforts and the plans that we will try to do to improve the conditions within our limitations that we have. What are the next steps or actions besides a follow up review that this summit will endorse to make sure that the conditions of our hospitals are improved? Thank you Mr. Secretary. Thank you everybody.

(Secretary Kempthorne) Thank you, that's a very beautiful report. One of the things we need to discuss as policy makers is the idea that you have four hours of electricity, three days a week. Is that acceptable for a hospital? When we think of the combined assets of DOD, VA, Health and Services, the Interior, is there something that should be done to have a steady source of electricity? The simple concept of gloves, you're making key decisions by using them in emergency and operating rooms, therefore you do not use it on the trash. Yet, in the trash, there is also disease. You did a really good job, thank you.

(Julio Marar) Chuuk has about half of the population (of all of FSM) with hospital capacity beds of little over 120 and a budget of a little over $7 mil dollars. Regarding hospital standards, we have our own challenges, similar to the others. We try to do things under the conditions, but it's difficult. We usually need outside assistance. We face a lot of problems, especially the island power. In Chuuk, compared to the other states, we have more power outages; in a week you are lucky if you can get a day or two days of power. We have no adequate portable water supply. We have breakdown of equipment and medical supplies, lack of trucks and medical supplies, and, currently, outbreaks of TB and Hepatitis A. We also have our share of man power problems. Although we don't have any formal quality insurance program, it is in the making thanks to PIHOA. We do our best under the current conditions to have safety and cleanliness of facilities.

Recently we have some renovations, thanks to OIA for helping us in our current budget. Per our request, we were granted minor budgets for renovations. And thanks to the USSN Mercy for providing health care services and treating our patients and for some repairs to hospital facilities and school facilities. Hospital accomplishments: minor renovation and painting of hospital wards; although we have limited and scarcity of resources, recently we have a newly created Medical ICU; and repair of our OR emergency rooms and wards. Also, I'd also like to acknowledge the assistance of Canvasback who helps us to treat some of the patients who can not be referred out because of lack of funds. And of course the UUS Mercy ship, they helped us renovate (showed photos of out patient and emergency rooms) our outpatient area and emergency room. And here it is (more photos). Thank you, Mr. Secretary, for the assistance in the back-up generators which help with outages. Here is the new generator. Because of your assistance, we now have reliable power. Sometimes only the hospital has power. Also your project, Mr. Secretary (show photo), the water system. I hope it will be fully installed and operational when I get back. The USS Mercy was able to treat over 10,000 people from the lagoon islands. Unfortunately, many of the people in the outer island could not make it to be seen. From the people that were seen, about 266 surgical patients were operated on. I'd like to mention something about the Dispensary plan. Before the problem was always the stocking and restocking of medical supplies. Here is the new room (show photo), and they are plenty of areas for stock and supplies. The Dispensary and Public Health, before they were two separate divisions, but now they are trying to work together and work collaboratively on the primary care and outreach in the remote area. Recently you know of, we have situations of outbreaks. Experts say that if we

don't get the power situation back on, we will always have problems relating to back-flow of sewage. We need help.

In conclusion, I would like to go back to what the Honorable Governor Togiola of American Samoa said yesterday regarding problems with power. I know others have problems, but I think Chuuk has the most serious problems. Also, to what my friend Dr. Palafox stated in the comparison of capacity of hospitals to budgets, one can see why we have so much problems.

(Secretary Kempthorne) While we're getting ready for the next presentation, it seems to me there are a couple of constants with regards to the islands, sunshine and trade winds. I really think, Nik, as we go forward, we need to really take a look at the power supply for hospitals. Why can't we tap into more solar and wind turbines, we also have wave and current. We ought to do an outreach program with these companies that are moving into the new technologies and give them a practical application to provide power to the hospitals in the islands through solar, wind, etc. We'll give them a demonstration opportunity.

(Justina Langridik) I don't have a Power Point presentation, so I will speak from the heart. The Marshall Islands are comprised of 1,125 islands which make up the twenty-nine atolls and five single islands, scattered over 700,000 sm of ocean, making the population very diverse.

If there is no transportation, if airlines have mechanical problems, it takes at least three to six days to go by ship. So transporting patients can be difficult and long. Health care in the RMI is comprised of two hospitals, the main one in Majuro, 90-beds, and Ebeye, 35-beds, and 58 health centers scattered throughout the islands. Because of the distance and transportation challenges, it can take up to a year to receive the items (ordered equipment and supplies). For instance, the incinerator mentioned in the report (OIG), it took us about a year to get the incinerator. Then, when the incinerator was to be installed, we noticed there was a missing part. It has been months since the reorder and hopefully the part will arrive soon. It takes longer for equipment and supplies to get to the RMI. And if a company doesn't know where the RMI is, it is almost always a partial shipment. One lady asked me if she could send the part by train. Those are some of the challenges that we are facing. We can email and call, but when we call someone who is not familiar with the pacific region, it takes so long to receive the things because of the distance.

Quality insurance: we are working on new ones. Over the years we have been able to work without written policies and guidelines. We do the work. But when someone asks if we have a written policy, then no. We are working on that now. We've established committees in the Ministry (of Health) so we can look at ways to improve medical services. Hospital sanitation is something we are trying to improve. We may not have the shining floor or your expectation of what we should look like, but we do the best we can with what we have. With limited supplies and high costs, we are facing many challenges. In the Ministry alone, we have less than ten staff in the housekeeping department for the hospital. But we make sure they clean the hospital rooms before

anything else. Most of the time, I mop and clean my own office because I can do that. Why give it to the housekeeping if they need to clean the patient's room first? That's the culture we were talking about yesterday. We do the best we can with what we have. How you do your work, act, speak defines who you are. If the people know how to do things that are appropriate, than we will do the best we can. Your expectations may not be what we can do because of the limitations of supplies that we have. An example of the limitations of getting equipments and the length of time it takes to receive: Thank you very much, Mr. Secretary, for your efforts to get us a new generator on Ebeye. We will have the new equipment because of you. And I am happy to say that scheduled for October 3, we will finally receive the generator on the island. So you can see the number of months it has taken to finally get the equipment sent to RMI. That's the reality of how long it takes to receive things in our country. Thank you.

(Carmelo Rivera) It is great to be here. Even though we are oceans apart, we have the same stories. I am hearing so many similar things, over and over again. We have a comprehensive and fairly successful public system of health care. We continuously aspire to meet world-class standards. We have come a long way and continue to make progress. Our system includes two acute care joint commissions, fully accredited hospitals with 300 beds. We recently opened a Cancer Institute and Treatment Center on St. Thomas, and in two weeks, Mr. Secretary, you are welcome to come to the opening in two weeks, in St. Croix we will open a Cardio Center. In addition, we also have six health centers throughout the three islands, two centers will serve veterans. In the private sector, we have an impressive list of health providers and professionals and several medical labs. Our physicians are licensed and come from many of the top medical schools in the nation. We are proud of our health system.

But despite our progress and development, we still share commonalities with our friends in the Pacific islands. We experienced many of the issues and challenges described in the Interior OIG report. We have many gaps in service and limited bed capacity in hospitals, insufficient long term care facilities, and are severely underfunded and our system is drowning in red ink. Our compensation salaries are relatively unattractive making it difficult to recruit and retain health professionals. Like everyone else, because of shortages of physicians and nurses, our staff is overworked and over stressed. Almost daily we have an exodus of people leaving our islands to seek health care services in Puerto Rico or the U.S. mainland where it is cheaper and readily available. We have an aging and obsolete infrastructure, faltering electrical systems, and skyrocketing energy costs, quadrupled in last few months. Disposal of hazardous medical waste is also a major challenge. We pay approximately $2.5 mil annually to prepare and ship out medical waste to Florida. We have equipment and technology challenges, suffer malfunctions because of maintenance or lack of funds to pay for repairs. Because of our rapid rise in violent crimes and lack of services for prisoners, hospital security has become a major priority. Recently, a murder in one of our hospitals occurred so hospital security is now very tight to ensure the safety of our patients and staff. This is very costly. Procuring supplies is often a challenge due to lack of funds. Vendors often require cash up front and shipping supplies to territories is very expensive, and, like some of you all, there are vendors who don't know where we are.

We struggle to comply with mainland standards and to remain accredited. We have no problems with standards, per se, and believe standards are necessary for quality care. But complying with standards requires technology; it requires ample equipment; it requires supplies; it requires expertise; it requires infrastructure modification and upgrades; it requires lots of money. If the Medicaid cap was significantly removed, and we had an infusion of revenue, we could quickly become a model health care system in probably 3 years. However, if the status quo prevails, at the rate that costs are increasing we will continue in a downward spiral and deteriorate. We will fulfill the subtitle of the report (OIG). Right now we are at a crossroads and the prime solution is more money, there's no elegant way to say it, more money. And the Medicaid cap (and cost/share provisions) must be changed. Thank you.

(Neal Palafox, M.D.) Secretary Peake, Secretary Kempthorne, Secretary Chu, Honorable members of the Pacific Presidents and Governors that are here, Directors of Health, I am honored to be here. I'd like to begin by stating I find it very important to know who is talking to you. I come from a perspective of living in the Marshall Islands for 10 years, and wearing a uniform as a U.S. Public Health Service, National Service Corps, I was an 05. I take care of, for the last 10 years, radiation-affected people. And I work with the medical school and do several projects there. I'm going to talk to you about Quality Assurance, a Pacific Regional Approach. There's lots of ground to cover as I'm trying to represent many hats as I also am on the Compact Impact Committee in Hawaii. I know very well what happens when things get loose in the Pacific.

Oceania Community Health, I'm a board member. We talked about volunteerism the other day and volunteerism has a very strong part in quality assurance. There are handouts in the back. Oceania Community Health is a Hawaii-based 501C-3 and the founder is actually now a physician who went though our medical program here in Hawaii, gets paid $25,000, lives in Yap and runs this program. He has put together many fine things. The group has facilitated community construction of an island health center, provided training for health care professionals there and enabled Yap to respond to Dengue outbreaks. And the focus now is on quality assurance. Volunteerism, 501 C3s, have a strong role in the Pacific as Jackie Spence and Jamie Spence said the other day, they also have a role in quality assurance. From the John Burns School of Medicine, my day job, I chair one of the departments there and because I am part of that I was appointed to the Compact Impact Task Force by the Governor of Hawaii. For the last 10 years we also take care of Marshall Island's people regarding radiation and I helped set up one of the original programs for that. I work a lot with the NCI, the CDC, many projects that I am proud to be principal investigator on. And we actually have 1 of 18 centers in the nation which is a CDC Center for Excellence to eliminate disparities in breast and cervical cancer. These are all Regional initiatives, and there's lots of paperwork in the back on this. There are lots of things going on which emphasize a lot of work the nation is doing in partnership with the Pacific. And its Regional work, and one of the things about the Center for Excellence, it is working with quality assurance also in these areas because without that, you cannot move these projects forward.

Hospital sanitation, why is the hospital dirty? Now this can really be replaced by anything. Mr. Secretary, I believe hospital sanitation is really a symptom. It's a symptom just like hepatitis A, like TB going out of control. It's a symptom that the system is not working well. Why doesn't it work well? Partly because of funds as you heard. It's because there are no health priorities, or what are the health priorities? It's because there's a lack of organization in management because there are no priorities. It's about health workforce training, and Dr. Dever talked about that, and it reflects the system's challenges. So hospital sanitation is bad, but it is one symptom of the whole system that is strained, they're very challenged. And this is what quality assurance is about.

