SB 251
TASK FORCE TO STUDY ELECTRONIC HEALTH RECORDS

MARCH 6, 2006

MINUTES[1]

Task Force Members In Attendance √, Absent x, Representative *:

√ Thomas Allen	√ David Gens	√ Victor Plavner
√ Stephanie Amey	x Mary Hendler	√ Jack Schwartz
√ Peter Basch	√ Paula Hollinger	√ Kevin Sexton
√ Beverly Collins	x *Aubrey Knight	√ Dorothy Snow
√ Barbara Cook	√ Carey Leverett	√ Angelo Voxakis
√ Rex Cowdry	√ Thomas Lewis	x * James Wieland
√ Jimmie Drummond	x Gina McKnight-Smith	√ Ken Yale
x Michael Flores	√ Susan Newbold	
√ Paul Fowler	√ Shane Pendergrass	

* Damian Doyle for Aubrey Knight
* Paul Kim for James Wieland

Staff
Lee Williamson

I. Meeting Call to Order

Task Force Chair Peter Basch, M.D. called the meeting to order at 1:11 p.m.

a. Opening remarks from the Chair & Vice Chair
b. Meeting agenda logistics

Dr. Basch noted that the regular monthly meetings of the Task Force would be held on the second Monday of each month, at the Maryland Health Care Commission (MHCC or Commission) headquarters on Patterson Avenue in northwest Baltimore. Task Force Vice Chair Kenneth Yale made opening remarks concerning the Task Force's potential involvement with the MHCC as the steering committee for Maryland's participation as a subcontractor to the research firm RTI, Inc. Next month, RTI, in cooperation with the National Governors Association's Center for Best Practices, will award federal funding of up to $350,000 to as many as 40 states, to examine the privacy and security laws and business practices that may present barriers to the creation of interoperable electronic health information exchange (HIE.)

The Governor designated MHCC as the lead State agency in seeking this subcontract, and the Commission on February 28th submitted a proposal in response to the RTI Request

[1] As amended in response to motion passed at the Task Force's April 10, 2006 meeting.

for Proposals, which established a March 1, 2006 submission deadline. Dr. Yale urged the Task Force to consider with an open mind an active involvement with the RTI project, since it would bring Maryland additional resources for its efforts to advance the use of health information technology in health care.

II. Comments by Delegate Shane Pendergrass

Dr. Basch introduced Task Force member Delegate Shane Pendergrass, who expressed concern that the areas of investigation specified by the RTI subcontract went beyond the charge to the Task Force outlined in last session's enabling legislation. She was also concerned that the considerable work required to fulfill the RTI deliverables would divert time and resources from what the Task Force had been appointed to accomplish. Delegate Pendergrass also voiced her view that the question of whether the Task Force should serve as the RTI Steering Committee appeared to have been decided, without full discussion and assent by the Task Force. Dr. Basch assured the members that a thorough discussion of this issue would take place later in the meeting.

III. Presentation by the Chair

a. Brief Legislative History Review
b. Vision/agenda for the Task Force
c. Rationale for Task Force Involvement in the RTI Subcontract

Dr. Basch gave a presentation intended to summarize the legislative history of SB 251, the Task Force's enabling legislation enacted during the 2005 session of the general Assembly, his thoughts on the approach the Task Force could take to its mandated work, and the rationale for the group's active participation as the Steering Committee to the RTI subcontract. Dr. Basch proposed organizing the Task Force into three work groups -- Electronic Patient Information & Policy Development, Computerized Prescribing & Policy Development, and Infrastructure Management & Policy Development – through which the Task Force would accomplish its legislatively-mandated tasks. He stated his view that a key rationale for the group's involvement with the RTI subcontract is that it requires the same types of studies and reports that the Task Force must do, but also provides direct funding for that work.

Task Force member Victor Plavner, M.D. addressed the interpretation of the legislative language "electronic transfer [of health records]" to mean "electronic health information exchange"; in his view, the legislature did not define the term, and the Task Force had not reached a consensus on its meaning, and the implication of the settled interpretation on the scope of the Task Force's work. Dr. Plavner also addressed Dr. Basch's statement that the "key components" of SB 251 included a charge to "evaluate potential obstacles to establishing a secure, effective, and interoperable system for the electronic exchange of health information in Maryland," and to "recommend broad policies related to the ownership of this vital and personal information, as well as its privacy, security, authentication, and use." Both Dr. Plavner and Delegate Pendergrass expressed concern about the characterization of those tasks as either legislative language or legislative

intent, and called their addition to the Task Force's areas of study an expansion of the scope of the law and of the group's responsibility.

