

SB 251
TASK FORCE TO STUDY ELECTRONIC HEALTH RECORDS

August 14, 2006
MINUTES

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

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

*Chris Gibbons for Jimmie Drummond

* Mike Fierro for Beverly Collins and Victor Plavner

I. Meeting Call to Order

Task Force Chair Peter Basch, M.D. called the meeting to order at 2:10 p.m.

Opening remarks from the Chair

Dr. Basch welcomed the members of the Task Force and the public to the meeting. He discussed recent news and developments concerning health information technology (HIT). Chairman Basch said that both the Centers for Disease Control and Prevention (CDC) survey on electronic medical records (EMR) adoption and another survey funded by the Agency for Healthcare Research and Quality (AHRQ) suggested that the rate of EMR adoption in private physician offices is approaching 25%. Both of the studies, however, reflected the fact that when physicians were queried as to all of the features of an EMR, the figure was closer to about 9%, with EMR adoption in small practices at only 4.5 to 5%. Chairman Basch also noted that he had distributed an article published in *Health Affairs* to members of the Task Force regarding utilizing HIT to inform purchasers of health care benefits.

II. Approval of the Minutes

Chairman Basch said that the Minutes of the July 10, 2006 meeting would be approved at the September meeting of the Task Force, as there was not a quorum at this stage of the meeting.

III. Presentation – W. Holt Anderson, North Carolina Healthcare Information and Communications Alliance

Vice Chairman Ken Yale introduced W. Holt Anderson, Executive Director of North Carolina Healthcare Information and Communications Alliance, Inc. (“NCHICA”) to the members of the Task Force.

Mr. Anderson said that NCHICA was established in 1994 by Executive Order of North Carolina’s Governor, as a 501(c)(3) nonprofit research and education corporation, whose mission is to improve healthcare in North Carolina by accelerating the adoption of information technology. NCHICA has 220 members, including health care providers, health plans, clearinghouses, state and federal government agencies, professional associations and societies, research organizations, and vendors and consultants.

Mr. Anderson provided information about several statewide NCHICA’s initiatives and discussed national initiatives where NCHICA is involved, which include its participation in the IBM contract to develop one of four prototypes for the Nationwide Health Information Network (NHIN), and as a subcontractor for RTI, Inc. in the Health Information Security and Privacy Collaboration, now known as the Privacy and Security Project.

Mr. Anderson talked about “connected communities” as consumer-centric collaborations or organizations focused on facilitating the coordination of existing and proposed e-health initiatives within a region, state, or other designated local area. These entities may be called RHIOs (Regional Health Information Organizations); RHINs (Regional Health Information Networks); or SNOs (Sub-Network Organizations.) They may be organized as a federation, comprised of multiple independent and strong enterprises in same region; as a “co-op,” multiple enterprises that agree to share resources and create a central utility; or as a hybrid of these two models, in a region containing both federation and co-op organizations.

Mr. Anderson described two models for organizational structure and key functional components of regional health information networks, according to their specific functional roles. “Utility” operators maintain a centralized database from which to exchange patient information, functioning as a clearinghouse and a patient information locator service. The more neutral function, as “convener” or facilitator, focuses on building consensus policies through which to bring together competitive enterprises, and, frequently, to bridge multiple RHIOs in a given geographic region.

Mr. Anderson stated that challenges to broader electronic exchange of health information include business/policy issues such as competition, internal policies, consumer privacy concerns/transparency, uncertainties regarding liability, difficulty in reaching multi-enterprise agreements for exchanging information, and economic factors and incentives. In his view:

- Statewide interoperability is important, but interoperability with bordering states may be more important for a RHIO;
- A successful entity should provide opportunities for statewide interoperability;
- Technology should be seen not as the end in itself but as the “enabler” of activities in areas such as patient safety (to bring all necessary/relevant information to clinicians at the place and time of need, to enable clinical decision support to help clinicians process vast amounts of data, and to resolve issues such as the legibility of orders and prescriptions); quality of care (to enable standardization of care/benchmarking), and efficiency (to save time, and to save money through elimination of redundant procedures).