If you look at hospital operations, we talked a little about this yesterday. In the U.S., the benchmark to run a hospital is about $1100 to $1400 per day (per bed per day). That is the U.S. benchmark for quality hospitals, around that range. In the FSM, in some of the hospitals they have $45 per bed per day to run it. In one calculation I did it was $21, but I refused to believe it so I moved it to $45. You can see why these areas are straining. We talked about the housekeeping yesterday and what it cost to actually do that. But these are real benchmarks and what it costs to run a good hospital with good standards. So, health care costs. We talked about the Wahiawa Hospital, it has a $42 mil budget (used as comparable hospital size), and then we talked about Chuuk where the entire health care budget is $7 mil, and that's for the entire health care system, including its hospital which alone has over 100 beds.

This is the reality check for me. The US spends $5700 per person on health care. Look where Chuuk is, $80. What are you going to do with $80? And look where American Samoa is? (referring to power point). These are the disparities and what they are operating at per capita. If you compare these numbers in the world standards, the Pacific numbers are comparable to Mexico and Turkey. So, when we are talking about health care and standards, what are the standards? Are we talking about Mexico? The US? And what do we have to do about that.

This is where quality assurance comes in - using performance data to improve a health system. It's about organization and the interdependency of the systems and the interdependency of the partners. It is all of us Mr. Secretary, and that's why I really believe in this summit. It is about all of the internal and support systems and increasing the capacity.

So, the first step, I believe, is to define the standard of care. What's desirable, what's possible? Is what's possible Mexico? Or is what's possible Harvard University? And then, what is desirable. So when all these countries entered into trust or compact or whatever it was, if you asked them, did you want Mexico's health care or did you want the U.S? And I bet you get different answers from different people. But that's my point, so the first step in quality assurance is what is that standard you're building, what is it?

And then you can create the priorities. Should we have dialysis? Maybe, maybe not. Maybe dialysis is an American dream but maybe it's not a Pacific dream. But that's what comes out of that standard of care.

Then you align the expectations after you know the priorities. Then the people know what to expect. And you can then plan within and plan with interfacing countries. Maybe these countries can provide a wonderful primary and secondary care system, and then the partners, such as Hawaii, provides the back-up for other services. And the partners know what their obligations are, what to expect and they say, "hey, we got your back" and they come through and you all coordinate resources.

As an example, using a military environment:

1. Battle objective: Standards of care. What are we trying to build? Is it Mexico? Is it Harvard?

2. Then when you know what the battle is, you then can determine the weapons necessary: This would be the finances and other resources. You would never send your soldiers in without the weapons and the bullets. Here it would be the financing, the medical supplies and equipment and so forth..

3. And the soldiers to fight – is there a sufficient number? Are they sufficiently trained?: That would be the health care workforce. And we have already heard about the challenges there - challenges to having sufficient numbers and proper training.

4. Who are the allies?: Who are the allies? Are they fully committed?

5. The Battle Plan: The Quality Assurance Plan is the battle plan. This integrates all of the above. This is what the plan is. These are the performance measures. It is a living document. How we look at it – measure performance, build on that to meet the objectives.

6. Command center: I believe should be pacific centered, it should be PIHOA and I will say that without any reservations. It should be the Ministers and Directors of health. The command center should not be the CDC or some others outside of the islands affected. It should be the island health officials. These are the people who live the circumstances and provide the care within the systems.

And so, Mr. Secretary, I would like to say in closing, the US has such great resources. As Secretary Garcia mentioned yesterday, yes, there are other areas that have it worse like Africa and other places and that is true. But, because the U.S. Insular Areas are so small, it would only take a small investment (relative) from the U.S. to make such a huge, huge difference, but it will take coordination to do that. God Bless you in all your work and I hope He works with all of you and I believe there are many challenges we can solve together.

(Captain Walmsley) Thank you, panelists. As mentioned by others, PIHOA is working with all of the health officers to establish QA, quality assurance, as one of the Pacific's top priorities. A lot of work has gone into that, and the efforts to promote QA programs are in full swing.

(Secretary Kempthorne) Thank you very much. Tremendous information. In regards to the 266 surgeries by the staff of Mercy, what were the results. Were there any infections?

(Julio Marar) I don't have the details but according to my information, all of the operations were successful.

(Secretary Kempthorne) I would like to know the details because you can have successful operations and still have circumstances afterwards, such as infections or other complications. Also, I would like to say to everyone, if you were not able to get to all of the slides, we still would like you to submit your entire presentation. Everything will be reviewed. When you talk about the lack of funding for things like gloves and such, who approves your budget? Is it different for every area?

(Vita Skilling) The annual budget that we submit is usually reviewed by the President of the Nation, or the Governor of the country. Then it goes on to Congress where they have to figure out where we fit into the budget of the whole nation, including the other departments. And, Mr. Secretary, yes do run out of gloves. Many times because we do not have the funding. Other times we have the problems of getting the supplies there on time.

(Julio Marar) For the states (FSM), we do have a process. Formulated by the state's Departments, goes on to the Budget Review Committee, on to state legislature, submitted to the National Government and, normally, the submission is sent directly on to JEMCO for final approval. And of course that is the role of OIA, to review the budget and make the recommendations to JEMCO for final approval.

(Justina Langidrik) For the Marshall Islands, we receive a budget circular from the budget committee and, usually, it gives us the ceiling for the year. We have to work our budget within the ceiling. The Department works on that based upon the ceiling provided. Then to budget committee for review, submitted and then reviewed by the cabinet and then on to the legislation for approval.

(Secretary Kempthorne) With regards to standards, one of the things that the Inspector General's report pointed out was biomedical waste and you referenced it that if you had a Clorox bottle that's where you put the needles yet citizens need the Clorox bottles. Are there standards that already exist that everyone is aware of and that simply a decision is made, because I have heard this phrase now many, many times, we do the best we can with what we have. Are the standards universal and a conscience decision is made that you can not achieve them? Or is it something that we need to look at what the standard should be for all areas.

(Vita Skilling) Like the rest of the standards, Mr. Secretary, it is an area we know we have to look at. The standard is we know that we have to put out the sharps so nobody steps on it. Unfortunately, there is only one dump site. And there is only one way of doing that, to bury it, once a month, twice a month, and that's where it goes. And from the hospital to the dump site, somebody has to take it there. Each of the four hospitals has a generator which is either not enough to take care of all of the waste or is not functioning at the moment. Through some assistance, for example, from the Japan overseas assistance, each of the four hospitals will receive a small incinerator to take care of immunization waste. And that would work for us for a while because we will be using wood. But, if we use up all the woods in one year, we will end up with a desert instead of our beautiful islands. So we also have to think about doing that. But yes, quality assurance in terms of waste management is part of what we are trying to do. At least now that we realize that those are the problems we have to take of also. And that is another reason why it is very difficult for us to take care of chemotherapy on the islands because we do not have the standards at all to dispose of the waste from chemotherapy surfaces.

(Secretary Kempthorne) Ok. Let me open it up then. Any comments, questions, points? We'll start right here.

(Patricia Tindall) Thanks. I'm Patricia Tindall again and I just wanted to make a few comments about some of the initiatives LBJ has been looking at and some of the problems we've run into. Yes, we have the same problem that everyone does and we all know that because we all read the report (OIG). On Power, we're pretty good. ASPA (American Samoa Power Authority) does provide power to our island. Power costs have gone up to .56 per kwh. That's very, very expensive. When I lived in Nevada power costs went from .08 to .12 and they built two new power plants. We're at .56, and we can't afford to pay our power bill which is really disheartening because ASPA also provides our water pressure. And ASPA does have problems getting enough water pressure to the hospital because we are on the same piping system that goes to the canneries, which are the major industries in American Samoa. Instead of just crying about the problem and saying, "hey we need water pressure", one of the things that we really have to do, and I thank our Governor for making it clear to all of the Government Departments, is work together. So we talked to the CEO of the power company and said "look, we need water at the hospital. If you can't provide water at the hospital all the time, give it to us between 6 to 8 in the morning because that's when our patients are getting up and using the facilities, and if we don't have water during those hours we have higher instances of infection". So working within the Government Departments is very important. And also remembering that a lot of times the systems are very fragmented and each department is competing for the same dollars. But we all provide services to one another so working together is really important. Regarding solar power, we did apply to USDA for funding. We did make the application for our hot water. The USDA finally came back and there is a match. So we are scrambling around trying to find a match.

(Patricia Tindall) …(speaking of engineers related to application for solar power) came out and had to do some kind of engineering and looking at the roofs and that sort of thing. There's only one company in American Samoa that provides solar power. And then having the funding to get some kind of consultants and looking at three different providers and following our procurement regulations is very difficult in applying for some kind of Federal funding to get that solar power. The last thing we are looking at is corporate partnership because of equipment. We have a major problem with equipment, our radiology equipment for instance is analogue, it's not digital. If we wanted to use tele-radiology we do an x-ray, we put it up on a light box, we get our camera, and take a picture of it, and then try to e-mail that picture of the x-ray on the light box and hope that somebody, obviously not a standard that were attaining but it gives us something and somebody can read it. Most of our equipment comes from GE. We try to keep it with one supplier because they can provide spares and then there are often consumables that go along with that equipment. We did work with GE. We were trying to find somebody with information about maybe used or refurbished equipment programs, or see what kind of philanthropic corporate partnership we could get into. I'm happy to have a big billboard sign with a big GE logo and tell them that all the my equipment is GE if they give it to me. It's very difficult because that's a large international Corp. and I was working with one part of that company in Nebraska looking at a trauma room, and then our ultrasound machine broke down, finally just disappeared no more pictures. So we are in desperate need of an ultrasound. I asked the same guy if we can have a new look at an ultrasound as it is an emergency right now for us and ends up there is another person I need to speak with is in Colorado. Colorado didn't know anything about ultrasounds because is different portion of that company. So often we haven't bought equipment in more than 12 years so it's hard to find out exactly what you need and how to get. And even if you're looking at corporate partnership or government or Federal grants, I don't know how to do this, making it easier to get through all of the loopholes in order to get some used refurbished equipment or Federal agency money. Finally when I did reach the right person in the right division they understood exactly what I needed it for because they knew that Somalia had no money and people were starving. And so I am not really sure when foreign policy includes Somalia as a territory, and I'm thinking that they might possibly be sending my ultrasound to Africa. That's another problem that we have to deal with because you can not put something on a train and get it to the Marshall Islands and these are not great ten school kids in Ohio we are talking about. These are suppliers of major corporations that don't know where we are and don't know who we are.

(Secretary Kempthorne) Thank you, Patricia.

(Bill Gallo, Senior Management Official, Centers for Disease Control and Prevention, Hawaii Office) My name is Bill Gallo and I'm with the Centers for Disease Control and Prevention. I'm the newly assigned senior management official here in Hawaii, also with the responsibility for the US-affiliated Pacific islands. First wanted to thank you guys very much. It means a lot to us, just the fact that you have come together

in such a senior level and that the heads of state and governors have come together to this level to address what is really an urgent issue. Thank you very much.

Everybody's talking about resources and limited resources, what we can do in light of limited resources, and at the same time we're talking about enhancing standards of quality of care. I just came a couple of weeks ago from the Association State and Territorial Health Officials meeting. It was a combined meeting with the National Association of City and County Health Officials, some of the health leaders here may have been at that meeting. I was very impressed to hear the discussions really moving as a group, and the CDC were all very much interested in advancing this idea and concept about the healthiest nation and focusing on the fact that we in America spend more than any other country on health care, but our health indicators are about 30th globally. And hearing this discussion about quality and focuses on quality of care and when you look at Neil's slide about how much money is spent per capita by the US, it is way out of line with everybody. I don't think that's something that we should aspire to. I think that's a problem and what they were saying at this meeting was that it was not sustainable and what we need to do in order to address that issue is not just solely focus on the quality of care. We have to focus on quality of health. And if we look at issues related to health promotion, to healthy lifestyles, to measuring health as opposed to measuring illness which is what were so focused on these days, this is really going to be a way to make use of these decreasing resources that are coming tougher and tougher to spread thinner and thinner.

