

GOVERNOR DOUGLAS: Thank you, Commissioner

22 Cline and Dr. Ruffin for leading our discussion, and

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1 Dr. Townsend and Mr. McCourt for their very helpful
2 presentations.

3 Moving on to another panel discussion now,
4 Governor Bredesen and I will need to excuse ourselves
5 for a couple of minutes. We talked about the
6 state/federal partnership that's so important here.
7 We want to maintain a good working relationship with
8 both branches of the government and we're going to
9 meet briefly with the new chairman of the Senate
10 Health Committee, Senate Kennedy, and we'll have to
11 tell him that he was favorably quoted.

12 (Laughter.)

13 GOVERNOR DOUGLAS: But he and Senator
14 Enzi, as I mentioned earlier, have been the key
15 leaders in the U.S. Senate on establishing some
16 relationships and providing incentives for states to
17 develop health IT programs. We don't want to miss
18 this opportunity. Let me turn it over to Attorney
19 General Carter and Dr. Sundwall for the next
20 presentation.

21 MR. CARTER: Thank you. I think we can
22 have our next panel come up so we can begin our

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1 discussion about health care practice. For this

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2 session, our panel experts will discuss legal and
3 professional practice standards that are inconsistent
4 with interoperable electronic health information
5 exchange, such as licensing standards and liability
6 issues. We'll have both speakers present, then we'll
7 have an opportunity for discussion. Dr. Sundwall
8 will introduce the speakers.

9 Doctor?

10 DR. SUNDWALL: Thank you very much.

11 Our speakers today are Lisa Robins, Vice
12 President of Government Relations, Policy and
13 Education at the Federation of State Medical Boards.
14 Also, Howard Burde, a partner at Blank & Rome, a law
15 firm in Pennsylvania.

16 I have an opportunity to give a talk right
17 now and all the wonderful things they've done. At
18 least, they said I had that latitude, but I can't
19 take it. I can resist, however, calling from their
20 biographies just a few things. The Federation of
21 State Medical Boards is a very, very important
22 organization. I've had rich and positive experiences

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1 with them over the years in my public policy work and
2 I just can't resist telling you the things you're
3 focusing on now from your biography about substance
4 abuse regulation, how a doctor's allowed to do that.
5 Internet prescribing is a big deal in Utah. I'm
6 ashamed to say we have the only Internet pharmacy,
7 which was somehow certified. I don't get it, but

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8 anyway, it's a problem that I look to you for
9 guidance on that.

10 Also, opiate analgesics -- we have the
11 distinct displeasure of having a 400 percent increase
12 in thefts of opiate prescription drugs, legal drugs
13 and I appreciate your efforts on that.

14 Also, Mr. Burde, I previewed your
15 presentations and I can't thank you enough for
16 several of your slides saying "What are the
17 implications for public health?" We look forward to
18 your presentations.

19 Lisa, go first.

20 (Slide.)

21 MS. ROBINS: I'd like to begin by thanking
22 the Alliance for offering the Federation of State

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1 Medical Boards the opportunity to be here.

2 (Slide.)

3 MS. ROBINS: When I was putting this
4 presentation together, I came across this cartoon. I
5 thought it was relevant to the task that the Alliance
6 is undertaking. It also reminded me of a story that
7 actually a physician shared with me recently about an
8 electrician who was called out to a home to take care
9 of an electrical problem. He opened the electrical
10 box and there was just a mass of wires. He took two
11 wires together, twisted them together, closed the
12 box. He gave the homeowner a bill for a thousand
13 dollars. The homeowner, of course, was aghast

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14 because the electrician had been there five minutes.
15 The homeowner asked for an itemized statement. The
16 electrician jotted some numbers down. The homeowner
17 looked. It said, "Service call \$1.00. Knowing which
18 two wires to put together, \$999.00."

19 I would like to applaud NGA and especially
20 the members of the Alliance for their willingness to
21 give their time and expertise to this very important
22 project, which I believe has the potential to vastly

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1 improve health care in this country.

2 (Slide.)

3 MS. ROBINS: I put a little bit of
4 information about the Federation. They do represent
5 the 70-state medical boards in the country and the
6 territories. We've been around since 1912.

7 (Slide.)

8 MS. ROBINS: We are organized with a
9 variety of programs and services and products, all of
10 which are designed to promote consistency and
11 uniformity and cooperation among the states.

12 (Slide.)

13 MS. ROBINS: Today I've been asked to
14 identify the major concerns, from a state board
15 perspective, the challenges we see in facilitating
16 interstate and intrastate health information
17 exchange. And finally, to offer some solutions,
18 particularly, for the practice of medicine taskforce
19 to consider.

20 Under our current state-based medical
21 licensing system, the practice of medicine is
22 generally deemed to occur in the jurisdiction where

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1 the patient resides and physicians are required to be
2 licensed in the jurisdiction where the patient
3 resides. For a physician who practices via
4 telehealth, this may require them to be licensed in
5 as many as 20 or more states. Eleven states are
6 authorized to issue a special telemedicine license.
7 This limits the license to telemedicine. But it
8 should be noted that most states recognize some
9 exceptions for consultations via telehealth or
10 otherwise as long as they're a licensed physician in
11 the jurisdiction that is accountable for the care of
12 the patient.

13 (Slide.)

14 MS. ROBINS: So why is license portability
15 a critical issue? Investments in technology may
16 revolutionize the practice of medicine, from a
17 technology position, dissolve interstate boundaries.
18 However, from a regulatory perspective, there are no
19 changes. In order to advance telemedicine in multi-
20 state practice, while not compromising the level of
21 protection afforded the public, a more
22 technologically efficient and uniform system of

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1 licensure will be required. Reforming the current
2 regulatory system will reduce the burden on
3 physicians who seek to practice in multiple
4 jurisdictions and reduce the administrative
5 redundancies and leave verifiable their core status
6 credentials, such as education and training in
7 multiple jurisdictions.