Task Force member Barbara Cook, M.D. approved of the workgroup design proposed by Dr. Basch, but asked how the Task Force could ensure that the groups did not duplicate the work of existing health information technology efforts and organizations. MHCC staff explained that Task Force leadership intends to bring in these groups, which have already grappled with some of the issues on the Task Force agenda, and any other resources the groups need; Dr. Basch emphasized that Maryland was not just beginning its efforts to advance the use of health IT, and that the groups would build on the work already done.

Task Force member Beverly Collins, M.D. returned to the idea that SB 251's term "electronic transfer" needed to be better understood and agreed upon; Dr. Yale suggested that this could be the focus of the workgroups, in each of their areas. Task Force member Jack Schwartz, Assistant Attorney General and director of the Attorney General's Office of Health Policy Development, observed that even if concern about the privacy and security of personal health information is not explicit in SB 251, this concern follows from a wider use of electronic health information exchange. This suggests that the Task Force has some latitude to define and expand the scope of its examination of the "electronic transfer" of health information. Task Force member Thomas Allen, M.D. noted that confidentiality and privacy necessarily enter into any consideration of expanding the use of electronic health information exchange.

Dr. Plavner emphasized that the Task Force needs to discuss more fully its legislatively-mandated tasks, and agree on its goals and objectives. Delegate Pendergrass expressed her concern that extrapolating from the legislative language to the components of the group's charge articulated by the Chair appeared to commit the Task Force to participating in the RTI subcontract in advance of the group's deliberation and decision in that matter. Dr. Basch deferred further discussion on this issue until its intended place in the meeting agenda.

IV. Presentation by Lori Evans: Maryland Task Force to Study Electronic Health Records – A National Context

Dr. Yale introduced Lori Evans, who worked with Dr. David Brailer, National Coordinator for Health Information Technology, during the establishment of that Office in response to Executive Order 13335 by President Bush. Ms. Evans began with an overview of issues in the current health care system that a wider use of health information technology could help to ameliorate, including the clinical and financial impact of preventable medical errors. Ms. Evans then described the evolving environment at both the federal and state levels in the use of health information technology, and outlined the nine elements of the National Coordinator's Strategic Framework for the adoption of interoperable electronic health records. Four of these initiatives are the focus of federal contracts: investigating ways to develop a widely accepted set of standards for health IT; developing criteria and an evaluation process for certifying EHRs and their operating

networks; designing and implementing four prototypes for the secure exchange of information between numerous provider settings, which will ultimately be combined as a prototype for a National Health Information Network (NHIN); and assessing the obstacles that variations in privacy and security laws and practices may present to development of an interoperable system of electronic health information exchange.

Ms. Evans also discussed health IT initiatives being undertaken by other federal agencies, by Congress, and at the state level. Many states have formal efforts underway to develop at least one regional health information organization, or RHIO. The Office of the National Coordinator has put forth principles to guide the development of RHIOs, calling for at least one such organization per state, to be established as a public-private partnership that will function as a leader and convener of stakeholders at the state level, and also provide liaison to the federal-level developments, including the American Health Information Community (AHIC), an advisory committee appointed and chaired by HHS Secretary Leavitt. The role of the states in the ongoing evolution of health IT should concentrate on providing leadership and coordination, regulatory oversight, and financial support, directly as capital resources or indirectly as incentives for adoption through Medicaid programs. The states will be a "key lever to drive" the expansion of electronic health information exchange.

Ms. Evans concluded by offering some recommendations to the Task Force, as it begins its work. Any state-level efforts to advance the use of health IT should involve consumers from the beginning, and incorporate privacy and security into both the business and technical infrastructures of any system developed. States need to develop a strategy for "engaging public partners" in health information exchange, and let the projects be driven by priorities based on the improvement of clinical outcomes, and advances in quality of care. She also noted the importance of developing trust and good will around efforts to expand electronic health information exchange, and to find ways to encourage shared investment and promote financial sustainability. The architecture of health IT and standards for system operation developed at the federal level should provide a framework and direction, but innovative approaches will happen at the state and especially the local level, where people receive their health care.