We really do have to focus and I've seen a lot here in this region. Folks have understood that for a longer time because their resources have been more limited. I really do think that there needs to be a major shift as far as looking at measuring health indicators and health outcomes to really focusing resources as much as we can in the area of prevention, in the area of health promotion. And when we talk about developing our leaders for tomorrow, our public health professionals HR for H, I think we need to make sure that the doctors' skills, the nurses' skills learn the traditional skills that are vital, are critical. They have to happen. But everybody has to have this public health and this prevention kind of context, and they need to learn about those things as well as about population based health in order for us to make best use of these resources. Because everybody knows that an ounce of prevention is worth more than a pound of cure later on. And so I guess the main message is really focusing on these preventive services, and I commend those that have already done a lot of that. And I think it's going to be our only choice in the future.

(Secretary Kempthorne) Bill, thank you. This aspect of the biomedical waste, gloves, these things were talking about, basics, what role does CDC play in this?

(Bill Gallo) CDC has a wealth of technical resources in the area of steering people to the best ways to deal with environmental health issues and they also are good resources as far as accessing standards and that sort of thing. But any kind of standards that are discussed, and I think the folks on the panel can address it much better than I can, the standards have to be adaptable. They have to fit the context. There isn't just a single

gold standard. It has to be something that works in different environments; and CDC understands that; and WHO also understands that and actually probably has a better understanding since they're looking at countries across the board from the poorest developing countries to the wealthiest countries. But CDC, my agency folks can contact me. I can plug folks into resources in Atlanta that can give guidance

(Secretary Kempthorne) I appreciate that. But when you say that they can adapt; but if I'm picking up something that is a hazard to my health, and now I don't have a glove; I mean I've adapted, but now I think I'm at risk.

(Bill Gallo) You can adapt standards as far as biomedical waste. For example, there are very high-tech ways that we address those issues in America; where we have a whole different scale of resources available to us. They're also very safe ways to dispose of these things. There are much more cost-effective manners that are much more conducive to situations that other people are operating in

(Secretary Kempthorne) So CDC could bring that into the equation?

(Bill Gallo) CDC could probably provide assistance, absolutely.

(Secretary Kempthorne) Did I hear correctly that there is a generator that would consume these? Incinerator?

(Vita Skilling) Incinerator Yes there are incinerators that will do that. But in terms of the other biochemical waste, like the chemotherapy waste, I'm not sure. We've never done that. I don't know how to dispose of that. But also, to go along with everything else, we get the funding from other programs, but there is also this problem of bidding. If I was to get this less expensive refurbished equipment, I have to look for two other companies that provide refurbished equipment. Good for Patricia, she can get all her equipment from GE. For me, I have to look for two other companies that sell the same thing. If I were to travel to Washington, DC, for a meeting, only Continental airlines fly Micronesia, but I have to get two other bidding from two other airlines and explain why I'm taking Continental as opposed to other airlines. Thank you.

(Pete Sgro) From the Guam Health care and Hospital Development Foundation. Your observation with respect to shiny floors actually goes much further than just a shiny floor. I want to analogize it to a hotel. First of all, housekeeping within a medical facility or hospital creates efficiencies within the operations of the hospital or the medical facility in the same way that it does for hotel.

I just wanted to announce and I would like to invite all of you to attend, in the next three months at the request of one of the Board of Directors of the Guam Memorial Hospital, our foundation will be sponsoring at no cost to individuals that will be attending this, the Adventist Health that is based in Maryland, we are going to be flying out their staff to Guam. They basically did what is called "throughput". They had a hospital that was overcrowded and couldn't take a single patient. But after a nurse took the challenge,

after one year of coordinating basically housekeeping, then they were able to get 10,000 more patients in a given year. So housekeeping plays an important role in the efficiency and also the savings of your revenues in the hospital. And I guess my final comment is that I've seen, from a personal perspective, the success of a foundation in how we collaborate with our hospital on Guam. And I'd like to thank the representatives of the Guam Memorial Hospital that are here, and our governor as well, and working closely with them.

I wanted to suggest something that may seem out of the ordinary. But you know there is more than just the Federal dollar. There is a private dollar up there. And if all of the Micronesia Islands, and I just come up with this name for lack of a better term is the Marianas Islands Health care Foundation, just to let you know that the Toyota Foundation has an awful lot of generators that could be shipped out to your islands. But you have to be a nonprofit foundation to interact with the likes of the Toyota Foundation. We have been in touch with the Toyota Foundation, and a number of different private foundations that could supply some of the things you need. But I think when there's more voices that are part of one foundation, I think you're getting the attention of more people of where exactly you are. So if any of you are interested in attending any of the conferences, we have the joint commission coming up in about four months. Please let me know before the end of the conference. I would be more than happy to send an invitation to you.

(Secretary Kempthorne) Thank you, Pete. I believe one of the outcomes that we need as part of this report is the identification of critical infrastructure needs.

(Governor Togiola) We're beginning to see some successes in the website that was the result of the business conferences the Department of the Interior had been convening. One of the things I suggested yesterday was creating a framework of cooperation throughout the Pacific. Some of the suggestions that are coming up here are going to be collected according to your mandate as a result of this meeting, and I was wondering if as a result of this conference there could be a resolution to create a website for all the islands. Through the Dept of the Interior we can all connect through and network on some of these best practices and ideas that are floating around that can be shared through that and as part of beginning that framework that will transcend administrations both nationally and locally. Because many of us will eventually leave our posts. But some of these practices must be in place for all to share. So this is a suggestion. Perhaps that's part of what we need to do because I think the new the business web link is really beginning to take hold. And we're sharing great information and exchanging ideas over the network. And than, perhaps, this can be a part of that or part of a new initiative towards health care and what we need to do.

(Secretary Kempthorne) Governor Togiola, I think that is an excellent suggestion. So we'll make that one of the items on our action list. Governor Camacho.

(Governor Camacho) Thank you, Mr. Secretary. In line with what Governor Togiola has mentioned, as we have this establishment of the Interagency Coordinating Assets for

Insular Health Response or ICAIHR, that would be the perfect venue for this website. It falls right in line with it.

(Toaga Seumalo) I speak on behalf of the APNLC. That's the reality of what we hear every annual meeting because nurses, what they see every day, it's always a patient safety quality of care issue. For the FSM, one of the problems or concerns that has come through the annual meeting, the fact that we talk about partnership and cooperation. As we hear the local problems from the area we feel there is no connection, collaboration and more strengthening of your systems that are in place in your own island jurisdictions. So for the island leaders that are here, I am asking on behalf of APNLC to please pay attention to a lot of the issues that the nurses bring up. Because when they come to these annual meetings, we see that there's fragmentation within each Insular Areas' system, public health is doing there own. So we hear problems from almost all the jurisdictions that public health is doing their own, there is no real connectivity within the services and agencies within each local area. So I am asking please for the leaders to take a look at what you can help with within your Insular Areas because we are talking about partnerships and collaborations within the regions. I'm asking that a local collaboration and strengthening of those systems must be encouraged. Thank you.

(Secretary Kempthorne) See and I believe too that your organization should be one of the portals. Then you can go to the website and access the organization, with your new office in Guam at the University. Doctor.

(Dr. Gregory Dever) Mr. Secretaries, thank you. There's an organization in Micronesia called a Chief Executives Summit when the Governors of Guam and the CNMI and Presidents of Palau, FSM and RMI come together. And they do it every six months. In the last three or four meetings there's been as part of the resolution process a recommendation that there be a new Institute of Medicine study. And letters have gone off to select members of Congress most recently endorsing that. With your excellent concept of developing the task force at the highest levels of our government, I would think that you'd consider also taking a look at the IOM process in terms of a new report. Because for us it is where the rubber hits the road. This has been an excellent document and a new report would give us a new report card of how have we done since 1998 with a view to the future of what should we be doing. I think it's consonant with your whole concept of where we should go

(Secretary Kempthorne) Thank you very much. And thanks again for the tour of your hospital. It was very memorable.

(Sela Panapasa, PhD, Research, University of Michigan) Thank you very much, Mr. Secretary. I would like to begin by echoing Dr. Palafox's closing remarks. The resources that are needed to make a difference, we are talking, given the demographics of these respective Insular Areas, is really very tiny compared to what the US population is investing in the continent and here in Hawaii. And in echoing that point, we need to be realistic and practical in our approaches as we seek out these resources. I think it's critical that the leaders of the Insular Areas and the local experts are brought to the table.

Have them define the priorities, the goals and what is important to them and their respective communities. I think what we've see over the past is that a lot of the definition and the priorities and goals are being defined and determined off island. And to be realistic, to be able to develop effective plans and programs that will reap tremendous differences, we need to bring them to the table.

And if I may echo the importance, I feel the need for baseline information needs to be addressed. I would like to propose that a national health survey be conducted in each of the Insular Areas so that we can address achieving the baseline information, and use the results to leverage additional resources. Because with the results, the Insular Areas can justify the need. And I'm concerned that there are a lot of missed opportunities of obtaining resources and funding from NIH (National Institute of Health) and HHS to be able to address the unmet needs. Thank you

(Secretary Kempthorne) Thank you. Dr. Palafox, you said, "We can make a huge difference with a small investment.", and I'm very interested in what that means so that the small investment doesn't just evaporate and there is nothing to show for it.

(Dr. Palafox) Yes, Mr. Secretary, I think again in the model of the battlefield. Once its determined what the standards are, there's not enough bullets and there's not enough ammunition, the finances. And I believe that with the partnerships that you mentioned, whether its CDC or NCI or even the communities partnerships, and we spoke a little about that, if people understood what the standard was then it would become clear how much the community would be involved, how much Hawaii would be involved, how much the CDC would be involved. So its not necessarily a cash investment, but its an understanding of the participation of every one when you understand what you're trying to build. I think there are going to be some resources because I do think there under-bullets, they don't have enough, just armor, and they don't have enough training. It's a combination of things; I'm not talking strictly cash Mr. Secretary. I think it's all those things that will make a wonderful health system happen.

(Governor Togiola) I might have a suggestion along the lines that you've asked Dr. Palafox. One of the problems that Insular Areas have when it comes to formulas for distribution of some of these benefits is the fact that every time that a formula is being developed, somehow Puerto Rico becomes the problem. Because every time something is devised to benefit the Pacific Islands, and if Puerto Rico is classed together with the Insular Areas, that goes out the window because of population. Perhaps somehow if Puerto Rico can be classified as a state and leave us alone, and I think we would benefit greatly by a little bit better considerations more often in terms of distribution of funding. Not only for health care but for other programs as well. And we're finding this a very difficult problem because every time that Puerto Rico is brought into the mix, we are not going to be considered. It's a reality. And I'm sorry if anyone is here from Puerto Rico, I'm not trying to put you down or anything. I just want a little bit better fair consideration in some of these areas. And that's a daunting problem that we face every time we go to a Senator or our Congressmen. They always tell us Puerto Rico is going to jump in and this is not going to go. Puerto Rico is an obstacle for the Insular Areas.

Why does it have to be? My suggestion is classify Puerto Rico as a small state, and then I think we'll be ok after that.

(Secretary Kempthorne) I wish to Dr. Garcia was here, and I'm going to have him call you (chuckles from throughout the audience).

Let's take a 10 minute break. And may I say to the Mayor's office of Tinian, thank you very much for these (island jewelry from beads and seeds), they're beautiful.

AV 09.30.08 HS 3: Panel 4-Telehealth and Floor Discussions

(Secretary Peake) People have been talking about all day, or the last few days, the issue of connecting, and so, we can go ahead and have our seats so we can let the panel do their trick. David, you chairing this panel today? Alright. Okay if I can get you to take your seats we'll go ahead and get started here.