8 It became very apparent after Hurricane
9 Katrina that a simple data system is critical to
10 provide the necessary redundancy to verify the
11 qualifications of physicians and other health care
12 professionals being dispatched to disaster-affected
13 areas. After Katrina, the Louisiana Medical Board
14 was completely unable to operate. Fortunately, they
15 had provided their licensing data to the Federation
16 Physician Data Center on a regular basis, so
17 Federation staff was able to step in and act as the
18 Board for a period of time verifying the
19 qualifications of physicians who were displaced after
20 the disaster.

21 (Slide.)

22 MS. ROBINS: I've worked with our member

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1 boards for a number of years, working at how the
2 system can be made more portable and still maintain
3 adequate public protection at the local level. Our
4 discussions were based on several assumptions and
5 current realities. The health care delivery

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6 environment is dynamic, rapidly changing due to
7 advances in technology as well as population
8 demographics. The regulatory environment is not a
9 dynamic environment and structurally, little has
10 changed in the past 50 years.

11 What has advanced as far as use of common
12 tools such as the common licensing exam and
13 recognizing qualifications for practice, which are
14 pretty much standard across all states. However,
15 there has not been a system to allow boards to rely
16 upon each other for verification of license
17 qualification.

18 Another reality is that none of the boards
19 are dependent on licensing fees to perform their
20 regulatory functions. The disciplinary functions,
21 complaint investigation and adjudication is very
22 expensive and this accounts for the largest share of

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1 the Board's available resources. Accordingly,
2 additional funding will have to be allocated to
3 implement the necessary innovations to significantly
4 improve license portability.

5 (Slide.)

6 MS. ROBINS: I want to spend just a moment
7 talking about a project that the Federation is
8 involved with on behalf of two regions of states in
9 the country. In September, we received a grant
10 administered by the Office of Telehealth for three
11 years. First, and probably the largest piece of it

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12 is to develop and implement a centralized interactive
13 data management system in these two regions. Also,
14 we will be conducting conferences of legal, policy
15 and technical assessments of these same boards to
16 determine the feasibility of expanding the system
17 nationwide.

18 Finally, we are going to evaluate the
19 utility of using special telemedicine licenses. I
20 really want to recognize the state boards that are
21 participating in this project. They've come forward
22 with willingness to dedicate their scarce resources,

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1 time and expertise toward this project. They are
2 Colorado, Idaho, Minnesota, North Dakota, Oregon and
3 Wyoming. And in the Northeast, Connecticut, Maine,
4 Massachusetts, New Hampshire, Rhode Island and
5 Vermont.

6 (Slide.)

7 MS. ROBINS: Another area of concern for
8 the medical regulatory community is the use of the
9 Internet in medical practice. The technology offers
10 tremendous benefit to improve patient care and
11 safety. Unfortunately, there are some that have
12 taken advantage of technology to engage in practices
13 that put the public health at risk. I am
14 specifically talking about Internet pharmacies that
15 prescribe and/or dispense prescription medication
16 based solely on an online questionnaire. It's
17 extremely critical that the same ethical and

18 professional standards of conduct be applied
19 regardless of the mode of delivery.

20 The standards we believe are important is
21 that a legitimate physician/patient relationship
22 exist, that physicians have the access to patient

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1 evaluation prior to diagnosis and/or treatment. That
2 would include prescribing. That prescriptions based
3 solely on an online questionnaire fail to meet an
4 acceptable standard of care and should be considered
5 a violation of the Medical Practice Act. There
6 should be standards in place for electronic
7 communication between providers and patients. These
8 would include authentication of patient's identity,
9 privacy and security matters, access to communication
10 responses, archival and retrieval and everything
11 should be documented in the medical record.

12 (Slide.)

13 MS. ROBINS: The number of challenges
14 remain before you transform the health system
15 regulating Internet pharmacies is a complex issue
16 involving multiple jurisdictional issues. States
17 have responded with rules and policies that could
18 interfere with legitimate telehealth practices. We
19 want to assure that we don't put up additional
20 barriers to legitimate telehealth practices while we
21 also figure out how to regulate these Internet
22 pharmacies, the lack of resources discourages

1 technical advancement and innovative approaches.
2 Statutory and policy inconsistencies discourage
3 interoperability and information sharing and
4 interstate agency cooperation and collaboration.

5 (Slide.)

6 MS. ROBINS: FSMB and others have
7 supported legislation at the federal level to
8 regulate these Internet or rogue pharmacies. The
9 prescription drug abuse is a growing public health
10 problem in this country. These operations account
11 for at least some portion of the drugs being abused
12 and diverted. There has been legislation introduced
13 in the last three Congresses. For one reason or
14 another, they have not been passed. We are working
15 again this year to get something in place. We think
16 it's critical that there's legislation that defines
17 what a qualifying physician/patient relationship
18 would be as far as a valid prescription is concerned,
19 that we disclose information about the pharmacy from
20 physicians associated with them and that state AGs
21 have nationwide injunctive authority.

22 The other issue is funding. Our state

1 agencies are charged with protecting consumers by
2 getting the qualifications of licensees and enforcing
3 standards of professional conduct.

4 (Slide.)

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5 MS. ROBINS: I encourage the Alliance and
6 I was please to hear in your vision and objectives.
7 I look to you for the evaluation of state laws,
8 standards and procedures and perhaps the development
9 of model legislation to be recommended to states so
10 that uniform standards can be applied throughout the
11 states for health records, electronic prescribing and
12 reimbursement.

13 (Slide.)