Following the presentation, Dr. Plavner noted the relatively low level of federal funding support for efforts to expand the use of health IT; Ms. Evans responded that the last 18 months have seen more support, because of the strong role played by the National Coordinator, but that federal funding is envisioned as the catalyst, not the source of significant ongoing funding. The states need to be the focus for the development of connectivity, at the local and regional levels, and with the national architecture under development. In response to comments by Delegate Pendergrass, Ms. Evans discussed the basis of variations in privacy and security laws among the states, as well as between state laws and federal HIPAA regulations, and the potential for these inconsistencies to become a significant obstacle to interoperability. Many providers – such as hospitals and large health systems – engage in a significant degree of electronic health information exchange currently, and so have well-established privacy and security business policies. Wider use of electronic health information exchange, however, will multiply the numbers

of exchanges, and states will need to facilitate solutions and achieve consensus and cooperation. Delegate Pendergrass asked why the federal-level agencies don't resolve this situation and mandate privacy and security policies for the entire country. Ms. Evans responded that feedback from the states convinced the Office of the National Coordinator that the best approach was to have these variations worked out at the state and local level.

Dr. Basch recognized Task Force member Senator Paula Hollinger, sponsor of SB 251, who recalled that, during the bill's consideration by the legislature, the questions repeatedly raised were very basic: how do we bring a system to create and use electronic health records together, how do we pay for such a system without leaving anyone behind, and how do we protect the privacy and security of the information? Senator Hollinger expressed her view that – especially at this early stage of its work – the Task Force should not apply for a federal grant. Senator Hollinger noted that she has asked Steve Mandell, Senior Director for Clinical Information Systems at the Johns Hopkins Health System, to represent her at meetings of the Task Force when she cannot attend.

V. Task Force Role in the RTI Subcontract

a. Discussion of Subcontract Deliverables

b. Task Force Discussion

c. Vote

Dr. Basch moved the Task Force on to its consideration of whether to be directly involved with MHCC, as the project Steering Committee for its proposed participation as a subcontractor in the RTI-directed Health Information Security and Privacy Collaboration. Task Force member and MHCC Executive Director Rex Cowdry, M.D. began this discussion with a brief presentation that put forth his vision of the guiding principles and best approach to the work of the Task Force. Dr. Cowdry expressed his view, which had also been expressed to members during the formation of the Task Force, that the expertise and viewpoints represented in this group were ideally suited for the multiple efforts now or soon to be underway, to advance the use of electronic health information exchange in Maryland. The Task Force was constituted at a level to provide high-level policy guidance in these key areas of public policy interest. Accordingly, asking the Task Force to take on essentially the same role as the Steering Committee role in the RTI project made sense, and represents a "value added" approach.

Dr. Cowdry maintained that the real center of the debate over widening the use of electronic health information exchange lies in reaching agreement on the appropriate guiding principles for developing a truly interoperable system for Maryland. He reviewed some potential principles from the national initiative as well as from present practices, and the fundamental questions already on our agenda to resolve. One of the most important questions – whether an individual should control his or her own medical information – Senator Hollinger observed is already clear in Maryland law, since the 2000 enactment of the Maryland Medical Records Privacy Act, of which she was principal sponsor. Regardless of the fact that HIPAA may not provide strong enough protection for privacy and security, Senator Hollinger observed, Maryland law is more stringent, and therefore supersedes HIPAA rules in this regard.

Dr. Cook called the group's attention to the question at hand, of whether the Task Force should assume responsibility for a significant policy role in fulfilling the RTI subcontract. Dr. Cowdry continued his explanation of the design of the RTI project, and the advisory role envisioned for the Steering Committee. From the same perspective, the Task Force represents the ideal group to provide policy advice as the MHCC and the Health Services Cost Review Commission (HSCRC) proceed with planning and implementation of a statewide health information exchange for Maryland.