The issue is "Telehealth: Connecting Island Health care. This issue of telecommunications technology, improving care and training and all of the variety of things that we've talked about today. Trying to explore the opportunities. So after the panel, we'll again have an open mike session, and try to capture the issues from the audience as well as from the panel. So David if I could ask you to go ahead and introduce your panel?

(Captain David Lane) Secretary Peake, leaders of the pacific island jurisdictions, and participants, thank you for having me here. I'm Captain David Lane, the Deputy Commander of Tripler Army Medical Center. We're talking about the Pacific Island Healthcare Project, which is Tripler AMC's contribution to health care delivery in the Insular Areas. Here's a history of the program (see power point presentation): It really began in 1988, when Senator Inouye introduced a bill to link graduate medical education programs at Tripler with some of the Insular Area health care needs and created an earmark for funding that allowed the program to get started. In 2003, the program received a shot in the arm with some changes to some legislation, and then here's an example of the legislation as it was amended in 2003. It talks about the relationship between the Department of Defense medical treatment facilities and the Freely Associated States.

We've seen the slide already from Dr. Poropatich's presentation yesterday. It just gives a sense of the geographic area and the demographics of the island areas that Tripler has been working with the past sixteen years. This is a roll up of the number of patients that have been referred from the islands to Tripler over the various years. You can see a slight drop off, a significant drop off, in 2007, and that was due to a hiccup in the funding stream. As I mentioned early on, there's a link between graduate medical education and the training of doctors and the nurses at Tripler and the health care needs. And every patient that is accepted in to the program is aware of this and the program itself. Since the topic of this panel is Telehealth, I should mention, this is all done via Telehealth until a patient needs to come to Tripler for actual delivery of health care by physicians and the health care team at Tripler.

It's all mostly, not all mostly, its all store and forward internet technology. It allows doctors at Tripler to have conversations, if you will, via the internet with the health officers in the Insular Areas and decide whether the patient is a suitable candidate for treatment at Tripler or for management at the health care facility in the islands. Once a patient has been, once this discussion has been held via the internet, and the patient is accepted, a multi-disciplinary approach is established to bring the patient to Honolulu for care. It involves web-based discussions and discusses the clinical aspects of the care,

patient administration aspects, social work aspects, and local liaison here with the island medical attaches.

Here's just some screenshots that show Dr. Don Person who was the director of the program for sixteen years until he retired, about six weeks ago. Having some of these discussions might involve the telephone or e-mail, web-based exchange of laboratory data or x-ray data and the like. But it's more than just bringing the patients from the islands to Tripler. It does allow for consultations to be done from Tripler to the island health care agencies. Here's an example of some instructions that are being provided over the internet to a sonographer (operating an ultrasound machine) at one of the islands, telling them how best to take the pictures, the ultrasound pictures, so that they can then be sent back to Tripler so that the radiologists here and other clinicians can interpret those films.

Here's an example of two children, two different islands, two different patients, with complex fractures that were managed locally on those islands with consultation with the orthopedic surgeons at Tripler. Again, using store and forward technology, exchanging clinical notes, exchanging discussions about the patient, as you can see on the left there, exchanging x-ray films. Here's an example of what the program has cost. The last few years it's been roughly five million dollars a year. A lot of that has been for transportation of patients from the island areas to Tripler. It typically involves about a hundred-fifty patients per year, coming to Tripler. Many, many more managed, as I just showed, cooperatively from Tripler to the island health care facilities.

This shows the principal users of the services through the Pacific Island Health Project: Majuro, Chuuk, and Palau being the three largest of the associated states. That concludes my presentations and I look forward to discussions later on.

(Secretary Peake) David, thank you. David your discussion, as we move along, I'd be curious, if you pulled out the transportation costs of moving patients around, what the telecommunications and infrastructure costs would be per patient, or per encounter, if you have that as you move forward.

(Captain Lane) I don't have that readily available. I can perhaps do some figuring here and come up with an answer when we have the discussion later.

(Secretary Peake) Thanks very much. Dale?

(Dr. Dale Vincent) So Secretary Kempthorne, Secretary Peake, Undersecretary Chu, distinguished panelists, and delegates, thank you for the opportunity to be here this morning. My name is Dr. Dale Vincent. I am a primary care internal medicine physician and the Director of Telemedicine at the University of Hawaii, John A. Burns School of Medicine.

Our areas of expertise include Telehealth, e-learning in medical simulation, and the things that we do at the Telehealth Research Institute are to first of all imagine innovative

solutions for health care delivery. We also manage programs and, importantly, we measure outcomes because the people that we work with are very interested in value. So, economists are interested in market baskets and CEOs of hospitals are interested in health care baskets and with Telehealth. We are interested in e-health care baskets and they come in different sizes and shapes and different functions. Let me give you a visual image of what makes up an e-health care basket. First component is fiber. Fiber, of course, is infrastructure. Next, you need people, and the people have to know what they want and they have to know what they are doing, and this speaks to the issue of health care and health care people resources. And lastly, you need to have a template, a design, a pattern so that you can make something useful, and this speaks to the issue of structure.

So I'm going to give some examples of issues in Telehealth, with respect to structure and people. Now, in 1984, Stuart Brand, who is shown here, famously said "Information wants to be free." Some of you will recognize Stuart Brand as the founder of the Whole Earth Catalog. With respect to Telehealth, I'd like to extend the idea that information wants to be free and leave with you the idea that hardware and software also want to be free. Witness the one hundred dollar laptop program and Google "health." Let me give you an example of success here in Hawaii with the structure component of e-health. And, to continue with the theme of wanting to be free, I'm going to talk for a moment about an open source product that is inexpensive and quite flexible that has been deployed here that appears to be developing traction. And this is a product that was originally developed in the Department of Defense and tested at Walter Reed and the New England VA, and it was used as a management tool for diabetes. When it was brought here in Hawaii, it was deployed in Waianae, Mililani and Molokai General Hospital to help to manage diabetic patients with retinopathy. But it has been extended and expanded and morphed and instead of just being a diabetes decision management tool it has become a tool used to manage patients with chronic hepatitis at Hawaii Medical Center East.

The Hawaii Kidney Foundation has wanted for a long to develop for a long time a program, a community based program, for primary care practitioners to help them manage early chronic kidney disease with the idea of stemming that tsunami of end stage renal disease that we are facing here in Hawaii. And I heard a speaker talk about in the Pacific Islands. So they (the Hawaii Kidney Foundation) gave a grant to our institute to develop this program to help develop a decision management tool for early kidney disease. The program is being modified by preventive medicine specialists at Tripler, to help them manage patients with latent TB infection. And in this coming year, we will be modifying it as a decision support tool for congestive heart failure patients.

And there are some points that I'd like to make. One is that this is a wonderful example of translational research, only instead of the usual model of translation from the bench to the bedside; this is translation from the DOD and the VA into the native Hawaiian communities and to the Hawaii community at large. It's an open source product and, like I said, software really wants to be free. The Diabetes Retinal Imaging Program is an example of Telehealth between communities. Again, this was prototyped at Walter Reed, tested at the New England VA, and now is being used across the country and also in three

communities here in Hawaii. The images are taken in a primary care setting of patients' eyes with potential retinopathy. And they are screened, and assessed by experts on the mainland. Now, this is an important program because it's an example of specialty care being introduced into a primary care setting. This is also a great example of translational research from two Federal agencies to the community at large.

I've talked about Telehealth, an example of Telehealth between communities and that's typically what we think of as Telehealth, it is specialty care being delivered remotely to patients. Let me talk for a moment about Telehealth within communities. This is really where I think the big future of Telehealth is. The example that I'm going to use is a system that's being used here in Hawaii now to monitor frail, elderly patients at home that are dialysis patients. The goal is to try to prevent them from developing heart failure and infections and landing in the emergency room. This is a program that connects patients with a nurse, hardly ever a physician, almost always the nurse. And it's an example of many patients using many devices and connecting to one health care provider.

With some simple reconfigurations though, this device can actually turn the idea of telemedicine on end, because this can be a kiosk. And by configuring it as a kiosk, you strip away the "tele" part of health care delivery. Instead what you have is a management decision support device where patients in a community or in a nursing home can actually use a sneaker network to come to the device, have health care readings obtained for example, a blood pressure or a glucose reading and they can have it treated. The value of using a device like this in a setting of a community, perhaps a village, perhaps a nursing home, is that it allows you to have a new vital sign which is the trend of data over time, which gives you an enormous capability that you didn't have before. When you think about it in the zone of chronic or communicable diseases, if one were to focus only on treating hypertension using simple inexpensive interventions, you could potentially impact the incidences of congestive heart failure, the incidences of stroke, the incidences of blindness. It's really remarkable what simple interventions have the potential of doing.

Now let me show a picture out of our current learners and the challenge that we face with educating a new health care workforce. These are our new learners. I think that many of us would agree that oftentimes in the classroom they are physically present and psychologically absent. They have different expectations of education and of educational delivery than we did when we were growing up. And I'll give you a simple example that we recently did at our Institute and that is that we use podcasts to train a group of medical students in an area that they had no training whatsoever in and that is first responder issues. We trained forty-one students; we used four five minute podcasts because we surmised that it would really appeal to them. When they are on the bus or when they are in between events, they would actually listen to the podcast if they were short. We used a variety of metrics, but the main one was that 98% passed our test, which by the way was pretty hard. I'm not really promoting podcasts, but I am promoting the idea that our health care workers of the future need to have a different model of education in place. And you heard the word pedagogy; I'd like to introduce to you the word andragogy.

Pedagogy sounds like teaching children. Andragogy is teaching adults, and we should be applying principles of adult learning to the next generation of health care workers.

(Patricia Tindall) First of all, Secretary Kempthorne, thank you very much for convening this meeting. I don't have a nice presentation partly due to the fact that I recently returned from the National Governor's Association State Alliance for E-health Seminar in Washington, DC, that the Honorable Governor Togiola was kind enough to invite me to join. Some of the things I'm going to talk about are items and issues that I learned at this conference which was a group of 43 of the states and two of the territories.

So Telehealth and I guess first of all, some terminology. I'm going to go back to basics because I think that's where we are in Samoa. Telehealth technology, and there were some questions that were given to us. What is available? First of all terminology, we talked about HIT which is Health Information Technology and there's a lot of technology available in health information. We have lab systems and computers and equipment in the lab; we have radiology equipment; there's notes, both physicians' and nurses' notes, that is health information and technology. We can get electronic records of people's health information; there's voice recognition packages; there's bar coding on drugs; bar coding on patients, on their wristbands. So there's a lot of health information technology there.

We also talked about Health Information Exchange or HIE, and the exchange here is the big difference between technology, and that's sharing that information that is available. We talked a lot about the sharing of technology within a state or territory and then between states or territories. And we also talked about whom are the players involved in this health information technology. The population of patients, these are the most important players because everybody knows that it's patient care that we're after. So these are our health consumers. That's a new concept, I guess. You're looking at a slide of some young people with headphones on, these are the consumers and people need a new way to consume health information, and everywhere in the United States we're talking about health consumers and people making choices about their health care.

I would say on American Samoa, people don't have a choice about their health care, they're not necessarily consumers. They're not consuming by choice, they come to LBJ because it's a one-stop shop, and it's the only game in town, but this is the population that we're serving. Also included in this Health Information Technology is the providers, and those are the health care providers. In our territories, that's very simple, it's not as complex as being in California where we have many hospitals, many private providers. We have LBJ, the hospital there, we have the Department of Health, we do have the VA – very grateful to have them involved.