14 MS. ROBINS: As policy makers and
15 regulators, we'll have to be willing to beyond the
16 conference center on the necessary standards that
17 must be established to create an effective
18 interoperable system for the states and even
19 international exchange for health information.

20 I've provided some resources. There are
21 number of policy resources that I would offer. Our
22 Legislative and Policy Division can give you the

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1 support which you require and we'll also recommend
2 the e-Risk working group has issued some guidelines
3 for online communications in October 2006 and they're
4 available on the web.

5 Thank you for having me today.

6 DR. SUNDWALL: Thank you very much, Lisa.
7 Howard, are you ready? We're ready to go.

8 MR. BURDE: First, I want to thank the
9 Alliance, the governors, General Carter, and Dr.
10 Sundwall for the opportunity to present this morning.

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17 issues. In fact, lengthy treatises to which I've
18 contributed some of them on the legal issues on
19 confronting health information exchange. For our
20 purposes today, given the charge from the Alliance,
21 I'm really going to focus on two interrelated issues,
22 privacy, which is sometimes confused with security;

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1 and liability for use and disclosure. Those issues
2 themselves raise other issues such as ownership,
3 which Governor Geringer and Professor Pritts raised.

4 I don't want to get into lengthy
5 discussions about them. That's not my purpose here
6 today. I will say, at the outset, that there is a
7 problem with using ownership as a model. Among them,
8 it invites questions about the division of rights.
9 Yes, information -- the health record is about the
10 individual, but it is not placed there by the
11 individual. It's not retained by the individual.
12 It's not, by law, stored and kept for a certain
13 number of years by that individual as Professor
14 Pritts as studied and written.

15 We're talking about privacy. We're not
16 talking about ownership, but rather the ability to
17 say when and where or to object to -- we'll get to
18 the presumptions involved -- when information can
19 flow and for what purposes. And the question of
20 control leaves us a more focused question, which is
21 what is the legal presumption involved?

22 (Slide.)

1 MR. BURDE: Do we want a legal structure
2 pursuant to which information will flow for certain
3 purposes unless otherwise indicated and sometimes
4 anyway? Or do we want a legal system that has a
5 blanket prohibition on transmission in the absence of
6 specific authorization. Which is better for
7 individuals? Which is better for the system as a
8 whole? What is opting really? Is it a blanket
9 authorization on enrollment? What is its duration?
10 What is the duration for any particular disclosure?

11 When we talk about disclosure, are we
12 saying for limited parts of the record or for all of
13 the records or just for those aspects of the record
14 maintained by a payer or by a provider? As we get
15 more gradually into these issues what we have is that
16 making blanket statements about the legal presumption
17 necessarily interferes with the development of an
18 information exchange where information can flow for
19 the purposes we really want, which, let's face it, is
20 communication.

21 So the setting of a presumption is
22 important because presumptions, if I may engage in a

1 small bit of law school primer, A presumption is
2 merely where we set the rules. Legal presumptions

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3 tell us under what circumstance and how we exercise
4 legal rights. The exercise of those rights may
5 shift, depending on where we place that power. The
6 presumption of innocence is the most famous one. We
7 all know about that. We're all presumed innocent in
8 a criminal context until somebody makes a case, until
9 the prosecutor makes the case that, no, you're not
10 innocent and therefore the defendant would have to
11 prove innocence based on that.

12 Well, the health rule is rightly based on
13 presumptions, but would have a profound impact on
14 public and private health. I'll give a couple of
15 examples. The reason I'm giving these examples is
16 because we ought not set presumptions with respect to
17 health information technology that are completely
18 separate from or devoid of the knowledge that we have
19 presumptions in the health care world already.
20 They're important presumptions and lead to very
21 different results in the case of the way that they
22 are set up.

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1 (Slide.)

2 MR. BURDE: So let's look at them. If we
3 look at legal presumptions in public health, we have
4 a presumption. Vaccinations came up earlier with
5 respect to Katrina. There is a presumption in this
6 country in every single state that parents will have
7 their children vaccinated for certain diseases. The
8 presumption is that's the law. You will do it or you

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9 kids will not enter kindergarten. However, that
10 presumption may be overcome in every state because of
11 religious objection, in every state because of
12 countervailing medical needs. In other words, if the
13 kid has an allergy to a particular vaccine and in 10
14 states for philosophical objection.

15 I should note that in a recent JAMA
16 article summarized by Dr. Paul Offutt in last
17 weekend's Wall Street Journal, the use of a
18 philosophical objection has led to deaths of kids in
19 every case where it's been exercised. But this has
20 been a huge public health success. The presumption
21 is that kids will be vaccinated because of that
22 presumption and because overcoming that presumption

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1 requires an act of the parents. We have basically
2 wiped out rubella pertussis, polio, mumps. By
3 contrast, what do we do with organ donations? I
4 realize it's a sensitive subject. That's exactly why
5 I'm bringing it up.

6 The presumption is exactly the opposite
7 with respect to organ donation. We must actively opt
8 in to donate our organs. Now in this country -- 20
9 years ago I had an argument with a law school
10 professor about this. In this country we have to opt
11 in. Our organs cannot be donated for purposes of
12 transplantation unless we actively agree ahead of
13 time and after we die and no longer need the organs
14 that they can be transplanted to somebody who does.

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15 In western Europe, the presumption is the
16 opposite. What is the public health result? The
17 public health result is that in this country we have
18 dramatic shortages of transplantable organs, which
19 can save people's lives. In the EU countries, they
20 do not have those dramatic shortages. The legal
21 presumption has a dramatic impact on the public
22 health implications.