To be successful in electronic health information exchange, Mr. Anderson stated that certain key factors need to be present. State leadership and leaders of health care organizations must continue to support dialogue and education on the issue; rural providers should receive funding assistance; larger health systems need to be convinced to collaborate, not compete, where health IT is concerned; barriers to interoperability and efficient exchange posed by HIPAA and other state and federal regulations should be eliminated as far as possible; and parties need to adopt a common terminology.

Mr. Anderson also recommended that any effort to establish meaningful electronic health information exchange involve “major players” like CEOs, COOs, CMOs, CIOs, attorneys and corporate compliance officers, to avoid what he called a “one champion” situation, or a purely technical view.

If NCHICA were to start over, Mr. Anderson said that he would focus on “clear drivers” of electronic health information exchange, including quality of care and its effect on costs; improving physician work flow through electronic medical records; building on “quick wins” – the “low-hanging fruit” with obvious benefits to the public such as immunizations and medications; and the most complex and costly health care cases, especially chronic conditions.

IV. Presentation Q&A Session and Discussion

Members of the Task Force and Mr. Anderson discussed various issues following his presentation. These included: the role of NCHICA as an advisor and advocate for the use of health IT in quality improvement and in compliance with HIPAA Privacy Rules (Vice Chairman Yale); measuring what NCHICA has accomplished, such as the Immunization Registry (Chairman Basch); the role of state legislation regarding interoperability of electronic health information exchange (Mr. Wieland); consumer input prior to this year’s creation of a Consumer Council in North Carolina (Mr. Schwartz); vendor investment relations (Mr. Fierro); development of standards, and the costs to physicians for targeted systems (Dr. Cowdry); ownership of data contained in personal health records (Dr. Lewis); lessons learned regarding long term care (Mr. Knight); initial communications with the legislature (Ms. Amey.) Staff asked about sources of funding for NCHICA

activities. Mr. Voxakis talked about e-prescribing and the impact of generic prescription drugs. Dr. Snow raised the issue of EHN interoperability, and the question of the use of disease registries – in which a provider’s treatment and outcomes in management of specific, often complex chronic cases may be measured against professional, state, or federal standards – versus the use of an electronic medical record. Dr. Cook raised the issue of potential effects of a relaxation of the Stark laws, and Ms. Newbold asked about health IT activities in other states similar to NCHICA’s initiatives (Ms. Newbold).

Chairman Basch thanked Mr. Anderson for his presentation, and noted that additional questions for Mr. Anderson from members of the Task Force could be directed to staff for coordination with Mr. Anderson.

V. Work Group Sessions

Each Work Group met for a brief session.

VI. Brief Summaries from the Work Group Leads

Mr. Wieland reported that the Electronic Patient Information and Policy Development Group focused on the development of a six-month agenda. The Work Group anticipated that a final Work Group Agenda would be developed and posted by March 2007. They also discussed the process for creating a process and strategy for meeting the goals of the group, and of assigning work to the group’s consultant.

Dr. Yale reported that the Infrastructure Management and Policy Development Work Group had asked its consultant to look at all HIT activities in the state of Maryland, flesh out good descriptions of projects, and develop an agenda for the further work of the group.

Mr. Voxakis reported that the Computerized Prescribing Work Group discussed the perceived inefficiencies of e-prescribing for physicians, and the work assigned to the group’s assigned consultant.

Chairman Basch thanked the Work Group members for placing focus on their agendas. He noted that the Task Force members should consider strategies and budget issues as they develop proposed comments to Governor Ehrlich regarding how to accelerate the process of adopting electronic health records.

VII. Closing Remarks by the Chair

Chairman Basch asked if there were any public members wishing to comment. As there were no comments, he thanked the Task Force members for the thoughtful and insightful discussion. He announced that he was presenting before the American Health Information Community on barriers to EMR adoption and optimal use, and that this presentation was embargoed until August 15, 2006, after which time he was free to share

it with the Task Force. In addition, Dr. Cook offered to share a report on barriers to pay for performance with the Task Force members.

Chairman Basch announced that the scheduled meeting of the Task Force in October had been changed to October 16, 2006, and that the next meeting of the Task Force was scheduled for September 11, 2006 at 2:00 p.m. at the offices of the Maryland Health Care Commission. There being no further business, the Task Force meeting was adjourned at 5:02 p.m.