And then, we talk about the payers. Again, if you're in California, there's numbers of insurance companies, there's Federal programs that pay, there's private payers. In Samoa and most territories I would say, there's not that many payers. We have the federal government, we're funded through the Department of the Interior, thank you very much, and we're funded through Medicaid and Medicare and TriCare so we really have two

major insurance companies and only, sort of, two payers – the territory and the Federal government. So there aren't that many players in order to put into place some good systems in American Samoa because we have a limited number of providers and a limited number of payers.

What are we getting at? We're trying to get to the electronic health record, this is known as the EHR and, basically, it's the health record of every individual and it's kept electronically. After that we are heading towards the personal health record and there was a lot of talk about personal health record and how much information goes into that and who is responsible for that information. I can honestly say that in American Samoa I can't imagine that people are heading towards a personal health record. We do have quite a few savvy and well-educated consumers, but as I was thinking about this last night, the bulk of our population probably doesn't have an internet connection at their home. They may live in a fale (Samoan-style open walled dwelling); they may live with a number of people; they have no idea what a personal health record or electronic health record is. All they really want is care when they get to LBJ.

Why are we talking about e-health, or telehealth? Well, it helps coordinate the care of that patient. If there are a number of providers, that electronic health record and having health information helps coordinate the care. That is very important in American Samoa because we don't have a primary care provider. Your provider is whichever doctor is on call in the emergency room when you get there, and if you get there this week and you come back next week, you may have a different provider. But each provider needs to have information to help care for that patient; information on what drugs they might be on or taking or have been prescribed to them; information on what happened to them last time they were there because the are not seeing the same doctor each visit. So coordinating care is an end to this.

Quality improvement in the data that can be obtained when you have an electronic health record, data is very, very important. You've heard quite a few people speak about data but that is baseline data, where you're starting and how you can improve the quality of the services they you provide. The electronic health record and electronic data can help you sort out where you're at. You need to know. I think that's another thing, we have had an initiative in LBJ recently for quality improvement in health care services. And our physicians basically know that they're in charge of the quality improvement at the hospital, but we don't even know where we're starting without a good system to obtain that health care data. We're starting, but we're not yet there.

Also electronic health record and electronic data can help reduce costs and reduces medical errors. It gives you information about possible allergies and drug interactions. It can increase the efficiency of the providers of services. It helps the doctors do a better job, and it will help focus clinical change. We also talk about evidence, base medicine, and so we need a baseline to know where we're at, then we can decide where we're going an electronic health record can help.

I'm just going to go through quickly some of the questions that were asked on this. What

is available in the territories? We do have access to CME and other training sessions through Honolulu, the University of Hawaii and some of the other hospitals here (in Hawaii). We have access to consultants, we've been very, very lucky in getting some revolving consultants and specialists coming to LBJ, they come for one week every quarter. But we have access to them through the Internet while they're away, and so our doctors can work with those specialists on continuity of care for those patients.

The Shriners' system, and thank you very much Dr. Ono, I know he was here. We have access to the Shriners, and we're able to work with them and share medical information about our patients. Maybe before they are sent off island for care at the Shriners Hospital, we could, if we had better equipment, have access to teleradiology and have a read be done. One of the other things that they asked about was barriers. I don't like to use the word barriers, because barriers are meant to be impregnable. I want to call these challenges to the system, because challenges are surmountable, and then you can have the success which is one of the things that everybody in health care provision wants. Even if it's a tiny little drop of success they want that to be recognized.

So some of the challenges:

Acceptance of this technology by our staff. A lot of our staff members are not even as young as I might be so they are not of the computer age, they aren't used to learning a computer system. Learning to type is very difficult. We need to train and educate the staff, training on the appropriate use of the data. Once the data is there, a very important thing is safety security and privacy, and you know, you're hit with compliance officers jumping up saying "Oh my gosh, we can't have this huge data repository. Anybody can look in there and see anything about anyone." So the appropriate use of this data is really important.

Lack of communication between agencies, even maybe within our territories, that's really important and this is known as an agency silo. So when you have different agencies working with the same patient, lack of communication between them is super important and that creates an agency silo. The lack of systems interoperability, I think that's really important. There are all kinds of systems out there, they're all based on platform called HL7, but if there's a lack of interoperability, that's a data silo.

Uncertainty among these agencies, as to what is legally required to record this data. This is medical data, so people look at what is required to record, what are you allowed to look at, who's allowed to look at it, and then we are looking at regulatory issues, HIPA, security again and then the question of ownership of this data. I'd like to change that word to stewardship because all of the providers that can look at this data really are the stewards of the data for the human being who owns that data. One of the other gray issues is medical identity theft, which seems like something very, you're only going to get that in New York City or something, but that's a huge, huge issue in Samoa. We have a two-tiered payment system, and if you're a nonresident, your charges may be higher. So your nonresident cousin is there and he might get sick, he uses your ID card to go get health services because it's cheaper for a resident. Well it can cause any number of

problems because included in that identification that this person has fronted up in the hospital and given, you can be the wrong blood type, can not have allergies noted because you're talking about a complete different person.

So the legal issues, any kind of high risk data and who owns that is really important and then why do worry about who owns the data? That information, a lot of that data leads to funding. A lot of that data is baseline data or the fragmentation of the system. A lot of our system is built on an individual grant funding so there may be a lot of different players that are interested in cancer data, for instance. We have like five or six different cancer grants in American Samoa. Whoever owns that data then can write a report and is able to go forward and get further funding in the future, so that's our data silo again and control of that data creates a silo as well. Training and sustaining staff for e-health, that's very, very important. Where do you find the staff that's really technologically savvy and can maintain that network. Where are those whiz kids? Often, they're in Carson, California, they're not in Samoa.

Infrastructure hardware and upgrades and data depositories and networking, how do we keep the information and where do we back it up to? What happens if there is an electrical outage and you can't get that data when you have an emergency patient in your ER? Standards and we talk about standards of care and quality of care but what's the standard platform that this data is going to be held on? The cost, what is the cost for this and when we talk about perhaps similar to Honolulu, what's the cost of a T1 line and how do we use the telephone or how do we use the internet in order to access the specialty care that may be available here? One of the other things if buy in from other physicians and have partners. That's really, really important. We do have a VPN, we use it quite frequently. We have three partners that we use it with quite frequently, but we need more partners, so we need to have peer-to-peer communication between maybe specialist physicians that are in the mainland and here in Hawaii with American Samoa

Then sustainable funding, because no matter what kind of system you have and what you implement, there's going to be upgrades that you're going to need to fund. You're going to need to fund communication costs and you're going to need to fund continued training for the staff that's using it and the staff that's supporting it.

One of the things I want to say is fragmentation is a big barrier and one of the needs that we really need are engaged leadership. So I also want to say thank you very much to our Governor, he's looking at the fiber optic cable network that will make interoperability and connectivity much, much better. We need participation by telerad groups and specialists, perhaps teachers and programs and hospitals so they can be at the end of the line when we have this set up, and ready to go out. We need somebody out there to be at the other end of the line when we're asking for help. We need common policies and procedures for the appropriate sharing of this information, probably MOUs and a whole bunch of legal documentation and paperwork. We need a roadmap to implement this and, you know, we do a lot of good talking but when it comes to implementation sometimes there's stumbling there because we don't really know what the best roadmap is to get from here to there. And we need to recognize the physicians that we have working on the

ground, they've been dancing as fast as they can and they are trying to provide services, and they're trying to raise the quality of the standards and they're trying to see every patient that walks into emergency room. And yeah, they need help. So, they need time as well.

(Luis Sylvester) Good morning. Good morning Secretary Kempthorne, Secretary Peake, Secretary Chu, and the representatives of the Health, Secretary of Health and Human Services. My name is Luis Sylvester. On behalf of Governor John P. de Jongh, Jr. of the Virgin Islands, I would like to think you for inviting the delegation of the Virgin Islands to this health summit. I will just give you a little overview of the Virgin Islands. The Virgin Islands consists of four main islands: St. Thomas, St. Croix, St. John, and Water Island and seventy smaller islets and keys. We have a population of 108,440 residents. We're sixty miles east of Puerto Rico and 1,075 miles south of Miami. Tourism accounts for about 70% of our GDP, or GTP. In 2007, we had 2,611,251 visitors, 1,970,878 cruise passengers and 693,373 were air passengers, and this is important because our health care system will not only have to take care of residents but, at the (same) time, take care of our visitors.

We also have our manufacturing and have a petroleum refining Hovenza, which is the third-largest oil refinery in the Western Hemisphere, located on the island of St. Croix. And we do have textile manufacturing, electronics, pharmaceutical and a watch assembly. The major player in health care in the Virgin Islands is the Virgin Islands Government Hospital and Health Facilities Corporation. It's a semi-autonomous government agency that operates in the Roy Lester Schneider Hospital in St. Thomas. It's a 169 acute care bed facility. It also operates the Charlotte Kimmelman Cancer Institute which was recently opened in 2006. On the island of St. John, it operates the Myra Keating Community Health Center. On the island of St. Croix it operates the Juan Luis Hospital, which is a 188 bed acute care facility and in October of this year. The cardiac center will open on the island of St. Croix.

Additionally, the Department of Health operates several public health clinics throughout the territory, and we have two federally qualified health clinics which are run by nonprofit corporations. Some of the challenges we face in the US Virgin Islands is health care manpower shortage. We have funding constraints; our unavailable and unreliable data collection; we need off island travel for certain specialty care; and we don't have interconnectivity among territorial facilities. Here is a picture of the Roy Lester Schneider Hospital. It is JCAHO accredited as well as CMS certified. Here's a picture of the Myra Keating Community Center on the island of St. John; and this is a picture of our Charlotte Kimmelman Cancer Institute, a state-of-the-art facility; here's a picture of Juan F. Luis Hospital on the island of St. Croix which is also JCAHO accredited and CMS certified. All of our hospitals are safety net hospitals and the budget for each of the hospitals ranges around $80-$90,000,000 for each hospital.

Telecommunication can help improve patient care in the Insular Areas through electronic health records, telemedicine, electronic billing for improved collections and by providing connectivity among hospital clinics and private providers, both local and stateside.

Electronic health records can provide a seamless continuum of care from clinics to acute facilities, provider to provider, from island to island. We have a lot of patients in the Virgin Islands who use clinics and then they may eventually end up in the emergency room. With electronic health records, their records can easily be accessed. Patients who have quote, "morbidity," have to use different physicians to deal with each of their illnesses, so electronic health records are very helpful in this respect.

Sometimes there is a need for patients to travel between islands, for instance if you're on the island of St. Croix and you need cancer treatment, you will have to come to the island of St. Thomas. So by having electronic records, it makes the records for the patients fully accessible. Some of the benefits: you have administrative efficiencies, reduction in average drug events, fewer duplicate treatments and tests, reduction in medical errors, improved coordination of treatment through timely access of health information, and is less a reliance on the patient's memory and this is very important especially when you have elderly patients. In the portability of health records, if someone has to go off island, you just have a jump drive with all your information.

Disadvantages of paper records: incomplete, often unavailable, illegible, inconsistent and not interactive. Some of the challenges of the electronic health record: The privacy concern; people are mainly concerned as to who may have access to medical information. The interoperability of systems, different providers using different systems, and, of course, there's always the cost, the infrastructure investment costs, the hardware, the software and the training of individuals.

The remoteness of the Insular Areas pose various challenges. For instance, we don't have easy access to specialty care centers, like trauma centers and burn centers. There's the high cost of travel for health care. We have to use air ambulances at times as well as pay for lodging. There's a challenge in recruiting specialists. We have unavailability of any advanced health care procedures. For instance, we don't do open heart surgery, nor organ transplants. A significant amount of care is received outside of the Insular Areas, and the cost of providing health care is higher. For instance, because we have a shortage of nurses, all hospitals spent a total of $12 million on contract nurses so that they can maintain their accreditations and certifications.