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1 Now a third example, fluoridation of
2 water. Walter Strong Haven warned us 40 years ago,
3 communism, these decisions are made by communities or
4 by the water systems. I have sadly never lived in a
5 jurisdiction where they fluoridated the water. My
6 grandmother, who immigrated from Poland in the early
7 part of the last century always lived in places where
8 they had naturally fluoridated water. And
9 consequently, when she passed away, she had every one
10 of her original teeth. But the presumption is that
11 the community can make a decision about the health of
12 individuals and the health implications of
13 fluoridated water, not only to dental health but
14 mental health and other issues.

15 (Slide.)

16 MR. BURDE: When we talk about when health
17 information may be sent and received, and we talk
18 about setting the presumption, when and under what
19 circumstances may information flow with consent,
20 without consent, and over objections, what are the

21 implications of those objections to the public
22 health? Naturally, the free flow of information for

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1 treatment purposes, leaving aside other things, has a
2 dramatic impact on improving public health. They
3 improve public health because people can get the care
4 they need when they need it if the providers have the
5 information they need to make decisions.

6 Now we have talked and people have talked
7 about it being adequate. Let me describe HIPAA in
8 the way the law actually describes HIPAA. We're not
9 going to go into a HIPAA discussion. HIPAA says that
10 health information, protected health information may
11 not flow, may not be transmitted or used for any
12 purpose other than treatment or operations with
13 limited exceptions for purposes of public health.

14 The privacy discussion, over time, has
15 shifted where everybody hears on the argument that we
16 don't have enough privacy protection can say, well,
17 look where this information goes. I think this goes
18 to what Senator Moore, I believe, you identified as
19 secondary uses. We may want to address the issue of
20 secondary uses, but we need to retain focus on the
21 purpose, which is have information flow for treatment
22 purposes and to set presumptions that allow that to

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1 occur.

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2 I must also state that consent itself can
3 be chimerical. How so? Well, if on benefit
4 selection, the people who sign up for their health
5 coverage, at that point in time sign many releases,
6 most without reading the page they're signing, let
7 alone the SPD -- I'm sure Commissioner Cline can
8 testify to that. Most people don't know what's in
9 their health policy, let alone the summary
10 description of any paper they sign, yet that is a
11 form of consent. Is that adequate consent? Is that
12 the consent we're discussing? Do we want to set a
13 system where we allow consent for certain things that
14 are really sensitive?

15 In fact, if you look at the system now
16 where most states have laws with respect to specific
17 kinds of information -- mental health, drug and
18 alcohol, HIV/AIDS, genetic information. If those
19 exceptions all were to be carved out, maybe there's
20 wisdom in the way that we have developed a system.
21 I'm not saying the system is perfect now, but we've
22 already recognized there are certain sensitive areas

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1 and that those need to be addressed and considered as
2 we develop the presumptions of when information flows
3 or needs to be considered.

4 (Slide.)

5 MR. BURDE: I want to quickly get to a
6 couple of issues because this really goes to the
7 points of liability. We ought not do this without

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8 understand where we are on liability issues.

9 (Slide.)

10 MR. BURDE: That is basically under
11 medical malpractice. There are three things you need
12 to know. Again, this is a bit of a law school
13 primer. There has to be an injury. The standard of
14 care would have to be breached. The standard of care is
15 set by testimony by expert witnesses. Who those are
16 is generally a function of state law. The breach of
17 that standard leads to injury and is the proximate
18 cause of that injury. That, in a nutshell, is a
19 malpractice case. In release of information, does
20 information have to be used -- does failure to use
21 that information breach the standard of care? Does
22 putting in incorrect information into the record,

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1 which might be done for good purposes, breach the
2 standard of care?

3 (Slide.)

4 MR. BURDE: And who can be a party? For
5 example, as we set up health information networks or
6 RHOs, can they be subject to malpractice liability?
7 The answer generally is thought to be no because they
8 don't have a provider/patient relationship.
9 Nevertheless, you need to watch out for other kinds
10 of liability that may exist.

11 (Slide.)

12 MR. BURDE: In the interest of time, there
13 are three cases on the subject of whether records

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14 need to be consulted. And if you look at what those
15 cases say, one says yes. Records must be consulted.
16 If information is available, the treating provider
17 must use it. I wanted to address this issue
18 specifically and race to the slides to get to it
19 because that is the most common question I receive
20 from the ultimate recipients of electronic health
21 information. Do I have to look at this?

22 Now there is something a bit upsetting

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1 about a doctor saying, gee, there's information about
2 the patient that I'm treating available to me in real
3 time that I could use to treat a patient, but I'm
4 scared to look at it. That has Hippocratic Oath
5 issues, but it also is a little bit disconcerting.
6 Why wouldn't they want to look at this information?
7 What do they do with it? What is the purpose of that
8 information?

9 First, two cases. One in Illinois, one in
10 Texas say no, the doctor doesn't need to look.
11 However, if you look at what I call the inexorable
12 progress of American jurisprudence, both in medical
13 malpractice and in every other field of endeavor, as
14 innovation leads to less expensive means of
15 protecting people, that becomes the standard of care.

16 (Slide.)

17 MR. BURDE: Of course, we'll adopt that as
18 the standard of care, whether it's lanterns on a
19 barge or a tug boat or glaucoma testing or fetal

20 monitoring or medical management in a nurse call
21 center. Courts have recognized that as technology
22 makes things, especially medical diagnosis and

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1 treatment easier and faster, that, in and of itself,
2 becomes the standard of care.

3 You'll note that AHIC and the Blue
4 Cross/Blue Shield Association for this year have
5 decided that the development of PHRs is going to be
6 at the cornerstone of what they do. I think that's a
7 really good thing. You may wish to look at one of
8 the reasons they did that. It is extraordinary and
9 expensive for payers to take their claim lab medical
10 management data and reduce it to a payer-based health
11 record, which may not be perfect, but provides a
12 tremendous amount of information to patients and
13 their treating providers.