Task Force discussion began with questions concerning what alternatives MHCC and Maryland would have, if the Task Force declined a formal role, and also what would happen if Maryland declined to participate at all in the 40-state effort. Dr. Cowdry responded that he was unsure at this point exactly what the alternatives would be, but that, to continue to pursue the subcontract, MHCC would have to assemble a health information technology (HIT) Steering Committee very quickly, given the RTI project's accelerated time frames. Dr. Basch asked if individual members could participate.

Dr. Plavner characterized the RFP as onerous, with an aggressive time line, and asked for clarification of its areas of investigation. Dr. Cowdry and Ms. Evans explained that the RTI project's purpose, at the direction of the Agency for Healthcare Research and Quality (ARHQ) was to identify the inconsistencies and variations between federal and State law, and between the business policies and practices of the health care sectors now engaged in electronic health information exchange.

Task Force member Thomas Lewis, M.D. noted that Maryland, as a leader in protecting the privacy of medical records, could, by participating in the project, have an influence on federal privacy practices, and bring our principles to bear in shaping a national policy.

Senator Hollinger expressed her view that the Task Force should be informed and involved in this effort not through a direct role and responsibility, but through MHCC and other, existing State resources and efforts, such as the Advisory Council on medical Privacy and Confidentiality, established in 2001 to guide enforcement of the Medical Records Privacy Act. Mr. Schwartz observed that an informed discussion of privacy and security of electronic health records is an integral part of the Task Force's role, and that the RTI subcontract provides resources for that same analysis and deliberation.

Several members expressed concern about the level of resources needed to do the work required by the enabling legislation, in addition to the significant amount of work prescribed by the RTI subcontract. The Task Force debated several approaches to this issue, including assuming a lesser role in the RTI project, and also the possibility of delaying a decision about its participation. Dr. Cowdry emphasized that this would not provide sufficient time for MHCC to assemble an alternative Steering Committee with which to proceed, if its proposal to RTI were accepted.

Dr. Cowdry moved to table the decision, to permit MHCC to consider the implications of a Task Force decision not to participate on its proposal to RTI. Delegate Pendergrass

seconded the motion, but – at several members' expression of concern that so important a question be left unresolved – she offered to rescind her second and allow discussion to continue. Instead, the motion proceeded to a vote, and failed by a vote of 5 to 9, so the discussion resumed. Members raised questions about alternative sources of funding for health IT-related work, including the resources in existing agencies available for its own legislatively-mandated tasks, and expressed concerns about the degree of commitment and the work involved in the RTI subcontract. Dr. Plavner emphasized the central role of the Steering Committee in RTI's project design, and asked the Task Force if it was comfortable making key decisions on a federal contract. Senator Hollinger stated that, while the work and interest of the Task Force and the RTI project overlap, they are not the same, and that the General Assembly did not intend that the Task Force serve in the kind of additional, formal role required of the RTI Steering Committee.

During discussion of the RTI contract, it was revealed that since the March 1 deadline [for submitting a response to the RTI Request for proposals] occurred prior to this Task Force meeting, the RTI contract was submitted with the Task Force labeled as the Steering Committee for this contract. Unfortunately this was done prior to having the Task Force discuss this issue in depth and agree to it being used as such. After subsequent discussion and agreement about the Task Force's legislative purpose, it was agreed that the MHCC will write a letter as soon as possible to RTI stating that the Task Force will not become the Steering Committee for the RTI contract.

Senator Hollinger proposed that the Maryland Health Care Commission use the Task Force in an advisory capacity in its efforts under the RTI subcontract, along with others. The Task Force affirmed this approach, by a vote of 15 in favor, none opposed, with three abstentions.

VI. MHCC & HSCRC Collaboration on a Maryland Health Information Exchange Study

VII. MHCC Webpage Features – General Information

In the interest of time, these two agenda items were deferred.

VIII. Closing Remarks by the Chair and Vice Chair

The Chair thanked the Task Force members for their interest and enthusiasm. The next meeting is scheduled for April 10, 2006 at MHCC's offices in Baltimore. Because this is the last day of the current legislative session, Delegate Pendergrass asked that the alternative date of April 17th be considered. Dr. Basch adjourned the meeting at 3:58 p.m.