In terms of medical specialties, we face a shortage in radiologic technologies, radiation therapist, pharmacists, medical technologists, and physical therapists. In terms of physicians, we have a shortage of pulmonologists, endocrinologists, neuron surgeons, and pediatric intensivists. Now this slide basically shows the Government of the Virgin Islands has contracted with CIGNA Health Insurance to provide health insurance to the active government employees, their dependents and retirees. In fiscal year 2007, a total of $65,441,362 were paid in claims, and when we break it down we see that $35,190,420 or 53.8% was spent on the US Virgin Islands where as $29,051,999 or 44.4% was spent on the US mainland. So we can see approximately about 46% of the government health insurance claims is spent outside of the Virgin Islands.

And even though we do have retirees from the Virgin Islands who are living on the

mainland using the insurance, if you look at about the bottom of chart B that only accounts for $4,552,418, so approximately $24 million and $24.5 million was spent outside of the territory on people who lived in the Virgin Islands but went to the mainland to seek care. So with telemedicine, it allows collaboration between local providers of medical experts across the country. It decreases the need to move patients off island. It enhances the recuperation due to the fact that when patients are able to have their family come and visit them, that tends to speed recuperation. And retention of health care dollars in the local economy – health care is a big business. We want to keep as much as the health care dollars within our community and not have it go off island.

Okay, in terms of some of the telehealth activity the Juan Luis hospital is using, what is called a PAC system which stands for Picture Archiving and Communication system and able to transmit x-rays, cat scans, MRIs to off island facilities. So when we don't have a radiologist on site to interpret, these it can be done by an off-island expert. And right now we are currently negotiating which some Nighthawk companies to provide that service. Edition remote hospitals have a medical technology system which keeps the electronic records of their patient's and can interact with the e-health system developed by the Virgin Islands Medical Institute. In 2005, the Virgin Islands Medical Institute launched an e-health initiative to create a total electronic medical network in the territory. So far they have issued 13 licenses to providers. This system uses Negev. The Frederiksted also has the NexGen system and the Department of Health is currently considering a proposal to install the NexGen.

With the e-health system, the V.I Medical Institute will be able to e-prescribe to the pharmacies because the pharmacies are connected, and they are on the verge of connecting laboratories so that laboratory results could be transmitted electronically. Now however, a number of physicians on the islands of St. Thomas have chosen a different system so there goes the issue of interoperability of both systems.

In terms of the Roy Lester Schneider hospital and their telemedicine capability, the hospital is setting up telemedicine equipment at the Myra Keating clinic with the Cleveland clinic so that some of the Cleveland clinic physicians can provide services that we have a challenge with providing to the territory. Some specialty services that will be offered will be: cardiology, dermatology, advanced gynecology, and you see the list of other services that will be provided.

In conclusion, I basically would like to say that telecommunications has a potential to bridge the physical distances and health disparities that exist between the mainland and the Insular Areas. I think in the Virgin Islands we are at the ground floor of developing the e-health system. It is very costly. It is challenging. But with some support from the Federal agencies, I think the potential exists for us to really develop a good e- health system that can be used as an example for some of the other Insular Areas, even parts of the United States. And always being attuned to looking into opportunities in tourism, we would eventually look towards medical tourism as another avenue to bring business into the territory. Thank you.

(Stanley Saiki) I would like to thank Secretary Kempthorne, Secretary Peake, Dr. Chu, and Mr. Lorentzen for allowing me to participate today. Also, I would like to thank Mr. Sylvester for doing an excellent job of talking about telemedicine and relieving me of that responsibility. I'm here today representing a couple of different capacities. I am with the VA Pacific Island Health Care System part of VISN 21. VISN 21 is in Northern California, also referred to as our mother ship. I'm also with the Pacific Telehealth and Technology Hui which is a joint venture of VA and DOD Information Technology Organization.

I'd like to reflect a little bit and say how happy I am to be here. I've enjoyed hearing about the real challenges that are apparent in the Insular Areas and inspired by how people have come together and overcome them in part. But there continues to be challenges that remain.

Governor Tulafono brought up the web and how our flattening world can be well served with telecommunications and telemedicine, and telehealth is certainly part of that now. I wrote telemedicine on my slide, but certainly telehealth being more encompassing, including education, including preventive medicine; preventive health care is actually more operable to the theme. This is our network. We communicate from the VA Care Clinic in Honolulu. With Guam, the clinic there has been mentioned, Kauai, Maui, Hilo, Kona, and our most recent CBOC in American Samoa, as mentioned. But also to our mother ship, VISN 21, where we get access to medical expertise and, often in challenging cases, transport our patients up there as well as to Tripler where a very large part of our work is done.

I did want to mention, though, that we also connect on the network to the University of Hawaii, to the State of Hawaii heath access network and to PEACESAT (Pan-Pacific Education and Communication Experiments by Satellite). Dr. Kristina Higa controls this network and you got to admire a woman who controls satellites. That's what a technologist aspires to. I can hardly program my GPS, but she controls these satellites and what it brings for connectivity and collaboration is a tool. It doesn't help you with power, it doesn't help with water, doesn't help with antibiotics or insecticides, but it does help you share what you can share and work together to leverage your resources, our resource to move forward.

Now this is quite an elaborate network, and I feel a little uncomfortable describing it because these folks really need to be on this panel. Dr. Okomura and Dr. Higa are some of the band width gurus for the Pacific. They have a number of projects and a good amount of funding to do that. Now I know a lot of the jurisdictions already do this. Many of the programs that we have talked about, they have already availed themselves to this technology and this system. And they (PEACESAT) have certainly the means to provide additional capabilities in the future.

Back to the VA; VA certainly has invested, over the years, in a lot of telecommunication and health information technologies. I come from the private sector, but when I came to

the VA, I said, "WOW". You know, they've connected 146 hospitals, 650 outpatient clinics on an electronic health record that can serve as the backbone for telemedicine. When you talk about store-and-forward, the talking part is there. You attach the pictures and you have store-and-forward telemedicine system. The ability to reach out to any of these clinics across the country, and it is really paramount and with our CBOCs in Guam and American Samoa. It covers very pretty much the globe. The VA does telemedicine in various modalities, certainly synchronized video teleconferencing, we do home monitoring services and store-and-forward capabilities as I mentioned.

I would mention I feel compelled to say that telemedicine, and telehealth is being discussed a lot at this conference; what I would want you to go home with is that it's not as easy as you might think. It's much more difficult than you think it might be because it is really much more complex. Not only do you have people on both ends of the communication who need to be coordinated, there is an exponential rise in the complexity. We've learned a lesson many times that you can't just buy equipment.

"If you build it, they will come?" Not at all. You'll have equipment lying around that you can't use, particularly in resource challenged environments. This is exactly what you don't want to do. And the big lesson is it is not the technology, it is really the people. You can overcome the technology, but the availability of people to pick up the phone is really crucial to a successful system. The other capacity I wanted to chat about was the VA, DOD Pacific Telehealth Technology Hui.

Hui means partnership in Hawaiian and it is an organization that stems from the vision of Senator Inouye; the leveraging of Federal capacities is emulated or tried to emulate the Alaska Federal Health Care Partnership. Mr. Hal Blair, here from Alaska, is very intimately familiar with that successful system. We've tired to do a similar effort here in Hawaii with the Hawaii Federal Health Care Partnership. The Hui is the technology arm of that partnership and it is an amalgamation of our technology shops at VA and DOD. Initially our early missions included supporting the Pacific Health Care Project that CAPT Lane discussed. We have successfully initiated other platforms, one is called Pacific Asynchronies Telehealth, that I believe Dr. Hedge talked about and is currently still in place at Tripler, and a number of other programs. But what I wanted to convey was the ability to form this joint venture organization that has allowed us to maintain a critical mass of technology, of experience. And with this mass we were able to help others through technology transfer, the ability to take government developed technologies, tax payer paid technologies and make them available to others. And we are happy to say that the early years of the Hui started with Senator Inouye and Director Burdge at the VA, as well as General Adams, and allowed us to work with LBJ and install VistA there. Mr. Tulafono, who's a real smart guy who we are lucky to have was able to take the system and make it your own. I think the ability to do that with open-source technology, open-source information systems enables many across the globe to do it and in fact the system is going in many places and its available without licensing fees. It is not to say that it is free. I'm sure it is very expensive if you have to maintain the technology and you have to maintain the people which is often the most important component. Similarly technology transfer of path, another platform similar to Dr.

Persons' and CAPT Lane's Pacific Islands Health Care project, has occurred and we actually moved this to local hospitals in Hawaii and it has been available to hospitals anywhere. So the ability to do that technology transfer, I think, is an opportunity and perhaps a model for being able to be enable you as Insular Areas, we as Island communities to leverage technologies. Unfortunately the Hui was predicated upon the ability of Indian health service or the Native Hawaiian community to participate and as such the bill has not been passed, so that has never come to fruition and we've not been able to maintain that structure. So Hui subsequently has realigned to function as a research and development organization.

So my closing points are, as we've heard through the conference, technology can be a force multiplier for resource challenge areas, remote areas and the Alaska Federal Health Care partnership might be on a model for collaboration that will allow technology transfer and certainly collaboration of a critical mass that other jurisdictions can indulge themselves of would be a useful thing. Thank you for your attention.

(Secretary Kempthorne) Thank you all very much. Do you believe we can develop a protocol with regard to equipment because it's not unusual for hospitals to say that they have the next generation of equipment, and therefore would make available and as you point out you may not have a source to provide the parts and you may not have a personnel to run it. Is there some way to just succinctly state so that when you have people who want to help, we can send the guidelines of what would be helpful and what would not.

(Stanley Saiki) I can give you an example: The Alaska Federal Health Care Network has identified standards they expect all their participants to follow. Certainly we are at something of a battle because in the competitive capitalist environment, everyone has their own system to sell and sometimes their profit motives in selling things that are not compatible because it compels you to buy things from them so that is a standards issue that we will overcome over time but for the moment it remains quite a difficult proposition.

(Secretary Kempthorne) Alright thank you. Let me open this up then.

(CAPT Lane) At this time I've been asked by Marina Tinitali and Ryan to introduce J. Peter Roberto who is the acting Director of Public Health and Social Services at Guam. While he's coming to the microphone, I'll answer Secretary Peake's question about the allocation of resources for the Pacific Islands Health Care project; about 60% in FY 07 went to in patient care, 30% patient travel and 10% out patient care.

(J. Peter Roberto, Guam) Well thank you, Mr. Secretary, good morning. Secretary Peake, Dr. Chu and Lorentzen, good morning. Hafa adai! I want to thank Marina for the invitation to come up to speak about the impending military buildup for Guam and what is basically happening with health and human services. I just want to say, Secretary Kempthorne, thank you for your leadership of the Department of the Interior and I think this conference is very much in line with the Governor's vision in moving forward and

preparing our island for what you very clearly identified yesterday – imagine a 40,000 population increase in just a short period of time and the work that is going to be needed. It is really going to take leadership at the highest level, and work that Governor Camacho set forth through the establishment of the civilian military task force. Of the 11 subcommittees, one of them is health and human services.

This subcommittee has been working very closely with not only HHS but also other Federal partners like Interior and Department of Defense as well, and over the past year and half I'm very happy to report that through the very close work with your Department as well as with HHS, we were able to establish four key priorities. And these priorities are going to set the direction for pretty much establishing the blueprint for change and transformation, meeting this population buildup. With these four priorities, we really see how they coincide with many of the issues being brought forth today in this Insular Areas summit.