14 Clearly, whether a court might at some
15 point say in a malpractice action -- you know, the
16 payer knew about this when it made a medical
17 management decision and didn't share that
18 information. Now I may be cynical in thinking that's
19 why AHIC and Blue Cross/Blue Shield Association
20 approached that information. I have inside
21 information that there's at least one of the things
22 they considered. And even if it is, it's a good

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1 decision. It's a really good thing that they're
2 doing to make that information to people to build
3 their own personal health records populated by
4 information that payers already have. And let's face
5 it, the payers have information across providers and
6 providers don't have information across providers.

7 (Slide.)

8 MR. BURDE: Well, I elect the summary to
9 you. I realize that we are short of time. Again,
10 let's focus on the goal. The goal is to make certain
11 information available so treatment can be provided at
12 the right time and the right place and that we can
13 structure a real presumptions in a fashion that
14 allows that to happen and a standard of care will
15 evolve.

16 (Slide.)

17 MR. BURDE: One last thought. This is
18 specifically directed to those who deal with the
19 insurance system and Commissioner Cline. One aspect
20 of the system we haven't focused on, and I didn't
21 write it here, is that we ought consider -- if you
22 really believe that using health information

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1 technology improves quality and safety, then we need
2 to bring the liability insurers into the equation.
3 Maybe discounts. Another way to fund this would be
4 discounts with those providers who are early adopters
5 and users of electronic health information.

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6 With that, I turn it back to you.

7 DR. SUNDWALL: Thank you very much.

8 I'm supposed to, if I read my script, make
9 a brief summary. Then we'll open it up to questions.
10 So let me just get out detracting to these very fine
11 presentations and thank you very much, say that Lisa
12 Robins, you shared with us some of the concerns of
13 the FSMB. The license portability thing is so clear.
14 Whenever we have an event to respond to,
15 notwithstanding any disaster or pandemic or any
16 unusual circumstance, neither doctors nor patients
17 behave as though there are exact state lines. We
18 know that with our proximity to Wyoming or down in
19 the Four Corners area, but it certainly in many
20 metropolitan areas, you straddle states. So you need
21 to modernize the process of licensure and centralize
22 the data.

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1 I couldn't help but reflect a bit. If
2 there's some kind of model for this, then the
3 National Practitioner Data Bank, which is a federal
4 repository of information on physicians who have
5 claims made against them, should be made available to
6 the public or a suit settled. I can't remember. It
7 was only adjudicated cases or claims made that
8 regardless it's considered a national responsibility.
9 But what you're asking for with the FSMB is some kind
10 of centralize data system on prevention.

11 I appreciated your --. Again, speaking as

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12 a state health officer, I'll tell the audience that,
13 in fact, the prescription of drugs online is not just
14 for ED, erectile dysfunction or hair growth.
15 Unfortunately, there's a promotion of eprodes all the
16 time. Vicodin, Oxycontin -- I don't know how they do
17 it, but they've somehow become available. It's a
18 public health problem. It's not just for
19 recreational drugs.

20 Also, I think you asked us -- I think you
21 were saying you would ask us to develop model
22 legislation that might help you settle standards for

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1 us. I would turn that back to you and maybe
2 encourage my colleagues on this important committee
3 or panel to say you have a good track record for
4 developing model legislation. You've done it for
5 what constitutes appropriate regulation of doctors at
6 the state level. We may be turning that task back to
7 you, but you raise an important question. Also, like
8 I say, you have a track record there.

9 Howard Burde, thank you for your legal
10 primer. I, as a physician, am always intrigued by
11 how the legal mind thinks and we've had a good
12 introduction to that. I would just question one
13 statement you made that there are no statewide RIOs.
14 In fact, if you'll allow me to toot my horn for just
15 a second, Utah has such. We've had a statewide Utah
16 health information network for decades that processes
17 over 90 percent of all claims for insurance. That's

18 doctors, hospitals, dentists. It's a remarkable fete
19 and it could happen in a place only that's relatively
20 small and where there's cooperation. We've building
21 upon this with federal funds. We exchange clinical
22 data and we're moving towards that at the statewide

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1 level.

2 Your discussion of cost and on legal
3 presumptions is most welcome and I think that your
4 focus on privacy and liability were very informative.
5 I won't repeat the summary that you just made, but we
6 appreciate I guess, if nothing else, we need to be
7 cautious as we interpret legal presumptions because
8 of their implications on public health and liability
9 issues.

10 Thank you very much.

11 I'd like now, not to ask you a question,
12 but ask if members of the panel would like to pose
13 questions to you. Yes?

14 REPRESENTATIVE CONAWAY: Thank you. I
15 guess by way of disclosure, I should say I'm also a
16 lawyer, although I don't practice. Listening to your
17 discussion about what a physician knows is a very
18 interesting question of when liability will attach.
19 As a primary care physician, patients go to
20 specialists and then the hospital. Information
21 sometimes gets back to my records by snail mail and
22 of course, I review that. Now in an era of the more

1 rapid flow of real time of information sharing and
 2 links between the lab and the radiologists are right
 3 back into my EMR. There may be things that land in
 4 that record now that I might see, depending on how my
 5 EMR works, I think that this panel, perhaps, to think
 6 about should states develop standards for EMRs, which
 7 would require them to file things that hit the
 8 record.

9 In my office, my secretary puts these
 10 things before me and I start to go through them and
 11 put a little mark on there. We do that, one, to
 12 protect myself, but also to make sure I've provided
 13 good care. There are a lot of people who hoard
 14 things that land in my records and there's liability
 15 attached. Maybe we should think about putting in the
 16 standard for EMRs that would allow for those records
 17 to be flagged and not just enter the record until
 18 such time as they're reviewed. But I want you to
 19 comment on that.

20 The other thing is, in terms of the
 21 standard, you had a case alluded to. There was an
 22 emergency room physician case that landed in that

1 particular practice that had a very extensive
 2 clinical and medical record. They were able to show
 3 what the standard of care was for a particular
 4 procedure by reviewing what 200 doctors did across

5 the state. That established the standard. That was
6 used to defend the physician in court. I wonder -- I
7 have concerns when you say that courts are going to
8 say what the standard is rather than looking at what
9 the practice is in the real world and then developing
10 standards, saying what the standard is based on
11 practice, pattern and practice, which is what I think
12 it should be. Your comments?

13 MR. BURDE: I think that's a fair comment.
14 Courts, when they operate, don't make up things
15 based on what they think good policy ought to be.
16 What happens when courts recognize the new standard
17 is they recognize the developments that occur in the
18 community and then establish a standard recognizing
19 that the ground just shifted. The examples that I
20 put up with respect to glaucoma testing or fetal
21 monitoring. The fetal monitoring case may be the
22 best example. A diabetic woman who was pregnant went

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1 to her physician, her obstetrician, gynecologist. He
2 decided that by palpating her stomach he was better
3 able to determine the progress of the baby rather
4 than using an available fetal monitoring equipment.

5 Well, the fetal monitoring equipment had
6 been available for 20 years. He just never got used
7 to using it. So the court said, you know something,
8 this has been around long enough and it's available
9 and it's inexpensive. Why wouldn't you use it? So
10 it's not the court reaching, but rather the court

11 recognizing and I think that's what happened in each
12 of those cases.

13 Does that answer?

14 MR. CARTER: I have a question for you,
15 Lisa. We're all concerned about things that are
16 transactions that are taking place over the Internet.
17 Obviously, there are some questionable ones relating
18 to the medical field. But you've mentioned that
19 there are some state laws that have gone into place
20 or regulatory efforts that have actually impeded
21 legitimate telemedicine. Could you share one or two
22 examples of that?

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1 MS. ROBINS: I'd be pleased to. I don't
2 believe, at this point, that they've been interpreted
3 as such, but it's so difficult to regulate these
4 things. Some states have set in place policy
5 statements that require an in-person examination.
6 Well, if interpreted literally, legitimate telehealth
7 interaction would not fall into compliance with that
8 policy. For that reason, our policy, as a general
9 policy, is that the practitioner would have access to
10 such information. Clearly, it's not always feasible
11 that there be a personal evaluation.

12 DR. TUCKSON: Could you, Lisa, describe
13 the slope of the curve on the number of states
14 adopting these interoperable licensure for
15 telehealth? You mentioned there were 11. Is that 11
16 stagnant as of three years ago or is it 10 in the

17 last one year?

18 MS. ROBINS: It's actually been fairly
19 stagnant for a period of time. There are a number of
20 states that telemedicine licenses work very well,
21 particularly states with large rural populations and
22 it's basically just a registration where the

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1 registration is based on a restrictive license in
2 another jurisdiction. It allows the physician to
3 provide services within the state. We believe it is
4 a good incremental approach, sharing information that
5 forces them to rely on each other is probably better
6 because it's not just limited to telemedicine.

7 I would like to clarify. I'm sorry if I
8 was misleading. I had a national database that would
9 replace the physicians doing their own licensing
10 evaluation and qualifications. I really think it's
11 more the sharing of information. The board would
12 have some interoperable system that they would be
13 able to share these credentials and qualifications as
14 well as disciplinary information. This now requires
15 some sort of interstate agreement, a compact among
16 the states. That the states -- it's imperative,
17 legally, that the state have authority of physicians
18 practicing within the state.

19 DR. TUCKSON: Very quickly then, so we're
20 focused as a committee -- several comments have
21 already been made as to important people think this
22 area might be. Is there a reason why the state

1 boards have not joined the 11? Is there something
2 that would be appropriate for us to consider to spur
3 that process on?

4 MS. ROBINS: As far as the telemedicine
5 license, I think it's been pushed back within the
6 states, from the states that have tried to adopt
7 telemedicine licenses from the profession within the
8 states. There was an issue several years ago when a
9 lot of the services were leaving the states. As far
10 as participating and information sharing, we have a
11 grant to assist the board to put this process in
12 place and I believe we have support from all of our
13 membership as far as this project goes. It's always
14 an effort to do a registration project because we're
15 able to identify funding that would support it. I do
16 think that there is a willingness and boards are
17 interested in making the process more user friendly
18 and also if it would increase quality or improve
19 quality, we'd be able to share information about
20 physician qualifications.

21 DR. SUNDWALL: Mr. Rodgers and then Mr.
22 Sensor.

1 MR. RODGERS: Could you talk a little bit
2 about the role of licensure credentialing

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3 privileging of a hospital as to where these standards
4 might be placed to require electronic exchange and
5 the difference between an open system versus a closed
6 system like veterans where there seems to be a
7 different way that we look at health care information
8 exchange imposed systems, which you could Medicaid
9 and Medicare an open system or a system that could
10 require that type contract? This is for both

11 MR. BURDE: There's a lot of that.
12 Frankly, it would probably not be an effective
13 approach to use the boards, the state licensure
14 boards to mandate particular technologies, a use of
15 particular technologies. Frankly, the doctors are
16 going to have to adopt those technologies anyway to
17 practice good medicine. What you may find is that
18 doctors who fail to adopt technologies, either as
19 defendants in a malpractice action or somebody brings
20 a complaint to a state board saying, you know, under
21 your general authority to ascertain and to assure the
22 quality of the practice of medicine, these doctors

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1 who don't use this technology are not meeting that
2 standard and that's how it would arise without the
3 boards having to generally adopt through a
4 legislative or regulatory process. It's simply a
5 much more likely way that that tool will occur.
6 Having said that, one or two states or state boards
7 adopting requirements with respect to technology,
8 again, fits the landscape with respect to adoption by

9 other states and by courts.