1) Workforce development is the first priority. Identifying the key shortages, and yesterday I heard some good news that our application for a health shortages designation, we are looking very good, and progressing to in the next step forward in getting this very important designation to address our health-care shortages;

2) Infrastructure building. It not only is looking at the capital infrastructure, for example the $100 million request to address the issues of our hospital to address the need for expanded beds as well as medical equipment and other capital issues, but it is also addressing program infrastructure. And when we look at the program infrastructure we need to look at a lot of the ways of thinking out of the box such as telehealth and other areas where we need to begin leveraging the resources and as a region. So it is really a very over arching priority.

3) Financing health. This is where Medicare, Medicaid, and I thank you Mary for coming up and doing a presentation because we're certainly going to have to look out at ways of financing health care. As we look at this population buildup as it affects Guam, we always have to have the broader thinking of what health care impact it will have within the region. So it is as much a regional buildup as it is a Guam buildup and it really is about regional value.

4) The forth that we're looking at is a pretty much our issues on regulatory and policy issues. We again need to look at the current regulations of health care and some of the policies that we're needing to change and adjust, because with something of as large an effect as this build up will have, we have to really revisit what some of the impacts will be. For example, with the issue of Medicaid cap. We really have to revisit that policy because, really, at the end of the day it is an issue of funding.

Right now the HHS subcommittee is getting ready to move forward with the strategic plan and, again, we appreciate all the help that we are getting from the Federal agencies. Thank you.

(Secretary Kempthorne) Very good. Thank you very much. It is an amazing undertaking. Alright ladies and gentlemen this is open mike.

(Ed Tepporn) Secretary Kempthorne, Secretary Peake, Under Secretary Chu, honorable leaders as well as distinguished panelists, thank you for this presentation on telehealth and how we can use it to build capacity of health care workers. I think it is also important for us to continue to look at the role of nongovernmental organizations, especially in the context of prevention and health education as part of health care. And in that vein, I just want to share with the summit lessons learned from PIJAAG, the Pacific Island Jurisdiction AIDS Action Group. Some of you in the room have had the opportunity to interface with PIJAAG. We actually also have one of the co-founding leaders of PIJAAG in Justina Langidrik of the Republic of the Marshall Islands.

PIJAAG, for those of you who aren't familiar with it, it is a loose coalition across the six Pacific Island jurisdictions that's made up of representatives from both the ministries of health and departments of health as well as of nongovernmental organizations in each of the jurisdictions. It operates without a budget, but we are able to do our work through a series a conference calls as well as tag-a-long meetings. And despite that lack of budget we have some successful opportunities such as the two Pacific Island PIJAAG summits on HIV that took place first in Palau in 2003, and most recently in the Federated States of Micronesia last year.

The three issues that PIJAAG really tries to work on, I think that they are tied to health care, are around issues of surveillance, around shipping of specimens, and around lab analysis of those specimens. And as you are looking at the infrastructure of hospitals, I hope that you're also looking at infrastructure of laboratories to also analyze the different tests that are going to be required at those hospitals. I wanted to offer two things: One is that we are currently working with the life foundation here in Honolulu on a case study of our best practices in terms of increasing capacity building especially in terms of the work around health care workers, the ministries of health and departments of health and nongovernmental organizations and how those three different entities can really work together to improve health. Two, I'd like to put you in touch with our two current co-chairs, Lexus Ovarian from the Gua'han Project in Guam, as well as Fara Utu, who oversees AIDS prevention in American Samoa. You may wish to dialogue with them about some opportunities where we maybe able to take some of the lessons learned from PIJAAG and apply them to your work in health care. Thank you.

(Secretary Kempthorne) Very good, thanks so much.

(Steve McBride) Secretary Kempthorne, Secretary Peake, Secretary Chu, I'm Steve McBride, I'm an internist and a VA physician and I wanted to thank you for this conference, and one of my most abiding concerns will be that the work that's begun here is carried on through the next administration. I, as a VA physician, have had the opportunity to visit several areas in the Western Pacific that we've talked about today. About two decades ago, when I first joined the VA, several governors ago and a couple of CEOs ago, I went down to American Samoa and began to take care of patients at LBJ

Hospital and also to do compensation and pension exams. Subsequently, I had the opportunity to go to Guam and take care of patients there, and here in our partnership with Tripler Medical Center I've had the opportunity to take care of individuals from Micronesia, including the Army Sergeant that was mentioned in the brief who is now living in Pohnpei.

One of the things that struck me always as I went down to these islands was the number of brave men and women who have served in the military. One only needs to go into the villages in American Samoa or out into Guam and see the flags of the various service branches that are displayed. We have men and women there who their commanders will say were among the bravest, most courageous, most dedicated, military personnel during their service, and they rose to the ranks of Command Sergeant Majors and the like in the various branches.

We in our VA medical centers have often emblazoned, "the price of freedom is visible here." Well the price of freedom has become quite visible in these islands as we see what Federal beneficiaries have to contend with in terms of getting their own health care, and Secretary Chu mentioned that these Federal beneficiaries do have entitlements. So I am relieved that we are looking and talking to this. You know someone has said to me, "You know, they choose to live where they live." I disagree. Every American Soldier, Sailor, Marine, Air men or woman should be able to go back home and have the kind of health care that they were entitled to just as if they stayed in the continental United States.

So, I certainly agree with Dr. Panapasa that we need to begin with a very careful analysis of health status, the health care resources and health care disparities. But we need to follow that up as we make those changes and allow for the implementation of better standards of care. I think that one of the lessons we've learned in the VA is the need to partner and, in Alaska, I'll offer you again the reminder that the Federal Health Care Partnership in Alaska was a voluntary partnership, recognition of the major Federal agencies and the state of Alaska that the wide geographic areas and the barriers to communication and health care were better addressed by partnering. Thank you.

(Secretary Kempthorne) Doctor, thank you for your service.

(Jamie Spence) I am Jamie Spence of Canvasback Missions. There's something I feel needs to be said before this summit concludes. There's been a great deal of focus on the problem and there's been some focus on solutions. But on behalf of the hard working health care providers of the Pacific nations, these people perform miracles. It is a daily miracle that they are able to sustain the level of care that they provide with the meager resources that they have to work with.

(Michael Epp) Good morning, my name is Michael Epp. I am the Executive Director of the Pacific Island Health Officers Association. Secretary Kempthorne, Secretary Peake, Under Secretary Chu, and Director Lorentzen, thank you for your very thoughtful leadership and obviously heartfelt leadership in this important meeting. I just want to share two thoughts. One is CAPT Lane's description of the Pacific Islands Health care

Project. That is probably one of the most successful examples, 16-18 years of telemedicine in the Pacific, and I would encourage anybody who is interested in partnering and developing that infrastructure that they take a close look at that project. We commend Tripler Army Medical Center for their continued commitment to it. The other thing I just want to share briefly because the discussions of telemedicine also invariably begin to envelop electronic health records and data questions, and I want to share some of the thinking that the health officers have undergone in the last year. One of the key priority areas that they have begun to identify in talking about data systems is really the issues of data literacy, and a challenge in the Pacific is really having health care workers at all levels really understand how data transforms the health care of the people around them, how a community health care worker who is collecting data from a village level might actually impact the health of their aunty or their village leaders.

Same thing within the health systems. In each of the health systems there's really a challenge for people often times to understand how do you take date information and use it in a transformative way. So there's a danger that technology is focused without a really careful calibration of what the educational capacity, and educational systems are within the region. And for this reason the Pacific Island Health Officers Association at the last meeting identified data literacy as one of the key priority areas in data development and endorsed a number of efforts to support data literacy. One is a public health training program that is now being accredited through the College of Micronesia, FSM and Palau Community College and will be made available to all the Community Colleges; an effort really to build a deep understanding within the health systems of how to use data and some of the basic principles of public health. So I would encourage the Department of the Interior, as we develop these regional initiatives focusing on education, that they consider ways to support these regional efforts.

This discussion of health is really incomplete without also having the education sector here sitting at the table because until the Pacific leadership really take a core understanding and leadership of health care – there are some really strong people in the region – but until the capacities are improved and built into the educational system, it will still be an ongoing challenge in 10 or 20 years. Thank you.

(Secretary Kempthorne) Michael, thank you.

(Jacque Spence) I'm Jacque Spence from Canvasback Missions and I wanted to thank you very much, Secretary, for the generator in Chuuk. I can tell you that there have been some very tense moments with our surgery teams, in the middle of a surgery, when the generator went down and we just had to wait patiently. So thank you very much.

I wanted to address the idea about volunteers as advocates for obtaining equipment. I know so often that in the islands they have been sold equipment with all the bells and whistles that are available that are not appropriate and the equipment is high priced, and often the maintenance is very costly.

An example of this is a blood analyzer machine that was purchased by Kosrae. When the

machine broke down, they went to the third person who purchased it, the middle man, he was out of business. They didn't know how to go to the company in NJ (where the equipment had been purchased from) and so I was asked to go and advocate for them. The equipment manufacturer said they would repair the equipment but it had to be sent to the Netherlands for repair. Now how do you get a blood analyzer machine from Kosrae to the Netherlands? It's almost impossible. Volunteers can serve as advocates. You want to get equipment from GE. It's hard to call from the Virgin Islands, but our organization Canvasback has served as an advocate for many of the island hospitals that needed equipment. Many of our volunteers are able to look at the equipment and say, "Hey that's not appropriate for the islands. They don't need that sophistication. It's going to cost too much." And they've gone over to their equipment manufacturers and companies have said, "You know that's really too expensive. You have a great contract with Kaiser and we have a great relationship, so I want you to help our purchase of equipment for the islands." So I just want to emphasize that volunteers can be a great deal of help. They need advocates on island and on the mainland to help them purchase equipment.

(Secretary Kempthorne) Very good. Jacque and Jamie, thanks for what you do with Canvasback.

At this point I'm going to turn to the island leaders and ask if there's any concluding comments. We're going to take a 1-2-minute concluding comment from each of the leaders, then I'm going to ask the members of this panel for their comments, Congresswoman and then we'll wrap. So with that, Vice President Chin, any concluding thoughts?

(Vice President Chin) Thank You, Mr. Secretary. I think, wow, this conference opened my eyes Mr. Secretary. There were a lot of things that I was not aware of and, because of this conference, it has opened my eyes. I've been to many but this is probably the greatest one I have attended.

Solutions, I think most of them have been addressed. But I think one of the things is you must have is a friend in Washington. I think, Mr. Secretary, that you are that person, and I want to thank you for that. Dr. Palafox explained some of the solutions. He mentioned defining standards of care as a minimum. I believe that's a must. We have to start from a point and know where we want to be. **(AV ends)**

(Vice President Chin) (continued) And then next year with the limited resources we can build our hospitals if necessary. But we must cooperate. We can't just say "give me, give me, we need, we need" and hence on and so forth. We have got to cooperate with our limited resources.

Purchasing medicine is one of the problems we face and I think somebody mentioned bulk purchasing. I think if we cooperate and get all of our purchase requests together, I think we can find a place where we can get discounts for our medicines. But we need an organization which will put all of our requests together and then find a place where we can purchase this medicine.

And then, finally, with the shortages of personnel in terms of doctors and nurses, I know there are retired personnel all around the world and that we could probably use those people to volunteer their time. I don't know the mechanism to do that, but I think if you do that, then you can utilize those people. In the meantime, we can do the training for the medical personnel for the near future. So, I just wanted to say that, Mr. Secretary.

I looked at the schedule for this afternoon and saw that there is an afternoon working session for Insular Area Health Officials. I don't know what's going to be discussed in there, but I believe it should be part of this conference report. So that is just my request, that they be included in the reports so that we all benefit from that. Thank you very much.

(Secretary Kempthorne) Very good. Mr. President, thank you very much. Governor Togiola?