10 In the Medicare/Medicaid question, which
11 is a separate one -- gosh, wouldn't it be great if we
12 could use the Medicaid and Medicare systems to
13 advance -- frankly, in some states we're seeing that
14 happen in different ways appropriately. States are
15 doing things to use the Medicaid programs and the S-
16 CHIP programs by contract to move adoption. The
17 Medicaid program, by its very nature, moves more
18 slowly.

19 MS. ROBINS: I agree with that. We should
20 give incentives to the doctors to put those in place.

21 MR. SENSOR: Thank you very much. I would
22 add my congratulation and appreciation to the two

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1 speakers. I think you framed the issues wonderfully.

2 Mr. Burde, that was one of the best legal
3 primers on the challenges we face I've ever heard.
4 You provide a wonderful framework to help information
5 protection taskforce to have to try to figure out how
6 we deal with those issues regarding interoperability
7 and information.

8 Like so many of my colleagues around this
9 table, we, in the fine state of Nebraska, have our
10 own interoperability effort underway. NEHI, Nebraska
11 Information Interoperability, taking off Mr. Burde's
12 comments, I think it's exceptionally important that
13 the appropriate stakeholders all be at the table.
14 We've been pretty much focusing with the insurance

15 companies, business and industry, government as well
16 as the entire provider community because all of us
17 have a stake in getting this to consumers and doing
18 it right. In our state, although we've slain this
19 dragon yet, we're trying to trace the value of how
20 they're funded, trying to get to each one of those
21 stakeholders and figure out what does it do for them.
22 Therefore, how can we pay for the thing going

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1 forward.

2 Mr. Burde, I know you said this perhaps
3 causally and in passing, and I learned a long time
4 ago never to argue with an attorney in a public
5 forum, so I'm simply going to recast because I feel
6 compelled. You made a causal comment about doctors
7 or a doctor being scared to look at information. You
8 talked a moment ago about unwillingness to adopt. I
9 will tell you we have 12,000 physicians working in
10 our health care system. I have a tremendous amount
11 of affinity and affection for those physicians and I
12 think the real challenge for us, as we move down this
13 path of interoperability, is to bring our physicians
14 along the journey. It's got to be real time. It's
15 got to be integrated in the workflow and we've got to
16 find a way they can afford it because right now
17 health care in America is delivered in physician
18 practices of two or three doctors and we can't expect
19 them to put \$150,000 on the table to build a system
20 that we think is good, we believe is good and some

21 day will prove it's good.

22 I know you said that just in passing. My

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1 notion would be that we get product and process in
2 place. I'm going to give the medical staffs of
3 America time to adopt.

4 MR. BURDE: I would agree that doctors are
5 very quick to adopt technologies that they view is
6 aiding their practices with their reasonable
7 investment and a decent return in a short period of
8 time. That's a good place to start. They all use
9 new medical technologies and if they view that as a
10 better way to treat their patients, I think that's
11 absolutely the case. I will say that it's a personal
12 experience -- not a personal medical experience, but
13 professional experience -- where, if I may share this
14 with you, I represent a number of community cancer
15 treatment centers and it's terribly sad that the
16 doctors did not want to rely upon a notebook, which
17 their patients used to reflect their actual
18 condition. Why is that? Well, cancer patients are
19 scared. We all would be. And often, when they're
20 face to face with their physician, with their
21 oncologist, they don't tell the truth about the
22 conditions, how they're feeling. Therefore, they

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1 don't get the right drugs at the right time. Using

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2 the notebook, they're more honest because it isn't as
3 daunting. You're not trying to be good. So what we
4 need to do is get the doctors over the liability hump
5 where they're worried about what's there so they can
6 get the information that will help them. That's
7 really what I was referring to. I didn't mean to do
8 it in passing.

9 DR. RUFFIN: DeVore?

10 MR. DeVORE: I want to make it very quick.
11 I'd love to know a little bit about this
12 demonstration project. Were you at in this? Is
13 it underway? When is it ending? Also, the
14 definition specifically of telemedicine. The reason
15 I'm asking that is, as a large employer, obviously,
16 you've notice the aging wave coming down the pipe.
17 We can predict the ultimate growing cost that are
18 driving the system. I think there are obviously more
19 and more uses of remote care, not just telemedicine,
20 but you've got the aging parents, the Baby Boomer is
21 taking care of parents in Connecticut. In
22 California, doctors could be who knows where. I'm

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1 Looking specifically at telemedicine as sort of
2 contained as you plan this into more of a broad mode
3 of health care.

4 MS. ROBINS: We were awarded the grant in
5 September this year or last September and we've just
6 gotten underway. The two states are meeting and
7 we're in the middle of doing a legal policy and

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8 technical analysis. It's not limited to telehealth.
9 This is being administered by the Office for the
10 Advancement of Telehealth, so, of course, we believe
11 it will benefit the expansion of telehealth services,
12 but it's not limited to telehealth. That's why I
13 mentioned it's an incremental step, an incremental
14 approach, but it's not broad enough and obviously the
15 way medicine is practiced, it certainly doesn't
16 recognize state borders.

17 DR. RUFFIN: A quick observation and then
18 ask a question of Mr. Burde. The observation is that
19 we should not think that we have to implement \$50,000
20 intervention systems for every doctor in order to get
21 the benefits of electronic health information
22 exchange. They didn't have to do that in Katrina and

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1 they got a lot of benefits. There's an awful lot of
2 information that is stored in transaction systems
3 today -- lab results, medications, diagnoses and
4 procedures.