(Governor Togiola) Thank you very much Mr. Secretary and Secretary Peake, Secretary Chu and Department of Health and Human Services. Congratulations are indeed in order to you, Pulelei'ite, as I said earlier for the vision to bring us all together to the table. I think first and foremost that having the ability to do this is really something that requires recognition, and I think everybody here recognizes the wisdom that you've all expressed in doing this. And, as has been expressed, the fear that we would always have is that we're starting something here, at the end of your administrations, and that it might not go anywhere. I've expressed that in my opening statement. But with your commitment that you've expressed through the joint statement between the departments and the joint statement of you, along with the leaders that I've cited, I believe expresses your commitment that you will not just leave this at the table here today. That you will find a way to make sure that this goes on and it will endure. And that we'll come back together some other time to check on the status; where we are at and where did we go from here. I am very much encouraged by that.

As a parting comment, let me just say that we've heard so much during these last two days, and, unfortunately, we're not in any capacity to absorb them all and be able to and to know them all by details. I hope some effort will be made, as you expressed earlier, to

document the presentations, and to have a summary of the transcripts of the presentations. Much of the information is very useful. Much of the information is very relevant. And all of it, in my opinion, needs to be delivered back to us. Some of us are running for reelection, so we may not be here next year. But I would like to pass them on; all of us pass them on because they're useful, there's no doubt about it. That whoever's going to be in governance next year, after all these elections, needs to understand these things and needs to know the efforts that had been made. I hope a good documentation of what has happened here will be preserved, so that we too can share with that information.

As a final comment, Mr. Secretary, I again reiterate what I had said earlier today, that I think some immediate effort for establishing networking should be made immediately. And I think as part of your efforts in bringing about the business links, I think this is very much part of our business in the Pacific. It's not so separated. Health care is very much an important business for all the Pacific leaders. And I think the business link website should have some portal available so that we can communicate, so our health officials can communicate. I think giving recognition to the VA program because, DELTA, which is our Distant Education Learning and Telehealth Applications network in American Samoa, is part of that. I think it's something also that should be promoted in all the jurisdictions that we can communicate for health reasons. I will say that we've benefited a lot from these two days of presentations. It has opened our eyes to very minor issues that we need to address to very complex issues. It has opened our eyes to minor concerns to very complex concerns and is kind of a reflection of where we came from, where we are at today, and what we need to do to go forward is going to be a very important part of this conference. Once again, congratulations.

(Secretary Kempthorne) Thank you very much. Togiola, I appreciate your very fine comments. We are going to do a compilation of what took place during these two days and I've discussed this with my staff, so from October 1 to November 1, that will be undertaken. November 1, then, that would be made available electronically for all participants. And we would ask those of you that can do so, to please review and in particular review your section where you make comments or where you made presentations and in that two-week review period, get back to us. And then on December 1 is our target. We would then able to finalize this and then, in December, distribute.

I will tell you the essence and the benefit of this is this would've been very helpful if, when I began my tenure, I had something that identified the challenges, identified the foundation, identified the assets, and had it passed forward. Now remember the compilation is just a summation of what was said here. It is not the game plan, that's to be submitted in June of 2009. However, in going through this compilation, those critical needs that are critical and therefore to the extent we can move on them, during a transition period which will occur after the election, that is the sort of information that I will pass to my successor that will be named. And the successor will want to know what the key areas of importance of the respective departments are. This will be one of them that I will then pass on to the transition team. So all of this will be very beneficial. With that, Governor Camacho, and concluding comments?

(Governor Camacho) Yes, thank you Mr. Secretary, I'd also like to express my thanks to David Chu and, of course, Secretary Peake, Tom Lorentzen who is here, and of course to Joxcel Garcia. To all the panelists that have been here, a tremendous resource. My observation is that although there are many problems and challenges and difficulties we all face, the one great thing that we will have going for us is if you look around the room here, you see many people have that passion and really care for what they're doing and are the difference makers. And so with the establishment of your Interagency Coordinated Assets for Insular Health Response, ICAIHR, for the compilation of data that you're going to have and the game plan that eventually will result from that, from the transition that will come for the next administration, it really is going to be important for all of you that are here working with the eventual leaders that do come out with the new administration to not let this fall that but rather to "give it legs". It's with your passion that we can achieve great things. There's a saying that goes: "in the multitude of counselors there is safety," and, Secretary, with your wisdom what you've done is exactly executed that here. These are the counselors, these are the people that understand it and live it day in and day out, and very eloquently laid out with great articulation the challenges we face.

I leave you inspired. I will meet in October at the chief summit in Pohnpei with the other Island leaders from Micronesia and they've agree that we are to work on a resolution and see if there's a way that we can come together and, perhaps through resolution, come up with some the concept of Micronesia as a Health District and taking it from there. I think we would be stronger united. We could perhaps get better recognition from the Federal government and, through common ground, begin to pursue things that are realistic and doable. I thank you for your leadership. I thank you for your, as Government Togiola had mentioned, your vision and, most importantly, for your stewardship.

It's been a pleasure working with you all these years. God Bless You.

(Secretary Kempthorne) Thank you, Governor, very much. Governor Camacho makes a key point. You all have articulated so effectively and now it will all be reported in one location. This report will be a tool. And many of the people of the respective departments are still going to be here. They are the dedicated career people. This is the benefit - you may have a few changes amongst us, but you have many of those individuals, all of you in this room, and now you have this tool. And so when the island leaders come together with the next administration, they have this tool that will help give them focus. It is going to be very beneficial. And now, Congresswoman.

(Congresswoman Christensen) Thank you for taking me now because I have to go and check out from my hotel room. But I want to thank you again Mr. Secretary and the other Secretaries for this conference. It's been very informative and the amount of information shared will help us as we move forward to improve health care for all of our territories. I want to say that I'm speaking on behalf of Congresswoman Bordello as well as we both Chair health for our respective caucuses and for Congressman Faleomavaega also.

A few points: 1) we've been inserting ourselves into the health care reform discussions that have begun and will continue into the next Congress and I know as Chair of the Congressional Black Caucus Health Task Force, I have put forward as one of our principles that territories and Native American Tribes must be included equitably, and I will continue to push that. Legislatively, we will want to follow-up on the IOM discussion that we had and add language inserted into the labor HHS appropriations bill to have an update on that IOM report and study for all of the territories. I mentioned that the Virgin Islands had asked GAO to perform a review on the quality and accessibility of health care for our (USVI) veterans. I will request that GAO expand the review to include services for veterans in all of the territories and the freely associated states.

Telemedicine offers so many opportunities. Telemedicine and health information technology and an electronic medical record. It ought to be made a priority. It can not only greatly improve the quality of healthcare we deliver, but it will also save dollars that can then be redirected elsewhere to increase salaries, to provide maintenance and buy equipment, or to meet some of the other needs that have been pointed out here. But it occurred to me as I was listening to the panel that we also have at various times in the Virgin Islands tried to have residents come to our hospitals and do rotations. We've not been able to do it to the extent we would like to because we don't have maybe the board certified specialists in their particular specialty to supervise. But telemedicine might make it possible for us to have residents rotate through our hospitals and enhance our staff and the services because they could be supervised by the board certified doctors where they are coming from, so that might be another opportunity for us. Lastly, we know you don't want to issue directives at our governors and the governors don't want directives issued at them, but regarding the OMIP funding, maybe some guidance might be given and coming out of this summit that a certain portion of the OMIP be considered applied to health care improvements based on the priorities that will be developed and as we discuss this further. Lastly, I just look forward to working with the interagency group that has been put together and help to implement, where legislation is needed, some of the proposals that will come forth.

Want to thank you Mr. Secretary, the other Secretaries, our Governors and Presidents and all of our representatives here today. And especially to thank those people who create those miracles everyday on the front lines of health care.

(Secretary Kempthorne) Thank you, Donna. Lest anyone think that we are simply going to compile and then we're out of here, I'm going to be meeting with these gentlemen (U.S. Principals) when we get back to D.C. We are about ready to launch something truly significant and exciting and beneficial.

President Mori had a meeting that he had to go to and he left closing comments.

(Closing Remarks for President Mori were delivered by Lorin Roberts, FSM Secretary of Foreign Affairs) Thank you, Mr. Secretary, for allowing me to express our appreciations to you on behalf of President Mori.

We found the discussions very informative, educational and interesting. We thank you very much for your leadership, your vision, and for highlighting the challenges facing the Federated States of Micronesia. We join others in welcoming the interagency group. We think that it will not only provide guidance and support to our health issues, but also importantly highlights the friendship and the partnership that we enjoy between our two countries, the United States and the FSM. Speaking of partnerships, we can't help but remember our young men and women in the US Armed Forces contributing to the peace and security of our world. We remember them, we support them, and we always remember them in our prayers.

My government takes great pride in the relationship with the United States. The United States has nourished us; it has sustained us; it has enriched us; and it has made us a strong, small island democracy in the Western Pacific. Thank you very much.

(Secretary Kempthorne) Very Good. I appreciate that very much. Because of flights, because of checking out, we are going to have to wrap this. So, to Secretary of Health Villagomez and Commissioner Fludd, I appreciate you both being here and if you want to submit something on behalf of your respective Governors, it will be included in the record. Thank you for your very good articulation.

With that, Director Lorentzen, any closing comments?

(Director Lorentzen) I just want to thank you Mr. Secretary, and the other Secretaries and the leaders, and everybody in the audience. On behalf of Secretary Leavitt, we thank you for all you do. I think the one message that I will walk away with most is how unique the challenges and needs are in the Island communities, and how they require unique responses. And also how uniquely important the health and well being of the people on the islands are to our nation. To everybody else here, thank you.

(Secretary Kempthorne) Tom, thank you so much. Dr. Chu?

(Dr. Chu) Mr. Secretary, thank you for your leadership in convening this conference. It underscores in the comments from our leaders, likewise underscore the principle we are all in this together. And we pledge that, in so far as I have responsibility with Department of Defense, I want make sure we do advance this developing agenda in these many months of this administration so there is a firm foundation for the future. I very much look forward to what the groups this afternoon are going to produce, and to what the ICAIHR team will produce in the next several months.

(Secretary Kempthorne) Perfect David, thank you so much. Dr. Peake?

(Dr. Peake) Let me just have all the VA people stand up. I guess the point I'm trying to make here is we're in this fight with you. We have a responsibility to those who have served this nation that are serving with a higher propensity (per capita) as we have heard over the last day and a half. The opportunity to synergize our efforts with those of you in

the leadership positions is a great opportunity. We've heard a lot about the power of information. There's been a lot of information provided over the last day and a half that I think will inform us and guide us to help us move forward with that synergy appropriately. As Governor Camacho talked about in understanding the local vision of the community of Micronesia, so we in the VA look forward to being a part of this. I thank you sir for the opportunity for being here.

(Secretary Kempthorne) Thank you so much Dr. Peake. Let me thank the island leaders, long-distances, they stayed through the whole thing. Let me thank all of you; you have added immeasurably to the well-being of wonderful citizens that are throughout our Insular Areas. We have talked the whole spectrum, from fiber-optic cables being laid on the ocean floor; hyperbolic chambers; incinerators; to rubber gloves. Every one of them is important. The heroes here are the health care providers, the nurses, the doctors, the technicians, the volunteers. We salute you and commend you.

I want to thank my team at Interior; appreciate what you did. Will my folks from Interior please stand so I can thank you. And in that team, Nik Pula, Doug Domenech, thank you for the leadership, the focus that we're bringing to this.

You saw us passing some papers around here this morning. We're going to distribute to those of you, we'll put it on the website, but it is Joint Statement of Resolve. We believe that it encapsulates, and probably will be the preface to, the report that ultimately comes out. Let me thank all of you for being here. Let me thank you for doing this. It was very beneficial. And there are children throughout the islands, and children yet unborn, that will benefit from the two days that we invested here, as well as people currently needing the benefits of health care.

God bless you all. Travel safely, and we're proud to be partners with you.