5 The beauty of what Dr. Kolodner is
6 leading, he's given us the standards for those basic
7 data to be exchanged between transaction systems that
8 do not have to be standardized. Yes, the full
9 medical record is ideal, but we will never reach a
10 point where every doctor, including the rectal
11 surgeons and the orthopedic surgeons agree on the
12 complete structure of clinical documents in a medical
13 record system. The best we can hope for is that we

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14 extract from whatever transaction systems doctors and
15 hospital use, diagnose the procedures, lab results,
16 medications and a few other key items that doctors
17 need to take care of patients. It's not the perfect
18 solution, but the perfect solution, as we've
19 discovered in England, is far too expensive and far
20 too difficult to accomplish.

21 The question I have -- that's an editorial
22 comment. But we need to keep in mind there's a big

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1 difference between a full electronic medical record
2 and having electronic data available to doctors that
3 will help them take care of patients.

4 The question for Mr. Burde has to do with
5 West Virginia code. You may not be familiar with it,
6 but the question is West Virginia is one of the
7 leaders, lead by Governor Maben, in promoting health
8 information exchange. The governor proposed and the
9 legislature passed, about a year ago, Article 29(G)
10 of the West Virginia Code that created the West
11 Virginia Health Information Network and in that law -
12 - and this is my question. As I understand it,
13 there's a paragraph that says, whether or not a
14 doctor uses the network, cannot be used as the basis
15 for lawsuits. If the physician makes errors, neglect
16 errors that lead to injury to the patient, that
17 physician can be sued no matter what medical record
18 system he or she is using. But just the fact that
19 the physician did or didn't check the system, isn't

20 grounds for a suit. That's my understanding, but I'm
21 not an attorney. Are you familiar with this?

22 MR. BURDE: No, I'll be happy to look at

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1 it. I'd like to address the question first and then
2 your comment.

3 With respect to that limitation on my
4 ability, while I understand the desire of the medical
5 establishment not to require doctors to access a
6 network, one of the greatest causes of action or most
7 common causes of action for medical malpractice is
8 failure to diagnose and that is based on information.
9 Now we can say the law may indeed protect these folks
10 and I don't wish to question the wisdom of the West
11 Virginia legislature or governor, and especially not
12 having read the law. I'm not willing to go to that
13 level of malpractice myself.

14 (Laughter.)

15 MR. BURDE: With respect to your comment,
16 I absolutely agree with you and I suggest for the
17 panel's consideration help coordinate a study of the
18 use of peer-based health records between Blue
19 Cross/Blue Shield and Christiana Care emergency
20 rooms. That's worth looking at. The HCSC, which is
21 Blue Cross/Blue Shield of Illinois, Texas, New Mexico
22 and Oklahoma, is basically implementing its peer-

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1 based health record for all of its network providers.
2 Again, there's nothing perfect about a peer-based
3 health record. They can be very good and we can
4 provide largely the information you just suggested to
5 Mr. DeVore's thing about doing what you can do now.
6 This is one of those things you can do now and that
7 states should consider with their Medicaid programs,
8 especially, since Medicaid beneficiaries tend to have
9 the highest rates of ER use of the population.

10 Secondly, as Medicaid and then, of course,
11 the financially uncovered population. Let's think
12 about if that's a good first step in getting people
13 to start with a system and not need to make great
14 investments.

15 MR. CARTER: Jane?

16 COMMISSIONER CLINE: Just to try to point
17 out a little history on West Virginia. West
18 Virginia, in 2001, had the great pleasure to form a
19 state-ran medical malpractice alternative for our
20 physicians because clinical malpractice was not
21 available. So through much pain and agony, we have
22 had some CERA-justice reform. We have formed a

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1 physicians mutual, things of that nature are put in
2 our code. It doesn't mean they will hold up when
3 they reach the Supreme Court level and the number of
4 reforms that we actually passed in '01, '03 and
5 Governor Maben's most recent initiatives have not

6 reached that level. So I think that Howard's points
7 really are very well on point, having had the
8 experience of a very litigious environment and very
9 creative opportunities for suits to be filed against
10 physicians.

11 The aspect is it's not just what happens
12 when you have a false claim filed. There's still a
13 huge drain on the part of the medical liability
14 provider and there is a huge drain on the physicians
15 themselves that are going through that and the
16 physicians partners and the whole delivery system.
17 So it is something that I think, even though you put
18 it in protection and you think the code is going to
19 uphold it, doesn't mean the court is. Then there's
20 also the really horrendous case that does come out.
21 I don't mean to sound like I'm all anti-consumer,
22 anti the patient, because clearly I'm not. We want

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1 the patient to get the best remedy and be taken care
2 of when there's been true malpractice, but failure to
3 diagnose is one of the things you do see over and
4 over. And it's like we often see a bad outcome,
5 which is not necessarily malpractice generate the
6 claim that further puts the whole drain on the system
7 and so the legal aspects are something I think we
8 need to be very cognizant of.

9 And just to address Lisa's issue, having
10 been involved in a number of state government
11 entities responsible for licensing issues, it is a

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12 major challenge that we have to look at and address
13 because you get into jurisdictional battles. You get
14 into turf battles and all those things and greatly
15 impede the system. So I think both speakers really
16 had some very valid points that we'd have to take
17 into consideration.

18 MR. CARTER: Thank you. We're a couple
19 minutes over our time. So I think we'll draw the
20 morning portion, which is now in the afternoon, of
21 our meeting to a close. We'll take a brief recess.
22 I think about 45 minutes. We'll be back at 1:15 and

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1 we'll lead off with health information protection
2 systems as our next panel. Thank you, panel.

3 (Lunch recess.)